

CULTURAL INFLUENCES ON THE USE OF BIOMEDICAL REPRODUCTIVE
HEALTHCARE IN THE ANDEAN HIGHLANDS

by

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Abstract

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This thesis demonstrates some of the many ways that indigenous women in the Andean highlands are influenced to utilize indigenous medical and biomedical reproductive healthcare services and contraceptive methods. It focuses on some of the deeply rooted influences that affect choice of care, in particular, the cultural construction of the female body, gender roles and authority, the theories and practices of biomedicine in relation to those of indigenous Andean medicine, and the historical exploitation of indigenous Andean groups.

Chapter 1: Introduction

The intersection of indigenous and biomedical systems and ideals has become a popular topic of study in recent decades as a result of the rapid pace of globalization (See Aizenberg 2014, Koss-Chioino, Leatherman, and Greenway 2003, and Rasch and Bywater 2014). In the rural communities of the Andean highlands, biomedicine has become increasingly accessible over the last thirty years, causing a change in healthcare practices and the understanding of how the biological functions of the body work. In indigenous medical systems of the Andean highlands that are tied by religious and humoral theories (Bastien 1985), the introduction and promotion of biomedical theory has caused interesting and varied problems in the medical practices and understandings of the region.

The promotion of biomedicine can be seen in practices and understandings surrounding women's healthcare, specifically menstruation, pregnancy, and childbirth. I discuss some of the ways in which indigenous women have come to incorporate biomedical principles and methods into their preexisting medical ideology. For instance, in locales where biomedicine is readily available, pregnant women choose to take advantage of both biomedical and indigenous services in an attempt to gain the best prenatal healthcare possible (Torri 2013). However, in many cases, the use of biomedical services and contraceptive methods are influenced by economic, geographical, social, and

cultural factors, which I analyze in this thesis. As biomedicine's presence in the Andes grows, it becomes increasingly important to understand how it is directly and indirectly influencing preexisting regional perceptions, such as the way the female body is fundamentally understood.

Statement of Research

The focus of my research is the Quechua- and Aymara-speaking indigenous populations who inhabit the Andean highlands of Bolivia, Ecuador, and Peru. This wide geographical range of study is a result of the many different locations of preceding scholarly research. The indigenous groups that are discussed in the scholarly works I have used are geographically scattered throughout the Andean highlands of Bolivia, Ecuador, and Peru, although many of the specific geographic locations are not readily available as a result of the practice of confidentiality in anthropological publications. Although I have used data that includes this large region and I discuss many similarities between the practices and perceptions of indigenous groups, I have attempted to not overgeneralize or assemble the different indigenous groups of the region together into one single indigenous entity. One way that I have attempted to do this is to identify the group of people or, more plausibly, the region or country which I use as a specific example took place, when that information is available.

My research focuses on women's reproductive healthcare and the ways in which the female body and its biological reproductive functions are perceived in light of the merging of the indigenous Andean- and biomedical systems in the Andean highlands. I

analyze how the female body and the biological reproductive functions of menstruation, pregnancy, and childbirth are perceived through the indigenous medical systems of the Andean highlands, and more importantly, how indigenous women view biomedical services and practitioners and the factors and how these views contribute to women's choices of care.

I also examine the forces behind the promotion of biomedicine in the Andes and what the campaigns entail. I found that the promotion of biomedical practices by government programs and nongovernmental organizations (NGOs) have influenced the types of care sought after by indigenous women in the Andean highlands (Gold and Clapp 2011; Torri 2013; Bradby 1999). I was particularly interested in researching how indigenous and biomedical practices are being used in accordance with or in opposition to each other in regards to contraceptive use and prenatal and delivery care in the Andean highlands. In my research, I found the two medical systems are often used by women in the Andes in conjunction with each other when available in order to gain the best prenatal care available through both systems (Torri 2013).

Because the two medical systems have often been viewed as being in opposition to one another, a set of social preconceptions and prejudices have arisen in association with each system. For instance, in the Bolivian highlands, "to admit to giving birth at home means admitting to being still rural, Quechua-speaking, economically poor, and oriented to tradition, rather than having made the transition to urban, Spanish-speaking, more affluent, modern ways of life" (Bradby 1999, 290). Because biomedicine is often acknowledged as being linked to the idea of modernity while indigenous medicine is

associated with and indigenous identity, the corresponding stigmas attached to the use of each system have come to affect the type of treatment women seek during pregnancy and childbirth. I explored existing literature for not only how the practices surrounding menstruation, pregnancy, and childbirth are perceived as modern or indigenous by Andean women, but also how these associations affect the prenatal and birthing practices and methods of fertility control that women in the Andean highlands choose.

Significance of Research

As social and political agendas continue to shift towards the biomedical model of healthcare, it is important to examine how the practices of biomedicine are affecting pre-existing Andean perception of the body, health, and illness. Based on my research, it is apparent that although the indigenous practices are to some extent being incorporated into biomedical facilities in the Andes, there is no suggestion that the cognitive differences of the two medical systems have been taken into significant consideration by those implementing the procedures of medical facilities. Whether intentional or not, it appears as though the biomedical epistemology is being introduced without consideration of the existing medical perceptions, thus creating a principal emphasis on biomedical theory and techniques. This indicated the need to investigate the relationship between indigenous and biomedical methods of pregnancy and childbirth in order to understand how the introduction of biomedicine is being received by indigenous women in the Andean highlands.

The ways in which different cultures understand and interpret the biological activities of the human body lead to differences in how those activities are treated. As mentioned previously, this is evident in the works of several scholars who emphasize the importance of historical and cultural context in understanding a given medical system. The differences in interpretations of the body are evident in the practices surrounding pregnancy and birth in the Andes. It is through textual analysis that I demonstrate how the introduction and promotion of biomedicine in the Andes has influenced the perceptions of female reproductive healthcare as the two medical systems intersect in the region. My research therefore serves as a contribution to addressing the concern of the changing healthcare scene in the Andean highlands as it pertains to female reproductive health.

Definitions

In the context of this thesis, I use the term *biomedicine* to refer to the medical system based in scientific theory as it is practiced in the United States, which “has emerged as a seductive standard for developing nations’ aspirations” (Jordan 1978, 49), and by *indigenous Andean medicine*, I refer to the system of medicine that has been and continues to be practiced by the indigenous peoples of the Andean highlands before the introduction of biomedicine. Each system has come out of very different cultural contexts and therefore differs in its approach to how health and illness are understood and treated. On one hand, biomedicine is based on scientific theory; attributes illness mainly to physical causes as opposed to social, cultural, communal, and until recently

psychological causes; employs technology as a key tool for diagnosis and treatment; and maintains highly regulated and institutionalized training. On the other hand, indigenous Andean medicine combines humoral theory with supernatural, social, and physical factors that are specific to the worldview, local histories, and natural environment of the indigenous communities of the Andean highlands to determine the cause of illness and supports apprenticeship-based training.

Structure of Thesis

I begin this thesis by providing the reader with the historical and cultural context for subsequent chapters. In the following section, I offer an overview of the pre-biomedical indigenous medical system and how the body is perceived within it. I then give a brief history of the development of biomedicine from its predecessor, European medicine. In order to set up the topics discussed in later chapters, I provide the historical framework of the introduction of European medicine into the Andes by the Spanish, discussing the means and goals through which biomedicine was introduced.

The second chapter of this thesis discusses literature regarding women's reproductive healthcare and the indigenous Andean and biomedical medical systems. This section serves to provide additional context and basis for my analysis of women's reproductive healthcare, as well as of gender and body constructions, and authority, and choice.

Following the description of my research and analysis methods in Chapter 3, I give three chapters of analysis, which are followed by my conclusions and final

reflections. In Chapter Four, I go into more detail about the indigenous perception of the body, specifically the female body and the biological functions pertaining to reproduction. In this chapter, I demonstrate how that the female body's reproductive abilities have entrapped women in the nurturing and caring role of motherhood.

Chapter Five begins to analyze one of the contributing factors that lead to the avoidance of biomedical services by indigenous women: the negative encounters between indigenous groups and biomedical personnel. Using the accounts of indigenous women, I demonstrate how they have been mistreated and violated during biomedical examinations. I then discuss the significance of what are known as fat-stealers to biomedicine and specific actions of biomedical doctors and political leaders and how such beliefs continue to contribute to the negative perceptions of those in positions of power and of non-indigenous people, in general.

I use Chapter Six to illustrate the desires of women in the communities of the Andean highlands to utilize biomedical healthcare during pregnancy and childbirth, and to obtain biomedical contraceptives. Despite this demand for biomedicine, women face many obstacles in actually obtaining it, some of which I address in depth. In addition to geographical and economic factors, women face the social influences of their husbands and doctors, as well as the deeply engrained beliefs of the indigenous medical system.

Historical and Cultural Framework

In the following sections, I outline the overarching historical medical trends that have led to the current practice of biomedicine in the Andes, specifically with respect to women's reproductive healthcare. I define and illustrate ideologies of indigenous Andean medicine and biomedicine and address the underlying principles of the body, health and illness within these systems. In order to help illustrate the context from which biomedicine was introduced to the Andes, I demonstrate the historical and theoretical framework of its precursor, European medicine.

Indigenous Medicine in the Andes

In this thesis, I use the term *indigenous Andean medicine* to refer to the medical system that is practiced by indigenous populations across the Andean highlands. I am not implying that all indigenous medical systems in the Andes are the same. However, for the purposes of this thesis, I am drawing on similarities that are found between indigenous medical systems throughout the Andean highlands of Peru, Bolivia, and Ecuador. Furthermore, by using the term *indigenous*, I do not imply that the medical system has remained static and uninfluenced since its formation, as it has clearly been adapted and altered throughout history, especially when the region was under Inca and Spanish rule (Bastien 1985; Bradby 1999; Sowell 2001). Although scholars debate the precise extent of European medical influence on indigenous Andean medicine, it is clear that European medical principles and practices were incorporated into indigenous Andean medicine

over time (Bastien 1985; Bradby 1999; Sowell 2001). Indigenous medicine in the Andes continues to incorporate techniques and theory of outside influence.

The Andean perception of the body

In the Andes, conceptions of the natural and spiritual environments play out directly within and around the body. The Andean worldview places a strong emphasis on animism, and therefore the essence of any object can interact with that of any other (Allen 1982). Because of this, there is a deep connection between the human body and the natural environment, and thus, forces of the environment may affect the body. As a result of the importance of the natural environment, the human body is categorized and understood in the same way the natural environment is understood, as a topographical-hydraulic system (Bastien 1985). The Andean body is directly related to the spiritual world, the natural environment, and humanity. Therefore, health is the result of a balance between these factors and may consequently be compromised by any of them (Cooley 2008).

In the Andean understanding of the human body, the body's hydraulic system and the body's functions are directly related to the community's natural environment and the mountain *ayllu* (Ay., Qu.). The mountain *ayllu* is categorized in the same way that the human body is categorized, in that both have a head, trunk, and extremities (Bastien and Donahue 1981; Bastien 1985). The top of the mountain is considered the point of origin and return for all humans and animals, just as the human head is the point for air, food, water, and other substances enter the human body. The mountain is a living entity that is connected by a hydraulic system of rivers and subterranean streams, which circulate

water and spiritual elements. Throughout the *ayllu* there are sites that directly correspond to specific parts of the human body. These sites can be used to cure illness in a corresponding human body part through ritual and offerings, which serve to empower, vitalize, and influence the mountain *ayllu* rather than to appease it (Bastien 1978). It is through offerings of coca and other objects that the earth spirit may be influenced into delivering good health and wellbeing to family and community members (Allen 2002; Koss-Chioino, Leatherman, and Greenway 2003).

Just as streams and subterranean springs and tunnels connect the mountain, the human body is connected by a similar hydraulic system that is responsible for the flow of primary and secondary fluids within the body. These fluids are also understood to flow between living things and the environment, once again demonstrating the deep interconnection the communities have with their environment. The primary fluids, air, blood, and fat, are responsible for providing life to all living things. Secondary fluids tend to be byproducts of the body and include urine, feces, sweat, milk, and semen. Fluids are regulated by the body's hydraulic system, which condenses, separates, and redistributes them throughout the body, allowing the body to function optimally (Bastien 1985). The emotional and humoral status of each of the primary fluids serves an important function in providing and sustaining life and health, but if their optimal status is not maintained, each of the fluids may lead to illness (Bastien 1985). The positive emotions of the body's fluids are desired for health, while negative emotions bring illness. Likewise, the body and its fluids require a humoral balance between four opposing humors: hot and cold, and wet and dry (Bastien 1985). Under certain circumstances, however, the body must

maintain an extreme humoral state to ensure health and wellbeing, such as during childbirth, when a woman's body must maintain a humorally hot state in order to facilitate and quicken labor, and protect the woman and baby from various illnesses and dangers.

Significance of the three primary bodily fluids

Air, synonymous with breath and wind, is an invisible fluid that provides life to all living creatures. This fluid travels and is shared by all plants and animals. After being concentrated in the *sonco*(Qu.), the heart and the center of the hydraulic system, air is dispersed to the muscles to provide lubrication and movement (Bastien 1985). Air and wind can often take a malevolent form and cause illness when it enters the body.

Malevolent winds are caused by an array of historical or spiritual circumstances. For instance, Allen (1982) describes how the ancestors of a Quechua-speaking community in Peru became malevolent winds and brought illness to the people of the community:

Machula Aulanchis, the benevolent ancestors, blend conceptually with the *Machus* (Old Ones), a race of malevolent giants said to have built the *chullpas* in a moonlit age, before this world began. When *Taytanchis* (Our Father) created the sun, the *Machus* were burned up by its unfamiliar heat. They fled to the springs and *chullpas*, where they remain as mummies and dried bones which walk abroad on moonlit nights, embittered against the human race which replaced them. When the moon shines they visit each other and work their fields – “Which are just where ours are” – and inflict disease and disaster on humans. An evil wind, the *Machu wayra*, blows from the *chullpas*, causing respiratory ailments and skin disease (Allen 1982,185).

In this case, the embittered ancestors take revenge on the humans by causing illnesses and disease. Allen's description also demonstrates the fluidity between the human and spiritual realms, and how they affect one another. In addition to causing respiratory

ailments and skin disease, malevolent winds can also cause muscular complications. Illnesses caused by malevolent winds are often treated through healing rituals that involve cleansing with smoke (Bastien 1985; Froemming 2006; Larme 1998).

Blood is generally considered a non-restorable resource that is vital to providing life. Each human has a limited supply of blood that, once lost, cannot be restored—except by blood transfusion, which is not a common practice in indigenous Andean medicine. Similar to the way air gives breath to the body, blood allows for the body to live. Blood-related illness can be caused by loss of blood or when blood changes viscosity because it becomes too humorally hot (fast), cold (slow), wet (thick), or dry (thin). In order to restore blood to a healthy state, one typically consumes herbs and other substances that balance the blood's state (Bastien 1985; Koss-Chioino, Leatherman, and Greenway 2003).

Fat is a necessary fluid that provides the body with energy. Fat is produced by the body in the bowels and, after being consolidated in the *sonco* (Qu.), is distributed through the body by blood (Bastien 1978). In the Andes, when a person is healthy, he is said to have fat, while a person lacking in fat is considered ill. Fat can either be lost as a result of poor metabolism of fat, in which case there is an insufficient amount of bile present to break up the fat so that it may be distributed from the *sonco* to the extremities, or by being stolen by a fat-stealer (Bastien 1985). The fat-stealer, known as *llik'ichiri* (Ay.), *khari-khari* (Ay.), *kharisiri* (Ay.), *ñak'aq* (Qu.), or *pishtaco* (Qu.-Sp.), is a popular figure in Andean folklore, who steals fat to sell for a variety of uses, such as to make holy oil and luxury soaps or to generate electricity (Blaisdell Ødegaard 2014; Canessa 2012;

Koss-Chioino, Leatherman, and Greenway 2003; Pelaez-Barrios 2011; Wachtel 1994).

The fat-stealer is associated with those who are in positions of power and is said to profit from the exploitation of indigenous peoples. Later in this thesis, I adopt the Aymara term *kharisiri* to describe fat stealers because it was the term that I came across most frequently during my research. Consuming fatty foods and performing appropriate rituals may restore fat that is lost or stolen (Bastien 1985).

Indigenous Andean healers and treatments

In order to cure illnesses in the indigenous Andean medical system, one must address the physical body as well as the spiritual and natural environment that is responsible for specific illnesses. Indigenous healers specialize in different areas of healing, such as herbal curing, spiritual healing, bone setting, or midwifery. Indigenous Andean healers gain their authority and expertise through a system of apprenticeship, by which knowledge is passed down from one healer to another (Bastien 1985). The women, who often take on the primary caregiving role for their families, also use this method. The health of a family is seen principally as the woman of the household's responsibility. Therefore, women use their regular visits with one another to casually learn and pass on information about herbal remedies and techniques to one another (Finerman 1989). During these casual conversations, women suggest treatments to one another and share experiences. The aid of professional healers is only sought in cases of severe illness that cannot be easily treated at home (Finerman 1987, 1989; Gold and Clapp 2011).

Finally, the indigenous Andean medical scene is not complete without the mention of coca, as it plays a significant role in everyday life in the Andean highlands.

Coca has the ability to connect the human community to the supernatural entities and is therefore used by Andean peoples in daily tasks and by specialized individuals in more complicated situations, who are better able to communicate and interpret between realms (Allen 2002). Coca is also used medicinally as a treatment for dizziness and for nausea (Allen 2002), and is ritualistically used by indigenous healers to assist in diagnosing illnesses and to promote healing (Bradby 1999; Koss-Chioino, Leatherman, and Greenway 2003). The coca leaves are also an important element of the typical diet of the Andean highlands. Not only does coca provide essential vitamins and minerals that are otherwise scarce in the high-altitude climate, but it has also been shown to assist in regulating the metabolism of a diet that is rich in carbohydrates. This is supported through the Andean notion that chewing coca, which has hot humoral properties, after meals is believed to balance the humorally cold properties of potatoes that are abundant in the Andean diet (Allen 2002). Coca is therefore important to both spiritual and physical health in the Andean highlands.

European Medicine

What I refer to as *European medicine* in this thesis embodies the manifestation of Europe's mainstream system of medicine circa the sixteenth to the nineteenth century. This system of medicine was influenced constantly by the changing ideologies of Europe through the ages. As a part of the former Roman Empire, the Greek philosophies of the body and health remained largely intact until the nineteenth century, when biomedical ideologies began to emerge (Martin 1989). As the Roman state underwent the conversion

to Christian rule, the Catholic Church influenced how the body, health, and illness were understood and contributed to the institutionalization of medicine in Europe (Sowell 2001). It is this combination of primarily Hippocratic and Galenic humoral theory that was translated and interpreted by Islamic scholars and Catholic perceptions that made up the medical system that I refer to as *European medicine*, which was brought by the Spanish to Latin America and the Andes in the sixteenth century.

European medicine relied heavily on Greek medical texts that emphasized the relationship between the human body and the natural universe. In this system, the natural universe was composed of four elements: fire, air, earth, and water. These natural elements were the basis of the humoral classification system of European medicine, which was comprised of the contradictory qualities hot and cold, and wet and dry (Bastien 1989). The four natural elements and the four humors directly correlated with one another: the element of fire being associated with the hot humor, air corresponded with the cold humor, earth corresponded with dry, and water with wet. The humors affected the human body through what was understood as the body's four fluids, blood, phlegm, yellow bile, and black bile (Bastien 1989; Sowell 2001), each of which also corresponded directly to the four humors: blood was associated with the hot and wet humors, phlegm with cold and wet, yellow bile with hot and dry, and black bile with cold and dry (Sowell 2001). The equilibrium of these humors within the human body results in good health (Bastien 1989). Each of the four humors may be affected by a multitude of factors, including the natural environment and seasons, age, sex, and social status (Bastien 1989). When any of the humors is thrown out of balance by factors such as

these, the result is illness. Illness, therefore, was treated by addressing the humoral imbalance within the body instead of the immediate symptoms (Bastien 1989; Sowell 2001).

After Christianity began to spread extensively in Europe, the Catholic Church soon “had positioned itself among the regulators of the medical professions” (Sowell 2001, 15). Through the early thirteenth century, clerics were active participants in all aspects of the healing professions, allowing for the Catholic Church’s system of medicine, which had previously remained in the realm of popular medicine in Europe (Sowell 2001), to contribute to the overall medical landscape in Europe.

In the Catholic medical system, emphasis was placed on the care and health of the soul over that of the body. Consequently, the treatment and care of the physical body were of little value, which is exemplified through the equivalence of poor hygiene to saintliness (Sowell 2001). “Faith in the healing power of God served as the foundation for most popular European healing ideologies” (Sowell 2001, 15). Illness was understood to be caused by the devil or evil forces, and could therefore only be cured through religious intervention and prayer (Sowell 2001).

By the turn of the fourteenth century, universities had become the centers of medical learning, which changed the role of the Catholic Church in the medical field from one of directing and regulating medical education to one of merely assisting in its regulation (Sowell 2001). By the sixteenth century, Catholic and humoral medical beliefs were joined into a single, integrated and increasingly institutionalized medical system

(Sowell 2001), and “Once in place, this medical system changed very slowly” (Sowell 2001, 19).

The curriculum of European medicine that was taught in universities, was based principally on Hippocratic and Galenic ideology as interpreted by Muslim scholars, specifically Avicenna (Sowell 2001). In the universities, “Students learned through the scholastic method, which left little room for either professorial flexibility or student creativity. This emphasis upon theory and texts was supplemented by limited clinical exposure, especially in dissection and anatomy” (Sowell 2001, 19). European medicine continued to be the dominant medical system until the late eighteenth century (Bradby 2002; Martin 1992).

The institution of European medical system was introduced to Latin America in the sixteenth century as a byproduct of the Spanish Conquest and “filtered down to the general populace from centers of learning, through elite practitioners, through religious order, and through informal social networks” (Sowell 2001, 20). The practices of European medicine in the Andes mirrored those in Europe. There were efforts towards promoting European medicine over indigenous medicine in the Andes, including legislation in 1646 that permitted only medical professionals with university degrees to legally practice medicine. Combined with previous “Imperial dictates [that] excluded those of “impure” blood or of Indian ancestry from the formal practice of medicine” (Sowell 2001, 23), this legislation not only created a distinction between the European and indigenous Andean medical systems, but also sought to encourage the practice of the

highly institutionalized European medicine while simultaneously disfavoring indigenous Andean medicine.

Although efforts were taken to limit the practice of indigenous healing in the Andes, European medical doctors, who were generally confined to urban areas, remained outnumbered by indigenous healers throughout the region, allowing for indigenous medicine to remain dominant in numbers (Sowell 2001). As European medical theory filtered down through universities, hospitals, missionaries, and herbal medical guides (Bastien 1989; Sowell 2001), the ideologies eventually reached and were adopted by indigenous Andean healers, who eventually “incorporated Greek-European humoral ideas into [the] telluric-metaphorical symbolism of the Andeans” (Bastien 1989, 48).

The Transition to Biomedicine

The biomedical system of medicine began to take shape in Europe in the nineteenth century, brought about by influences of the scientific approach of Islamic medicine, changes in the understandings of diseases, the development of germ theory, and an understanding of microbiology, which led to radically new medical ideologies and methods of treatment (Saniotis, 2012; Sowell 2001). At the time biomedicine was developing, Europe and the United States had become highly industrial and capitalist societies, preoccupied with the notion that machines and efficiency was the epitome of civilization (Bastien 1982; Martin 1987). This idea revolutionized the perception of the human body, which was understood to be, in itself, a machine. Biomedical practices supported this view of the body, in that the body, a machine, was healthy when all of its

components are functioning optimally, while illness is perceived as a malfunction of the body. As biomedicine developed and organ transplants became a viable means of healing, the perception of the body as a machine was only reinforced in that its parts were suddenly interchangeable. The role of biomedical doctors is akin to the factory workers, who maintain the optimal efficiency of the human machine by correcting malfunctions (ailments) and maintaining the body's optimal function (Martin 1987).

The underlying philosophy of the nineteenth century also contributed to the development of biomedical theory. The scientific, rationalist approach of biomedicine took "its authority from a claim to represent the natural world – a world whose characteristics could be revealed by scientific investigation" (Sowell 2001, 31).

Biomedical theory therefore seeks to find the underlying scientific cause of illnesses and prescribe cures that are equally based in science. When a malfunction occurs within the human machine, several methods may be used to correct the problem, including surgery, such as replacing a non-working organ for a working or artificial one, or through the use of pharmaceuticals, which are able to alter the body's biological and chemical functions.

Practitioners of biomedicine particularly "rejected other medical beliefs as inferior or, more often, primitive and inaccurate" (Sowell 2001, 31). The elite European intellectuals showed a strong preference toward this early form of biomedicine, which furthered its rapid incorporation into the mainstream and into medical institutions. "By the 1870s, therefore, the rationalist medical ideology was firmly entrenched in universities, medical journals, and professional associations of a corps of medical practitioners" (Sowell 2001, 38). This medical trend made its way to Latin America as

well, although it was not until the late nineteenth century that biomedicine became more commonly practiced in the Andes. As European medicine in the Andes transitioned to a scientific approach of early biomedicine and was endorsed by many states in Latin America as the official system of medicine, it acquired a stigma of modernity, thus pushing indigenous medical beliefs into the peripheries as popular medicine (Sowell 2001).

Biomedicine in the Andes

The medical trends in Europe were generally mirrored throughout Latin America (Sowell 2001). It was not until the mid-twentieth century that there was a more urgent push toward the use of biomedicine throughout Latin America, and by the late twentieth century, many Latin American countries—Peru, Bolivia, and Ecuador notwithstanding—underwent healthcare reform that called for the increased availability and promotion of the United States’ model of biomedicine (Armada, Muntaner, and Navarro 2001; Bastien and Donahue 1981; Jordan 1979). One key factor that led to the need for biomedicine was the enormously high infant and maternal mortality rates of the region as compared to more developed countries that were heavily utilizing biomedical principles and techniques. In an effort to decrease infant and maternal mortality rates across Latin America, governments began to adopt and promote biomedical methods for pre- and postnatal care and childbirth (Bastien and Donahue 1981; Bradby 2002; Camacho, Castro, and Kaufman 2006; Cooley 2008; Gold and Clapp 2011; Guerra-Reyes 2009). While healthcare reform varied by country, in general, the neoliberalism movements

were to privatize healthcare and further promote the biomedical model of medicine (Craven 2010; Ganti 2014). In Ecuador, however, this privatized model of healthcare was eradicated in the early twenty-first century, in favor of a socialized system of free biomedical healthcare (Rasch and Bywater 2014). While initial efforts were expected to replace indigenous medical systems with the biomedical model, it soon became clear to both scholars and policymakers that the indigenous systems were not disappearing, but were in fact adapting to accommodate biomedical theory and techniques. In association with the indigenous rights movements in the Andes in the late twentieth century, the phenomenon resulted in heightened discussion and efforts regarding the integration of indigenous and biomedical systems in the Andes as well as in Latin America overall (Aizenberg 2014).

The promotion of biomedicine in the Andes, as in other regions around the world, generally followed the same top-down approaches that were used to promote European medicine. Governments and nongovernmental organizations use different tactics to coerce and encourage indigenous and rural communities to use biomedical facilities across the Andes. The range of strategies to promote biomedicine included requirements for indigenous healers and midwives to undergo biomedical training, teaching children biomedical views in schools, free health screenings and subsidized biomedical services, and distributing food at biomedical facilities. Governments even created policies that legally required people to undergo biomedical services in order to continue with commonplace events, such as shop keeping, attending schools, performing religious ceremonies, and giving birth. For instance, in Ecuador, infants are required to receive a

series of vaccinations before they may be legally baptized, children must undergo vaccinations, health screenings, and laboratory tests for parasites before they can register for school, merchants must undergo physical examinations to renew their shop licenses, and the deceased may not be buried without a death certificate from a biomedical facility (Finerman 1989). Similarly, in areas of Peru, families have difficulties obtaining a death certificate if a person died as a result of illness and was treated at home instead of in a biomedical facility (Gold and Clapp 2004), and women who choose not to give birth in biomedical facilities have difficulties in obtaining birth certificates (Zug 2013).

Summary

Indigenous Andean medicine has evolved over time as other medical systems have been introduced into the region. Indigenous medicine generally defines the body in relation to the social, spiritual, and natural environments of a given community. It also incorporates aspects of European medicine, such as the humoral concept.

European medicine developed out of Hippocratic, Galenic, Islamic, and Catholic medical principals, and eventually gave rise to the scientific approach of biomedicine. In the late twentieth century, Latin American governments began to heavily promote biomedicine in part as a means to decrease maternal mortality rates by training indigenous medical practitioners in biomedical theory and methods, and by encouraging indigenous women to utilize biomedical services.

This section has provided a general description of the historical framework that the following discussions of women's reproductive health are based on. In the following

chapter, I further discuss conceptions of the female body and its reproductive functions and the ways in which they have contributed to the creation of the female gender roles in Andean society.

Chapter 2: Literature Review

In the following sections, I examine relevant scholarship while simultaneously providing the contextual basis from which my own research and analysis draws. I offer a brief discussion of women's healthcare under both the indigenous medical and the biomedical systems, and situate this thesis in theories of gender, choice, and authority.

Indigenous Medicine in the Andean highlands

In order to understand the worldview of those in the Andean highlands and how it relates to the indigenous medical system of the region, one must look to Bastien (1978; 1987; 1985; 1989). Bastien's in-depth analyses demonstrates how the perceptions of health and illnesses in Andean communities are rooted in time-established observations, beliefs, and practices and also how they are altered and adapted as new ideas permeate the cultural landscape. According to Bastien, the body is understood as an extension of the mountain in a physical and spiritual sense, and the body is intrinsically bound to the larger community. Additionally, in the Andean highlands, the body is understood to operate on a humoral and hydraulic system, in which fluids of varying humoral properties (air, blood, and fat) are distributed or expelled throughout the body in order to promote good health and wellbeing (Bastien and Donahue 1981; Bastien 1985; Cooley 2008; Koss-Chioino, Leatherman, and Greenway 2003). The ways in which the overall human

body is understood in communities throughout the Andean highlands are important to understanding how, more specifically, the female body and its biological functions are understood in this region.

Similarly, in understanding the ways in which common illnesses are perceived and treated, I am able to better interpret how the mishaps and dangers of pregnancy are understood and treated by the indigenous women of the Andean highlands. Froemming (2006), Bastien (1987), Finerman and Sackett (2003), Wayland (2001), Gold and Clapp (2011), and Vandebroek et al. (2004) discuss in detail some of the indigenous remedies that are common in the Andean highlands. These authors provide a great resource for plant- and animal-based remedies used for both general ailments as well as for female reproductive health concerns (Finerman 1989). Froemming (2006), for instance, describes the different remedies that are used as galactagogues in the Peruvian Andes, such as sesame seeds and heath in a beef broth, or a broth with toasted and ground Andean flicker meat. These descriptions of remedies helped provide a basis from which I built my research and interpretations of indigenous reproductive healthcare techniques; I compared and contrasted this with biomedical reproductive healthcare techniques to shape and support the analysis of my research.

Indigenous Women's Reproductive Healthcare in the Andean Highlands

A quintessential element of my research focus is data on the practices of women's reproductive healthcare and the ways in which the female body and its reproductive functions are socially constructed and understood by women in the Andean highlands.

Hammer (2001) and Beyene (1989) give details about of the way that menstruation, pregnancy, and menopause are understood in the indigenous Andean medical system with respect to Bastien's (1985) presentation of the humoral theory. The indigenous Andean medical system describes the correlation between menstruation, pregnancy, and menopause through the use of a limited supply of blood that the body uses up at varying rates (Beyene 1989; Hammer 2001). The constant loss of blood of the female body is a key component to the perception of the female body as weak, which is discussed by both Larne (1988) and Koss-Chioino (2003). In what some have indicated to be a variation of the western humoral theory of medicine, Koss-Chioino (2003) goes into detail on the reasoning that the female body is viewed as inherently weaker than the male body in the Andean medical system, as a result of their loss of irreplaceable blood through menstruation, giving birth, and lack of sweating, a function that is understood to rid the body of illness-causing substances. Larne (1988) similarly describes that by midlife, women are understood to be in a permanent state of vulnerability and chronic ill health as a result of the loss of blood and inability to sweat out toxins.

Detailed accounts of beliefs regarding women's health in the Andean highlands, as well as corresponding practices of pregnancy, birth, and indigenous midwifery within the region are found in Bolin (2006), Bradby (2002), Ingar (2009), Jordan (1978), Larne (1988), and Lefèber (1994). In these texts, elements such as prenatal massage as a diagnostic method of midwives, the bodily positions that are commonly used by laboring women, and the exchange of authority that occurs between midwife and pregnant/laboring woman are thoroughly discussed. I use these sources to demonstrate

how the female body is constructed in the Andean highlands, and how that construct affects the type of care that indigenous women seek during pregnancy and childbirth.

Childbirth in the Biomedical System

Craven (2005; 2007; 2010), Davis-Floyd and Sargent (1997), Jordan (1978), Martin (1987), and Morgan (2014) offer a basis for my understanding of childbirth through the biomedical system in the United States, which becomes a foundation for the ways that United States biomedicine is manifested in the Andean highlands. Martin (1987) and Harris and Young (1981) discuss medical systems as productions of society and cultural ideals and specifically address how understandings of reproductive health and its accompanying practices are culturally constructed. They describe various ways in which women view their bodies as a product of larger social understandings. For instance, Martin (1987) describes the perception of the body as a machine, and more specifically the female body as a baby-producing machine, showing how they are directly correlated to larger social ideology—industrialization and capitalism—which regarded the machine as the epitome of modern civilization.

Similarly, Jordan (1978) and Davis-Floyd and Sargent (1997) describe childbirth within the biomedical health system as a medical event and discuss the general sense of delivery practices in the United States. The United States' model of biomedicine has the same scientific basis as biomedicine in European countries. However, there are important differences in the ways that biomedicine is practiced in the U.S. In general, U.S. biomedical practices emphasize technology, medication, and surgery. This is evident in

the way labor and delivery are handled in biomedical facilities in the U.S., which commonly employ pain killing and labor-inducing drugs and caesarian sections, whereas other biomedical models do not necessarily place as heavy of an emphasis on these practices (Davis-Floyd and Sargent 1997; Jordan 1978; Martin 1987; Morgan 2014).

Morgan (2014) offers an analysis of the epistemology behind the common pregnancy traditions in both the United States and in the Ecuadorian Andes by describing the differences in the ways a fetus and personhood is understood. By perceiving the fetus as a part of the mother, such as in Ecuador, or as a separate entity of personhood, as viewed in the U.S., the way in which the pregnant body is perceived and experienced by the individual and by the community (Morgan 2014).

Biomedicine in the Andean Highlands

Bastien (1982) focuses on the historical and cultural contexts of biomedicine and indigenous Andean medicine. He describes the biomedical system as a phenomenon that has been shaped to fit the industrial and capitalist circumstances of Western society. He states it is capital-intensive and backed by expensive machines and laboratories in facilities whose staff are highly trained and specialized through an expensive medical school system, as opposed to the Andean medical system, which is a system based on specialization and on-going reciprocity, and whose practitioners learn through apprenticeship. Bastien (1982) and Martin (1987) both make it clear that an understanding of the historical and cultural context from which a healthcare system arises is essential to understanding the healthcare system itself.

Bastien and Donahue (1981), Bradby (2002), Finerman (1989), and Gold and Clapp (2011) explain the politics surrounding the promotion of biomedicine in the Andean highlands. In recent decades, biomedicine has become increasingly available to Andean communities and ideas about biomedicine have systematically infused the minds of those in Andean towns through countless means, ranging from free screenings and treatments to “soft threats” (Gold and Clapp 2011, 101) of legal difficulties issued by biomedical doctors—such as having troubles obtaining birth or death certificates—and healthcare workers, to teaching biomedical views in schools (Finerman 1989). Political measures (in terms of government or NGO agendas, etc.) play a huge role in the ways biomedicine and indigenous medicine are used and perceived in the Andes; it is therefore important for me to have an understanding of this landscape.

Several scholars have discussed the ways in which biomedicine and indigenous Andean medicine contradict one another in their methods of aiding birth by examining the biomedical procedure of the caesarean section (C-section). Although a common and even desirable practice in biomedicine, the C-section continues to be rejected and even feared by many Andean women as a method for giving birth because it is in complete opposition to the indigenous practices that employ a humoral theory. Therefore, a C-section, although considered a routine and safe procedure in the biomedical system, is viewed as an extremely dangerous practice in the indigenous Andean medical system (Martin 1989; Jordan 1979; Sargent and Bascope 1996; Torri 2013).

The topic of the mistreatment of indigenous women who give birth in biomedical facilities is also a recurring topic found in many scholars’ work, including Gold and

Clapp (2011) and Sargent and Bascope (1996), and Torri (2013), who discuss how racism, patriarchy, and language and cultural barriers lead biomedical doctors to assume complete authority during labor and delivery, allowing the laboring woman little say in her laboring environment, who may be present, her delivery method, or even her laboring position. Scholarly accounts of indigenous women giving birth in a biomedical environment demonstrate that biomedicine and indigenous medicine are often seen in opposition to one another by indigenous women, medical practitioners, and scholars. As I continued my research, I found evidence that various indigenous medical aspects were being integrated into biomedical facilities as a means to encourage indigenous women to use these facilities. According to researchers' accounts, however, many of the pilot sites that originally incorporated these indigenous Andean practices have since discontinued their use (Guerra-Reyes 2009; Zug 2013).

Ample evidence for the selective use of both medical systems is found the literature (Bradby 1999; Finerman 1989; Gold and Clapp 2011; Maynard-Tucker 2013; Torri 2013). Torri (2013), for instance, describes the use of both medical systems during pregnancy. She found that it is not uncommon for women with the appropriate means in the Andes to visit both a biomedical doctor and a midwife during pregnancy. Many women prefer to utilize the services of both practitioners, as each offers services that the other does not. By doing this, women can be assured of their baby's wellbeing from both medical perspectives (Torri, 2013). By examining the diverse literature on the incorporation of biomedicine in the Andean highlands and in other regions, I am able to

show how specific elements of other regions' successful integration of the two medical systems are evident in the Andean highlands.

Many scholars have used their research to determine methods through which biomedicine and indigenous medicine can further incorporate one another in the Andean highlands. Bastien (1982), for example offers behavioral and methodological suggestions for traveling biomedical doctors who frequent rural communities in the Andes in order to bridge the cultural gap. Additionally, Guerra-Reyes (2009) and Camacho, Castro, and Kaufman (2006) discuss the need for biomedical practices in the Andean highlands to accommodate indigenous methods as a part of their standard procedures. The discourse surrounding the topic of incorporating the two systems in the region gives a great deal of insight into what has or has not taken place, while also presenting elements and viewpoints that scholars and activists consider to be of importance.

Authority and Autonomy during Childbirth

Craven (2005; 2007; 2010), Davis-Floyd and Sargent (1997), Jordan (1978), Martin (1987), and Morgan (2014) all discuss questions of authority in biomedical childbirth, and Bradby (1999) explains questions of authority in the Andean context. Indigenous women in the Andean highlands maintain autonomy over their bodies during homebirth, regardless of the presence of specialized birth attendants. When these women give birth in a biomedical setting, there is often confusion over authority as women must often relinquish their autonomy to the authority of the biomedical personnel (Bradby 1999).

The politics of the body and of authoritative knowledge are also crucial to understanding the changing scene of women's reproductive healthcare in the Andes. I explore these concepts, which are addressed by Davis-Floyd and Sargent (1997) and Ginsburg and Rapp (1995), by examining how authority is played out during prenatal care and childbirth in the Andean indigenous and biomedical systems as described by Jordan (1979), Martin (1987), Torri (2013).

Body and Gender Constructions

I use the works of Butler (1990), Hartsock (1983), Lugo and Maurer (2000), Martin (1987), and Ortner (1974), who discuss the notion of the body as a cultural construct and describe gender as a performative action, in order to explore the ways in which the body is constructed in the Andean highlands. I pair these notions with the descriptions from Camacho, Castro, and Kaufman (2006), Llanque Channa (1972) Hammer (1997; 2001), Larme (1998) and Torri (2011) to discuss this cultural construction of the female and how it is used to define the female gender roles in the Andean highlands. The cultural perceptions of the female body as well as the ascribed female gender roles in the Andean highlands contribute to the ways that women perceive forms of healthcare and to their decision to utilize certain services or methods.

Choice and Decision-Making

My analysis of a woman's choice of care is greatly influenced by Corrêa and Petchesky (2007), who explain that the notion of a woman's 'choice' is "meaningless,

especially for the poorest and most disenfranchised” (Corrêa and Petchesky 2007, 298) populations, which the indigenous women of the rural highland Andes often fall under. Instead, a women’s ‘choice’ to utilize certain reproductive healthcare services is often the result of an extremely complicated web of influential factors, and therefore ‘choices’ are not “equally ‘free’ for everyone” (Corrêa and Petchesky 2007, 302). In this thesis, I only examine a handful of these varied and deeply engrained influences.

Similarly, Obermeyer (2001) brings attention to the uncertainty surrounding the decision making process of individuals in choosing healthcare services, and the many viewpoints that are involved. She also discusses that culture shapes the perceptions of reproductive healthcare, a concept which I draw on throughout this thesis.

Craven (2005; 2007; 2010) discusses the choice of reproductive care in the wake of neoliberalism in the United States. The childbirth movements in the United States, first towards institutionalized biomedical birth, and then in recent decades towards homebirth, offer insight into the ways that authority is understood and played out during childbirth and general perceptions towards biomedical childbirth that I apply to biomedical childbirth in the Andes.

Chapter 3: Methods

Data for this thesis was gathered through findings of secondary sources, primarily found in the George Mason University Libraries. I used books, journal articles, and doctoral dissertations principally from anthropology, but also works from sociology, history, public health, and philosophy. The sources provided historical and cultural contexts of perceptions of health, the body, and reproduction in the Andean highlands and the United States (the United States' model of biomedicine has become the standard model used by government and non-government agencies), which I analyze and compare in this thesis.

My general research approach followed the grounded theory method (Borgatti n.d.; Glaser and Laudel 2013), and was conducted based on the overarching concepts of perceptions of the body and the practices surrounding pregnancy and birth in indigenous Andean medicine and in biomedical medicine. As I collected data, I compiled, coded, and indexed it into a Microsoft Word document. In order to keep this document well organized, I coded sources, ideas, notes, and quotations using a series of mnemonic codes; these codes eased the indexing process, and allowed me to easily sort through the large amount of data. My codes represented combinations of key concepts that I later used for analysis, including larger topics and keywords, such as biomedicine, prenatal care, birth, identity, etc., as well as more specific terms, such as caesarian, heat, tools,

stigma, etc. I used as many codes as necessary for each item in order to maintain the most detailed records possible. By using these codes and an index derived from them, which also included demographic information when available, I was able to easily access relevant items when I began the process of analyzing my data.

I began the intensive analysis of my data to determine any evident patterns, themes, or ideas, keeping in mind the principal themes of gender, perceptions of the body, and the varying ways in which biomedicine and indigenous Andean medicine are used during pregnancy and birth. In my analysis, I drew on preexisting patterns and themes presented in the literature. I then integrated the data into themes and patterns and determined the exceptions or variants in order to begin forming my analysis of the data (Glaser and Laudel 2013). Paired with sufficient supporting arguments and evidence, this analysis of the data is presented in my thesis.

Chapter 4: The Female Body

The roles and responsibilities of women in the communities of the Andean highlands are largely based on the manner in which the female body is constructed within the indigenous medical system and cultural worldview. The reproductive abilities of the female body are understood to provide women with fertile and nurturing powers that are akin to those of the female deity Pachamama. These abilities as well as the anatomy of the female body contribute to women's perceived state of chronic weakness and poor health. In the following sections, I demonstrate how the female body is perceived within the indigenous Andean medical system and culture, and how these perceptions have influenced the gendered roles and responsibilities of women in highland communities.

The Role of Blood in Female Reproductive Functions

The physical reproductive functions of the female body are explained in the indigenous Andean medical system through the use of blood. In this medical system, blood is viewed as the source of life and is essential for optimal health. Any loss of blood can be dangerous to one's well-being and may cause illness or death. In many regions of the Andes, blood is believed to be limited in supply, the amount of which is established during childhood. Once this supply has been depleted, it may not be replenished, although the remaining supply can be fortified by consuming specific foods, including

bat's blood, milk, meat, or animal hearts (Bastien 1985; Larne 1998). In other regions it is believed that one's blood supply may be replenished by consuming these foods or by undergoing intravenous injections (Hammer 2001). Despite the differences in specific regional beliefs, it is generally acknowledged that when one's blood supply is strengthened or replenished, the replacement fluid is never as strong as the original blood (Larne 1998; Hammer 2001). Therefore, despite the quantity, blood loss can contribute to weakness or illness that can amass over an individual's lifetime.

Understandings of menstruation, pregnancy, and menopause within the Andean medical system are based on the use of the body's supply of blood and the ways in which the blood is being directed within and used by the body. According to indigenous Andean medical theory, menstrual blood is thought to be the female's fertile substance and is necessary in forming a baby. Conception in the Andean highland indigenous medical system is understood to be a result of the combination of semen and menstrual blood and, therefore, it is believed that conception is most easily achieved during or just after menstruation (Canessa 2012; Hammer 2001). Because of this important role of menstrual blood in reproduction, the onset of menarche indicates the beginning of a female's childbearing potential, while menopause marks its end (Hammer 1997). The initial amount of blood a woman may have varies and may even be genetic. Women who have more blood than others are said to have inherited this trait from their mothers. These women tend to have longer menstrual periods and are considered to be at a higher risk of hemorrhaging during childbirth (Hammer 2001).

Although women in the Andean highlands understand menstruation as a monthly occurrence, in actuality, these women generally do not menstruate regularly as a result of poor nutrition, frequent pregnancies, long periods of lactation, and high altitude (Canessa 2012; Vitzthum et al. 2000). According to indigenous medical theory, amenorrhea is explained as being caused by humoral disturbances or by the misdirection of menstrual blood within the body. Menstruation is considered a humorally hot state in the indigenous Andean medical system, and therefore by coming in contact with an opposing cold element, menstrual blood will thicken and coagulate into tight balls that become stuck within the abdomen. The thickened blood becomes firm and must be warmed through humorally warm foods or poultices so that the body can expel it (Hammer 2001).

Menstrual cramps are also results from clotted menstrual blood. The lumps of cold blood or other growths that appear in the abdomen unrelated to pregnancy are considered a danger to a woman's health. Women have adopted the biomedical terms "cancer" and "tumor" to describe severe and terminal cases of menstrual conditions that are identified by growths in the abdomen unrelated to pregnancy. Women who are menstruating must therefore avoid humorally cold elements and foods, and immerse their body, specifically their hands, in water in order to maintain the hot state. Amenorrhea may also be caused by menstrual blood having been redirected and used by the body; examples of such would include an injury that causes blood loss in another part of the body, by pregnancy, which redirects the blood to the fetus, or by lactation, which redirects and converts menstrual blood into milk (Hammer 2001).

When a woman's allotted supply of blood has been exhausted, she experiences menopause, which is understood by indigenous Andean women simply as the end of her ability to reproduce (Beyene 1989). In indigenous Andean medical theory, there is a correlation between the onset of menstruation, the number of pregnancies experienced, and the onset of menopause and the finite blood supply used for these purposes. It is understood that an early onset of menstruation will result in an early onset of menopause, likewise a late onset of menstruation will result in a late onset of menopause. The number of pregnancies a woman experiences also affects the onset of menopause in that a small number of pregnancies will allow for a later onset of menopause, while a large number of pregnancies leads to an early onset of menopause. This is explained by the supply of blood being used up at various rates over a lifespan; some women use up their blood supply earlier (early onset of menstruation) or by having many children (birth uses up a large amount of this blood supply), while others begin to use their supply later or more slowly by not having as many children (Beyene 1989). Women correlate an early onset of menstruation with an early onset of menopause, and a large number of pregnancies (which uses a larger amount of blood than menstruation) with an earlier onset of menopause (Beyene 1989) and a lesser number of pregnancies with a later onset of menopause. These understandings support the notion that the human body has a fixed and limited supply of blood to support life and various functions of the body.

In this framework, a woman does not menstruate while she is pregnant because the menstrual blood is being used to form and nourish the growing fetus (Hammer 2001). Pregnancy in the indigenous medical system is made up of two stages, which are

distinguished by fetal movements. The first stage consists of the first four to five months, when the woman cannot feel fetal movements. During this stage, the fetus is described as a mass of blood and tissue with an amorphous shape (Canessa 2012). Once the fetal movements can be distinguished by the woman, the undefined mass begins to take on the shape of a fetus and is said to have bones and hair (Canessa 2012), and the second stage of pregnancy begins, lasting until the woman goes into labor.

Unlike western perceptions of the fetus, unborn fetuses are not viewed as humans in the Andean highlands, but retain an ambiguous identity throughout gestation and infancy (Morgan 1997). The fetus is perceived as being in transition between the world of the spirits, from which it has come, and the world of the humans, into which it is entering. The pregnant woman, as the vessel of the ambiguous fetus, is by association also considered as in transition between the worlds. This liminal state makes women vulnerable to illness and malevolent winds (Ingar 2009).

The Female Organ

The primary element that distinguishes the female sex and gender from their male counterparts is the presence of the *madri* (Qu.). While the particular functions and meanings of the *madri* vary between regions in the Andes, it is generally described as a small, round organ that is usually settled within the intestines, although it is able to move around the body according to its will. Although there is no biomedical counterpart for this organ, it is the *madri* that gives women their reproductive potential (Hammer 2001).

The *madri* produces and circulates fertile blood, which is essential for reproductive functions. Because of this function, the *madri* is often understood as being the lower abdomen counterpart to the upper abdomen heart. As explained through the indigenous medical system, during the first stage of pregnancy, the *madri* is located next to, but not attached to, the uterus, where it supplies the growing fetus with blood (Hammer 1997). However, after the first stage of pregnancy, the growing fetus restricts space in the abdomen and the *madri* begins to wander to other locations in the body. The movement of the *madri* can cause a dangerous reversal in the flow of bodily fluids and, therefore, can be potentially fatal to the woman.

The *madri* is the location of the pain and physical disorder for ailments linked with work, loss, and misfortune. It can be dislodged from its place in the abdomen by strenuous lifting or through experiences of extreme loss of personal relations or material goods. A Cororo healer with expertise in *madri* ailments, Doña Teofilia, states, “It’s principally from *madri* illness that women die. Sometimes in that moment right after birth but at other times also. Especially after a woman has suffered many births, and when they are already old women, the *madri* ails them” (quoted in Hammer 1997, 198). Although the *madri* is responsible for allowing women to reproduce, it is also a source of health concerns. The presence of the *madri* and the overall ability of women to reproduce is connected to the roles and responsibilities prescribed to them in the Andean highlands.

Fertility and the Female Body

In the indigenous Andean medical system, the female body is defined by its fertility and reproductive capabilities. As a result of its reproductive potential, the female body is closely linked to the fertile, reproductive, and nurturing powers of Pachamama, the feminine deity that is synonymous with the landscape, and the cycles of reproduction in agriculture and business, and with every aspect of nature and fertility. Pachamama is viewed as the creator of the world and the protector of life and is believed to prevent evil and illness and ensure profitable work and a secure home (Blaisdell and Vindal Ødegaard 2014; Bolin 2006). It is through the fertile powers of Pachamama that plants, animals, and humans are able to grow and reproduce, and therefore, Pachamama is intrinsically connected to an individual throughout their life. At birth, a human is granted spiritual life by Pachamama, which is eventually be returned through death (Bolin 2006). Throughout a person's life, Pachamama provides them with food, drink, and protection in exchange for offerings (Blaisdell and Vindal Ødegaard 2014; Bolin 2006).

In the Andean highlands, the physical reproductive capabilities of the female body connect women with Pachamama. As a result of a woman's ability to reproduce life, she is believed to exhibit all of the powers of fertile and nurturing powers of Pachamama (Bolin 2006; Ingar 2009; Larne 1998, 1008; Pacino 2015). These fertile and nurturing powers that are associated with their body's reproductive capabilities have become an essential identifier of the female gender (Canessa 2012, Hammer 1997; Ortnier 1974). The prescribed gender roles of the women in the Andean highland communities are as the

“producers of crops and as reproducers of babies” (Larme 1998, 1008), which reflect this connection to the perceived fertile, reproductive, and nurturing powers of women.

The depth of this connection is evident through speech and in one’s choice of words. For instance, as Doña Lidia, a midwife in Sucre, Bolivia, describes her method of prenatal massage to determine the position and health of the fetus, she also demonstrates the connection of women to Pachamama. “I smear on a poultice of egg, and through this, you see, and with sugar, I straighten the baby out in her belly,” she explains. “From here, and from over here, like pulling something together into a pile, I put it into position just here, as if I were scratching the earth, I smear it on” (quoted in Bradby 2002, 180). Doña Lidia’s metaphor exemplifies that the woman’s pregnant belly is comparable to the earth in that they can both be physically manipulated. However, by using the metaphor of scratching the earth into a pile to describe how she manipulates the fetus in utero, Doña Lidia is also inadvertently referencing the deeper, spiritual connection between the female body, especially the pregnant female body, to the fertile powers of Pachamama that manifest in the land.

Gender Roles

The association of women’s bodies with reproductive, fertile, and nurturing powers leads to their primary responsibility being motherhood and the rearing of children (Allen 2002; Camacho, Castro, and Kaufman 2006; Llanque Channa 1972; Hammer 1997; Larme 1998; Torri 2011). As an extension of motherhood, women’s culturally ascribed responsibilities also include caring for animals, managing household tasks like

cooking and cleaning, and overseeing the household and small-scale economics, which includes finances, market activities, and deciding which produce will be used for consumption and which will be used for seed (Allen 2002; Bolin 2006, Canessa 2012; Llanque Channa 1972; Larme 1998). Based on these gendered roles and responsibilities, women are valued as prospective wives in their abilities to work and manage household resources, and, more importantly, to care for children and animals. Women also spin and weave clothing for their family, which is done sitting down, in contrast to men, who knit standing up (Canessa 2012). Weaving in a seated position re-emphasizes the connection of women to the earth and to Pachamama. Although women are responsible for taking care of the household, within the family the man has the ultimate authority and a wife is expected to take on a submissive and subordinate role to her husband (Llanque Channa 1972; Larme 1998; Torri 2011).

Playing out their prescribed role as caretakers and nurturers of the family, women are responsible for advising and controlling the behavior and health of their family members, and are the bearers of moral standards within the family (Hammer 1997; Finerman 1989). Additionally, they often diagnose and treat ailments by administering herbs and home remedies and, when available, pharmaceuticals purchased in stores (Larme 1998). Women learn and share medical knowledge and remedies amongst themselves (Hammer 2001, Finerman 1989).

This role of primary caregiver also includes treatment of female reproductive problems, including irregularities in menstruation and infertility (Hammer 2001, Finerman 1989). Although mothers and elder women do not forewarn or prepare

prepubescent girls for menarche, once it begins, it is the mother's role to offer care and advice. When menstruation does not begin in a given month, women turn to female relatives for recommendations on curative actions to induce or increase the flow of menstruation. Infertility in women is explained as the disruption or misdirection of the normal flow of humoral fluids relating to the *madri*. Some causes of infertility of women include previous traumatic events; white, pale colored, or thin menstrual blood; or an inverted womb, which causes the fetus to be unable to settle in the womb and therefore fall out of the womb, causing miscarriage (Hammer 2001). Women within the family freely share information with one another about the proper diet regarding menstrual regulation and the particular herbs that are useful in ensuring flows of the fertile menstrual blood, and will prepare the foods and herbal mixtures for one another (Hammer 2001).

In contrast to the caring and nurturing roles of the female gender, in Andean highland communities, male gender roles are related to economic production. This division of labor is not specific to the Andean highlands, and is even argued by scholars to occur in every culture (Lugo and Maurer 2000; Ortner 1974). As in many cultures, in the indigenous Andean highland communities, “El mundo de la mujer es el mundo del cuidado, el del hombre es el del trabajo” (Llanque Channa 1972, 109), which translates to, “The woman's world is the world of care, that of the man's is of work” (my translation). In the Andean highlands, ideally the gendered roles of both men and women are valued as they are both essential elements that contribute to the community. However, men's work is more highly valued than women's work in the highland communities

because it is seen as more physically strenuous and because it produces economic resources (Larme 1998). The more traditional male responsibilities such as chopping wood and agricultural labor are not only perceived as being more strenuous than the household tasks of women, but also result in a resource with economic or monetary value (Canessa 2012; Koss-Chioino, Leatherman, and Greenway 2003). Over the last few decades, there has also been an increasing trend for men to migrate to areas with economic opportunities, which allows them to earn and participate in a monetary economy.

During the mid-twentieth century, men from Andean highland communities would migrate to locations of mines or plantations, or other areas in need of laborers, for a span of weeks or months. In the late-twentieth century and into the present day, the expanding international economy and the ease of travel has allowed men to migrate internationally, especially to areas in the United States and Europe, for periods of years to earn money and send remittances to their families (Larme 1998; Meisch 2002; Pribilsky 2007). As a result of men being able to acquire economic resources through their work, the work they perform is more highly valued than that of women. Furthermore, men are valued for their laboring power and ability to bring in economic resources, and not for their sexual potency as in other areas of the world (Canessa 2012; Delaney 1991).

Although these are the general gender roles and divisions of labor in the communities of the Andean highlands, in the event of the absence of a member of the relevant gender, it is not uncommon for members of the opposite gender to perform a task (Canessa 2012; de la Cadena 1995; Pribilsky 2007; Larme 1998). This is especially

prominent in migrant communities, in which men leave the community for extended periods, thereby requiring the women to run the community (de la Cadena 1995; Larme 1998; Pribilsky 2007). With the increasing absence of men in the communities of the Andean highlands because of migration and the increasing value placed on migrant work, women are required to fulfill both their existing gendered responsibilities as well as those of the men. Although women must perform these male tasks, it is believed that her reproductive functions inhibit her from performing those tasks as well as a man could (de la Cadena 1995). It is the prescribed female gender roles as defined through their reproductive abilities, paired with their bodies' biological reproductive functions that contributes to the perceived chronic social and physical illness of women.

The Weakness and Vulnerability of Women

According to indigenous Andean medical theory, the susceptibility to illness varies throughout the course of life for both men and women. For instance, during infancy, childhood, and old age, one is considered weaker and therefore more susceptible to illness than in adulthood, regardless of sex. However, women specifically must endure a perceived predisposition to weakness and illness throughout their lives as a result of the combination of physical, emotional, and social hardships that they must face as they work to fulfill the ascribed responsibility of caring for their families (Larme 1998; Koss-Chioino, Leatherman, and Greenway 2003).

The physical female body and its biological functions contribute to a woman's increased risk of illness. The presence of an additional natural opening in the female

body, the vagina, increases the chances of illness-bearing malevolent forces to enter the body (Larme 1998; Koss-Chioino, Leatherman, and Greenway 2003). Larme (1998) explains:

The female body is, by its very nature, considered to be more *debil* [weak (Sp.)] than the male body. Females have an extra orifice, the vagina, through which illnesses can enter. During menstruation a woman's body is considered to be "open" and vulnerable to illness, and a loss of blood contributes to *debilidad* [weakness (Sp.)]. Females also expose themselves to illness when they squat to urinate, which may allow illness bearing vapors to enter their lower bodies (1998, 1010).

The dangers of women exposing themselves to illnesses are relayed through stories. One of Larme's (1998) participants in Peru explains the dangers that women face when travelling to the lowlands:

Women get sick in the lowlands a lot. This happens because the lowland heat makes them sleep during the daytime. *Saqras* (Qu. devils) in the form of snakes make women's bellies swell. The remedy is to tie a piece of cheese outside of the vagina. The snake comes out to eat the cheese and can then be caught. Snakes are attracted to bad odors, especially when a woman's clothes are dirty, or when she has her period. They want to go in and eat the blood... These things do not happen to men, only to women. This actually happened to a woman from Cusco (Fieldnotes 3/88) (1998, 1312).

This anecdote demonstrates the perceived inherent vulnerability of women to external causes of illnesses. The woman's biological anatomy and functions are reasons for her vulnerability: her vagina, the extra orifice for illness-bearing forces to enter, in this case in the form of a snake, and her ability to menstruate, from which the blood provides an enticing meal that attracts the snake. The fact that men, who lack a vagina and the ability to menstruate, are not at risk from a snake entering their stomachs further emphasizes that it is the woman's physical body that puts her at risk to illnesses according to indigenous medical theory.

Emotional upsets and gendered tasks also contribute to women's vulnerability to illness. Women are also more susceptible to illness because they express negative emotions (sadness, worry, anger, and fright) more frequently than do men (Larme 1998). Sobbing and sighing are believed to allow malevolent winds to enter the body through the eyes and mouth (Larme 1998). Furthermore, the gendered tasks that women perform do not promote sweating, which, similar to European humoral theory (Martin 1987), is explained by indigenous medical theory as a method of cleansing impurities from the body. Because men's labor is viewed as more physically strenuous than women's labor, men are understood to have the regular opportunity to excrete more sweat than women and, therefore, men are routinely cleansed of illness-causing substances, while women are not (Koss-Chioino, Leatherman, and Greenway 2003). Women's lack of routine cleansing by means of sweating leads to the buildup of impurities, which adds to their susceptibility to illnesses.

While having an extra orifice, more frequent displays of emotions, and less opportunity to sweat all contribute to a woman's state of weakness, it is her body's reproductive functions that are the greatest source of women's perpetual state of vulnerability (Larme 1998; Hammer 2001). It is through the regular loss of blood during menstruation and the greater quantities of blood loss during childbirth that women constantly deplete their blood supply, thereby steadily increasing their weakness and susceptibility to illnesses (Hammer 2001). In the Cororo community of the Bolivian highlands, women describe "the onset of menarche, they say that an adolescent girl becomes "accustomed to getting sick each month" [...] This same notion of becoming

sick [...] also refers to the act of giving birth” (Hammer 2001, 244). Furthermore, during menstruation and childbirth, a woman’s body becomes symbolically and physically “open” and vulnerable to the cold and malevolent forces, her internal organs may become damaged and displaced, and she loses valuable blood (Larme 1998). As a result of frequent and consistent blood loss through menstruation and childbirth, “by midlife, many [Andean] women are perceived by themselves and others as being permanently *debil* [weak] and in chronic ill health” (Larme 1998, 1011).

The perception of women as being chronically weak or in ill health does not only describe the physical symptoms of weakness or the increased susceptibility to malevolent forces. In addition to these factors, the notions of “getting sick each month” or “being permanently *debil* and in chronic ill health” also refer to the general “hardships that women suffer throughout their lifetimes as bearers and rearers of children and as a result of discrimination associated with their ascribed gender status that limits access to resources” (Hammer 2001, 244). In addition to the physical discomforts and illnesses brought on by the body, women in the Andean highlands also refer to their lifelong oppression, of being tied to the home and impoverished circumstances that associates their ascribed responsibilities to bear and rear children. This is reflected in the common phrase, “to be a woman is to suffer” (Hammer 1997, 81). Because “bearing and rearing children is considered tiresome but obligatory work...and is central to female domestic roles,” the “discomforts of menstruation, pregnancy, birth, postpartum and other aspects of reproduction are experienced as part of the suffering inherent to womanhood” (Hammer 1997, 80). Because the ascribed role of women is linked to the reproductive

abilities of their bodies, the social and physical discomforts are understood as intrinsic qualities that women are required to endure throughout their life.

Relief from these inherent physical and social discomforts comes in the form of menopause and contraception. Throughout Latin America, menopause is described as an end to menstruation and the ability to bear children as a result of using up the finite supply of blood that is allotted for these purposes (Beyene 1989; Hammer 1997). Menopause marks both the end of a woman's childbearing abilities and her "liberation" and relief from the physical suffering that accompanies pregnancy and childbirth (Hammer 1997). "In anticipation of such transition, women exclaim, !Una está liberado de esso [sic]! (One is liberated from that)" (Hammer 1997, 118). A woman is able to "liberate" herself without having to wait for the onset of menopause by the use of contraceptives or tubal ligation. Women refer to contraceptives, especially intrauterine devices (IUDs), and tubal ligation as a "cure" (Schuler, Choque, and Rance 1994, 215) to childbearing.

Although menopause, contraceptives, and tubal ligation offer women a "cure" to and "liberation" from childbearing, a woman's child rearing responsibilities remain intact. Women who have undergone sterilization or use contraceptives are still expected to rear any existing children they may have, and there is a continuing expectation of postmenopausal grandmothers to participate in the rearing of the children of their sons and daughters (Hammer 1997).

A Risk to Self and Others

The anatomy and functions of the female body not only put women at risk, but, if not managed properly, are able to inflict harm onto the environment or other humans. During menstruation and pregnancy, the woman must be especially careful that her body does not cause harm to others.

The female body is considered to enter a state of extreme fertility during menstruation because menstrual blood is the female fertile substance that is necessary for conception. This extreme state of fertility can have detrimental effects on a woman's immediate environment, particularly young crops. For instance, women who are menstruating are advised to avoid going near sprouting fields or stepping over vines of plants because the hot and fertile state of the woman's body will lure these forces away from the young crops and towards the body, therefore causing the fields to dry up and the plants to wilt and die (Hammer 2001).

A woman must also take caution when she is pregnant because her actions can easily affect, injure, or kill her fetus. It is understood within the indigenous medical system that a woman's body not only makes the woman vulnerable to illness, but it can be responsible for increasing the vulnerability of others, especially during pregnancy when they can easily transfer illnesses to the fetus. When a woman becomes pregnant, she is expected to follow certain guidelines to prevent doing harm to herself, the fetus, and her surroundings. The precautions that are prescribed to pregnant women also reflect the widespread fear and preoccupation with maternal mortality in the region. According to The World Bank, the 2015 maternal mortality rate of Bolivia is 206 deaths for every

100,000 live births; Ecuador is 64 deaths for every 100,000 live births; and of Peru is 68 deaths for every 100,000 live births. For comparison, the estimated 2015 maternal mortality rate in the United States is 14 deaths for every 100,000 live births. Death during childbirth is therefore a very real possibility for women in the Andean highlands, and they take many precautions to reduce the complications during birth, thereby reducing the risk of death.

In the indigenous Andean medical system, miscarriage is largely attributed to physical strain on the woman, conflicts within the family or community, and unfulfilled desires of either the fetus or the pregnant woman (Hammer 1997). Therefore, pregnant women are advised to take certain precautions and avoid many activities, although in actuality social and economic circumstances make this difficult. During pregnancy, women generally avoid the more physically strenuous activities, such as carrying heavy loads, although they continue much of their routine work, including housework, taking animals to pasture, and helping their husbands in the potato fields (Bolin 2006; Canessa 2012; Hammer 1997; Ingar 2009). Although taking such precautions is ideal for pregnant women, many women are not able to follow them due to changes in social and gender roles and the resulting additional workloads incurred (Ingar 2009). Additionally, in order to build strength for both the baby's development and for childbirth, pregnant women are prescribed a diet that contains sufficient amounts of fortifying foods, including milk, cheese, meat, and vegetables (Hammer 1997). Unfortunately, these food items are considered luxuries in the Andean highlands and many women do not have access to

them, which leads to few actual dietary changes and little extra food, therefore, pregnant women are commonly referred to as being undernourished (Bolin 2006; Hammer 1997).

There are many precautions that women are able to take, however, in order to protect themselves and their fetuses from the predisposed vulnerabilities and delicacies of the pregnant state of their bodies. For instance, a woman and her husband make regular offerings to the principal household spirit throughout the pregnancy to ensure the health of the woman and baby and an easy birth. Women also often wear threads of black and white wool spun to the left on their ankles and wrists, and occasionally around their waists, to keep away malevolent forces that can cause illness, death, and misfortune to them or their fetus (Bolin 2006). Although weaving is a typical activity for women in the rural communities of the Andean highlands, when pregnant, they must refrain from wrapping balls of yarn, spinning, and weaving because all of these acts put the fetus at risk of getting wrapped or tangled up in the umbilical cord, which would trap it in the womb and cause complications at birth (Bolin 2006; Hammer 1997).

Furthermore, because pregnancy must be maintained as a humorally hot state, women take care not to expose themselves to cold temperatures or submerge themselves or, more specifically their hands, in water. Exposure to cold causes complications and slows the delivery process, which puts the woman and the baby in danger (Ingar 2009). Conversely, pregnant women must also avoid intense heat, such as sitting with their back to the sun, which causes the placenta to stick to their vertebrae, potentially causing fatal complications at birth. Although all age groups and both sexes refrain from the intense

heat of high altitude sunlight, pregnant women are particularly vulnerable as a result of their already hot humoral state (Hammer 1997).

In an effort to minimize the risk of transferring various illnesses or causing immediate death to the growing baby, a pregnant woman must be also extra cautious about which activities she participates in, her emotional displays, and what she is witness to. Contact with death, whether visual or physical, can cause harm to the fetus or the mother. If a pregnant woman views a corpse, for example, the fetus will die or, should it survive and is born, it will slowly waste away and die (Larme 1998). Similarly, Doña María of Ecuador states that she inadvertently caused herself to miscarry three months into a pregnancy when she witnessed a woman slaughter a pig (Morgan 1997). In some regions, women are also advised not to carry meat because it risks birth complications and can cause the deaths of the woman and baby (Bolin 2006).

A pregnant woman is also capable of transmitting her negative emotions to the fetus in her womb, which could be detrimental to its health. Therefore, pregnant women must avoid intense emotional reactions, or thinking of unpleasant or troubling events, which would negatively affect the health of the fetus (Bolin 2006; Ingar 2009). A lack of companionship and emotional support, as well as a lack of assistance during labor from family members will contribute to perinatal difficulties. When men migrate away from their community to work or fail to give their wives the proper care during pregnancy or excuse them from strenuous work, the mother and baby suffer during the pregnancy and at and after birth (Hammer 1997).

The precautions taken during pregnancy are designed to protect a woman and baby from complications of childbirth by warding off malevolent forces, humoral imbalances, or physical difficulties. All of these are designed to decrease the risk of maternal death during childbirth, and promote the health of the woman and baby before, during, and after the birth. Not only is a woman at an increased risk because of her body's anatomy and predispositions, but the vulnerabilities and state of her body can also affect her environmental surroundings or, if she is pregnant, put her fetus at risk. Therefore, women must not only take precautions to protect themselves, but also to protect their immediate surroundings and their fetuses.

Summary

The cultural construction and perceptions of the female body plays an important role in women's reproductive health and in the healthcare that women seek. In this chapter, I have explained how the female body's biological functions are understood, and how it is directly related to woman's role within the community. The female body is defined through its reproductive abilities, and it is through its reproductive potential that women are associated with the fertile and nurturing powers of Pachamama. Many of the responsibilities that women are ascribed by society in the Andean highlands reflect the perceived innate caring and nurturing qualities of women. The culturally ascribed roles of women in the Andean highlands are directly related to their body's reproductive abilities. By being associated with the fertile and nurturing powers of Pachamama, women are

bound to fulfill the role of mother and caretaker of the household and any related roles that extend her nurturing role.

Based on this perception of the female body, women consider themselves in state of chronic social and physical weakness, which can be transmitted to others. The woman's body and its functions put women at an increased risk to illness and leave women in a state of chronic physical, emotional, and social weakness. The physical anatomy of the female body makes women more vulnerable to illness-bearing forces, while the reproductive functions of their bodies contribute to a perceived chronic state of weakness as a result of constant blood loss. Furthermore, the gendered tasks that are attributed to women based on their body's reproductive abilities deny the cleaning that is necessary for optimal health. The woman's body is also capable of causing harm to the environment and others, therefore, women must take specific precautions not only to protect themselves from the vulnerabilities of their own bodies, but also to protect their crops or, if pregnant, their fetus, which can be affected by the state of her body or by her actions.

The perception of the body is essential to the way illnesses are understood to affect the body, and thus how those illnesses can be treated. In the following chapters, I discuss some of the social and cultural barriers that prevent women from seeking biomedical healthcare services. I demonstrate that in many cases, indigenous women choose health services based on how those services address their physical body, but also based on how those services are understood culturally.

Chapter 5: Negative Encounters with Biomedical Personnel

The encounters of indigenous women with biomedicine and biomedical personnel remain a major factor in indigenous women's avoidance of reproductive health services offered in biomedical facilities. In this chapter, I discuss the historical, cultural, and social context that contribute to general negative perception that indigenous women have of biomedical personnel. Indigenous Andean women frequently report their physical and cultural discomfort when visiting biomedical facilities. These negative experiences are often caused by discrimination on the part of biomedical personnel or the divergences between the indigenous Andean and biomedical practices. Furthermore, the overall perception of exploitative doctors is prevalent in the accounts of indigenous women's experiences with biomedicine. This perception is fueled by a history of exploitation by outsiders, which has been personified as the *kharisiri*. In the second part of this chapter, I argue that the association with biomedical personnel with the *kharisiri* further contributes to the feelings of distrust toward the biomedical system.

Divergences between Indigenous Medicine and Biomedicine

Many women do not seek biomedical services because of previous negative experiences with biomedical personnel. These negative encounters are the result of various barriers, which can include language barriers, divergences between the

indigenous medical and the biomedical system, and discrimination by medical personnel. These types of experiences are also evident in many instances throughout the world (Bradby 2012; Gold and Clapp 2011; Hardon et al. 2012; Jordan 1979; Neuman and Obermeyer 2013; Sargent and Bascope 1996). Although the reasons for tension between indigenous women and biomedical personnel vary greatly, I discuss some of these difficulties that are caused in part by divergences between the indigenous Andean medical and the biomedical systems. Many indigenous Andean women often avoid biomedical services because they fear being mistreated and misunderstood by biomedical personnel, and because biomedical services often conflict with indigenous medical theory.

Antagonizing Indigenous Medicine

A key aspect of biomedicine is the rejection of other medical systems (Sowell 2001). Therefore, biomedical personnel often discredit indigenous medical techniques and theories as superstitions, and have a lack of knowledge regarding indigenous medicine (Camacho, Castro, and Kaufman 2006; Hammer 1997). Additionally, biomedical personnel often only mention indigenous medical techniques when they are condemning and devaluing the practices as harmful (Hammer 1997). When seeking biomedical services, indigenous women are often scolded and reprimanded by biomedical personnel for their poor health, their reluctance to follow the advice of biomedical personnel, and even for lacking necessary funds for treatment (Hammer

1997). This tendency leads to the further alienation of indigenous women from biomedical personnel and discourages the use of biomedical services.

Authority During Childbirth

During childbirth in a biomedical facility, women do not have autonomy (Sargent and Bascop 1996; Zug 2013). Through the United States' model of biomedical system, which is the primary biomedical model adopted in the Andes, "birth is overwhelmingly seen as a medical event" (Jordan 1979, 49), and a procedure by which the laboring woman is the patient in need of medical treatment (Martin 1989). In general, biomedical birth is performed as a procedure with prescribed stages and actions. If the stages of labor do not progress according to their prescribed length of time, then medical personnel perform corrective actions.

The laboring women have no authority in the process of childbirth, but instead, they "experience their selves as becoming an object the doctors manipulate" (Martin 1989, 84). Thusly,

The woman has no part in the decision-making process. Since parturition is seen as a medical event, the woman appears, and is treated, as a patient... [O]n admission to the hospital, decision-making authority and power are automatically transferred from the patient to the hospital's medical and administrative staff. This means that a woman in labor, regardless of whether it is normal or medically complicated (however defined), is relieved or responsibility for her state, is defined as incompetent to manage the situation, and is expected to submit to the professional competence of the physician (Jordan 1979, 89).

As primary caregivers to their families and themselves, indigenous women of the highland Andes are accustomed to maintaining autonomy regarding their health and their bodies. In biomedical facilities, indigenous Andean women lose their power to make

decisions regarding their health and wellbeing, and therefore, in an effort to maintain autonomy, many women avoid seeking biomedical services for prenatal care and childbirth (Hammer 1997). For instance, in both the government and private health clinics in Peru,

all pregnant women receive a “birth plan” on their first visit. This is a regionally pre-drafted contract that commits women to giving birth at the government facility in the position most convenient for the health provider. There is no real space to voice desires about specific interventions or preferences during birth, and women are assumed not to know much about the institutional process of childbirth to voice opinions anyway (Zug 2013, 64).

When admitted to the biomedical facilities for childbirth, women relinquish their authority to biomedical personnel and the procedure of childbirth is intended to follow a prescribed sequence. Women are expected to accept the ultimate and unwavering authority of the biomedical personnel. In the private facilities of Peru, “every first-time mother receives an episiotomy, and gives birth on her back with the help of Pitocin with a few, if any, exceptions” (Zug 2013, 66). When the researcher asked if women ever requested otherwise, “the physician was puzzled by my question, but assured me that this never occurs; these women are educated and they know how birth must proceed” (Zug 2013, 66). The mere consideration of a woman not succumbing to the given authority of biomedical personnel confuses the doctor, demonstrating that his authority goes uncontested.

The importance and authority of biomedical personnel is also reflected in the birthing positions during a biomedical birth (Martin 1989). The position of the laboring woman during biomedical birth is on her back with her feet in stirrups, and the genitals

exposed. This position, despite making it more difficult for the laboring woman, if she were able to play a role in the birth, facilitates the extraction of the baby by the doctor.

This position is at odds with the preferred laboring positions of indigenous women. It is generally very rare for a woman to give birth lying down during a homebirth in the highland communities. Instead positions such as squatting, standing with knees bent, and kneeling, or on hands and knees are preferred (Bolin 2006; Canessa 2012; Bradby 1999). All of these preferred positions allow for the baby to be born downward, which is an essential element of birth in the Andes, as it contains great spiritual and symbolic meaning. Depending on the region, the baby must be born downwards, toward the earth, so that it can be received by and establish its first contact with Pachamama or to symbolically be associated with “the astronomical configuration of the “black llama” giving birth to her young, which marks the onset of the rains which fall to earth” (Bradby 1999, 292; Ingar 2009).

In addition to their symbolic meaning, these laboring positions, and the choice to change between them reflect that during a homebirth, indigenous women are able to maintain autonomy during the childbirth process (Bradby 1999). In a pilot site that was established through the Peruvian government’s efforts to accommodate indigenous customs in biomedical facilities, there are ropes hanging from the ceilings of labor rooms, which were designed to facilitate vertical birth positions. However, the ropes are avoided because the biomedical personnel feel that they cannot catch the baby from a vertical position, and the dirty floor will cause contamination (Zug 2013). The authority and preferences of biomedical personnel overrides the preferences of the patients.

Violation of the Body

Biomedical prenatal care and childbirth often violates the cultural rules of the Andean highlands, leaving women feeling violated and poorly treated. In the rural highland communities of the Andes, cultural standards of modesty prohibit a woman from disrobing in front of anyone except her husband, or exposing their genitals (Torri 2011; Zug 2013). Vaginal examinations are a routine procedure during prenatal checkups and during childbirth, which call for women to both disrobe and expose their genitals. An indigenous woman in Bolivia explains:

I don't like to be attended by a doctor...in many cases doctors are men...besides doctors normally examine the genitals and they touch them. I feel ashamed to be seen or touched by a man who is not my husband...on the other hand a *partera* [midwife (Sp.)] is a woman and she never touches the genitals...this is why I feel much more comfortable with a *partera* [midwife] (Torri 2011, 409).

The necessity for biomedical doctors to touch a woman's genitals during a prenatal exam violates the cultural standards for modesty. Disrobing for and allowing a (usually male) doctor to touch the genitals seems unnecessary as compared to the methods of the midwives. In the indigenous medical context, a midwife performs prenatal exams and is able to determine fetal health and position by massaging the woman's abdomen, and the extent of dilation is determined by measuring the laboring woman's pulse (Bradby 2002; Torri 2011; Zug 2013).

The sense of violation by biomedical personnel is exemplified through a portion of a conversation between Barbara Bradby, Doña Lidia, a midwife in Sucre, Bolivia, Doña Lidia's daughter, and Mary Aguilar, a biomedical nurse (Bradby 2002), in which they discuss the intrusiveness of biomedical doctors who routinely touch the genitals of

and insert their hands and tools into laboring women as a part of examinations and birth assistance.

M: ...Because in hospital, their hands, they're always sticking them up
H: THEY DON'T LOOK, do they. Not ONE moment do they look!
P: IN goes the HAND! HUHH! [[very angrily]] (2002, 74).

Bradby explains:

This assessment by the daughter comes as a forceful interjection while Mary is still speaking, *immediately* she mentions the word 'hand' (*makin*) in association with hospital personnel, and *before* she has even pronounced *sat'isanku*, a Quechua expression that is used for stuffing a hole or a sausage, for raping a woman, and for anal sex between men (Perroud and Chouvenc 1970). Her mother's angry outburst, '*In goes their hand! Huh!*' (3320), occurs after Mary has pronounced this latter word, and interruption and reinforces her daughter's response (2002, 78).

The doctor's technique of "sticking his hand up" into the woman to examine her is equated to acts of considerable vulgarity and violation, such as rape or homosexual sodomy. This is juxtaposed against the method of midwives, used by Doña Lidia of looking at the laboring woman's hand and veins and taking note of the difference in her pulse in order to determine when she is about to give birth. Therefore, the biomedical doctor's act of inserting his hand into the woman's body is seen as even more violating simply because there is an equally effective and much less intrusive alternative known.

The Cultural Emphasis on the Placenta

In the indigenous Andean medical system, birth is understood to occur in two stages. The first stage, known as the first birth, begins with labor pains and end with the birth of the baby. The second stage, second birth (Bradby 1999), is the expulsion of the placenta and the recovery period (Camacho, Castro, and Kaufman 2006).

According to midwives, the placenta must be expelled in under an hour after the birth of the baby (Ingar 2009). If the placenta is not born immediately after the baby, the cut umbilical cord is tied to the woman's left toe with a woolen thread "spun to the left" (Bradby 2002, 85) in order to prevent the placenta from retreating up the body and suffocating the mother (Bradby 2002; Bradby 1999). In order to help the woman expel the placenta, her birth attendants will continue to massage her back and abdomen and give her more warming tea (Bolin 2006; Bradby 1999). While the woman will rarely, if ever, use a lying-down position for giving birth to the baby, such positions are occasionally adopted for expelling the placenta (Bradby 1999).

The rituals of traditional birth in the Andes are focused more on the birth of the placenta than the birth of the baby because the placenta is considered a part of the spirit world. When the baby is born, it leaves the world of the spirits and enters the world of the humans, although it remains symbolically and physically linked to the spirit world through the umbilical cord. This link therefore needs to be cut and the placenta must be carefully returned to the world of the spirits (Bradby 1999; Canessa 2012). The sacredness of the placenta is demonstrated by the healer of Wila Kjarka, Teodosio, who uses the fat of the placenta to spread over the newborn baby as protection from evil spirits and malevolent forces. This protection is interpreted as a blessing on the part of the house spirit to which the placenta will be returned (Canessa 2012).

In order to return the placenta to the spirit world, a death ritual must be performed in which the placenta is washed and either burned or buried, depending on location (Camacho, Castro, and Kaufman 2006). In the Chillihuani, for instance, the placenta is

washed and burned in an open wood fire (Bolin 2006). Alternatively, in Wila Kjarka, the placenta is washed before being returned to the home and buried in the corner of the house that belongs to the house spirit (Bradby 1999), or buried nearby the dwelling thereby returning it to Pachamama (Ingar 2009). By properly disposing the placenta, the woman's continuing fertility, health, and the health of the newborn baby is ensured (Bradby 1999; Guerra-Reyes 2009; Ingar 2009).

Biomedical birth does not place a strong emphasis on the birth or disposal of the placenta, which causes anxieties over its disposal among indigenous women (Guerra-Reyes 2009; Hammer 1997) One woman exclaimed: "At the hospital, they just throw away the placenta, or burn it, who knows?!" (Hammer 1997, 282). This anxiety over the proper disposal of the placenta, and subsequently over the future health and wellbeing of the woman and newborn baby, contributes to the indigenous feelings of distrust towards biomedical personnel.

Unattended Birth

The prevalence of unattended birth becomes evident through indigenous Andean women's stories of childbirth in biomedical facilities. In the Andes, unattended hospital births "turned out to be a relatively common occurrence" (Bradby 1999, 288) and are frequently brought up in accounts of both indigenous women and medical personnel. According to Bradby,

A young nurse confirmed that it was indeed the case that women sometimes give birth alone in the hospital bed. She reasoned that this was because the woman came in very late, and that there was only just time to bathe them and put them to

bed, where they would give birth while the nurses were attending another birth in the labour ward (1999, 296).

The nurse explains that the women often give birth unattended because they arrive at the hospital at a later stage of labor and therefore give birth before hospital staff are available to assist. In the case of Doña Alejandra whose husband insisted she give birth in a hospital, she did not even have time to arrive at the hospital to give birth alone. Instead, she gave birth in the taxi on the way to the hospital (Bradby 1999).

During the birth of her second child, Emilia of the Peruvian highlands was frequently left alone for long periods of time. “Emilia speaks sadly of the loneliness she felt there, left by herself for hours at a time, and what relief she felt when José arrived with a big pail of soup” (Allen 2002, 197). During her experience in the hospital, Emilia was neglected by medical personnel, and was almost certainly not permitted to eat during her labor. When José came to visit with soup, she was relieved not only at the prospect of a meal, but also for social interaction.

During a homebirth in the rural Andean highland communities, birth attendants play an active role throughout the birth. They are responsible for tending to the comfort of the laboring woman, ensuring that she is comfortable, fed, and maintains the proper warm environment throughout the birth process (Bolin 2006; Canessa 2012; Ingar 2009). The perceived inattentiveness of the biomedical personnel is in stark contrast to the attentiveness of home birth attendants, which promotes homebirth as significantly more comfortable than biomedical birth.

So far, I have discussed some examples of the specific biomedical practices that are in opposition to indigenous medical practices and understandings. These specific

practices are barriers that dissuade indigenous women from seeking biomedical services. However, these practices are only part of the overall perception of biomedical personnel, which equates to another barrier to the use of biomedicine.

Historical Exploitation of Indigenous Groups

Indigenous groups in the Andean highlands have fallen prey to countless methods of exploitation in their short history of Western contact, which unfortunately continues into the present day. This history of exploitation has accumulated in cultural perceptions of non-indigenous individuals, which manifests in the widely-documented phenomena of the *kharisiri*. The *kharisiri* can be, and has been, applied to the various aspects of the relationship between indigenous and non-indigenous peoples. Through the accounts of indigenous participants, it becomes evident that the behaviors of doctors and governments in their efforts to promote biomedical birth and diminish infant and maternal mortality rates, have continued to reinforce the concepts behind the *kharisiri*, and thus continue to weaken the relationship between indigenous and non-indigenous groups.

The mistrust of biomedical health workers by indigenous groups was apparent throughout many of the accounts that I came across in my research. While there are many reasons for this mistrust, the connection to the fat-stealer, *kharisiri*, cannot be overlooked. Stories of the *kharisiri* are well documented throughout the Andes even into the present day. The names for the fat-stealer vary throughout the regions and communities of the

Andes. However, throughout my research, the most frequently used term to refer to the phenomenon was *kharisiri*, which is what prompted me to use it in this thesis.

Fat in the Indigenous Andean Context

According to the indigenous Andean medical system and worldview, fat is a life force and is an important means of communication with spirits (Canessa 2012). Fat is seen as protective against hard physical labor and the rapidly changing air temperatures of the Andean highlands (Bastien 2003; Blaisdell and Vindal Ødegaard 2014). Having a sufficient amount of body fat is associated with vitality and good health and those with more fat are considered more powerful (Bastien 2003; Canessa 2012).

Non-human fat is prominently used in offerings to spirits as a substitute for human sacrifice. It is through offerings that humans are able to reinforce their relationship with the spirits, who feed off fat for sustenance (Canessa 2012). Fat also plays a significant role in a range of rituals, including to feed spirits, anoint leaders, and dispel curses and is therefore an important element in health and healing, social changes, and the political process (Bastien 2003).

The Stealers of Fat

Kharisiris appeared in the Andean historical accounts around the same time that the Spanish came to the region and are generally expressions of otherness and racial tensions, and the violent historical and present-day relationships between indigenous communities and colonialism, capitalism, racism, and exploitation (Blaisdell and Vindal Ødegaard 2014; Canessa 2012; Canessa 2000; Wachtel 1994; Weismantel 2001). As the

personification of these tensions, the *kharisiri* profits monetarily by stealing the fat, and consequently the life, of the indigenous peoples. The *kharisiri* sells the stolen fat to various organizations and institutions, which use it to make chrisem oil, candles, soap, cosmetics, medicine, machine and train lubricants, and even rockets for the United States (Canessa 2012; Blaisdell and Vindal Ødegaard 2014). In the 1980s, there were even widespread rumors that the fat of indigenous peoples had been used by government officials of Peru to pay off the country's national debt (Blaisdell and Vindal Ødegaard 2014).

Kharisiris can potentially be any strangers or outsiders who lack a relationship with the spirits and do not participate in or follow the typical acts of reciprocity that are exhibited within the communities of the Andean highlands (Blaisdell and Vindal Ødegaard 2014; Canessa 2012; Canessa 2000; Weismantel 2001). They are associated with positions with access to power, resources, or knowledge that originated elsewhere that have been historically used to exploit indigenous groups in the Andes. Such positions include clergymen, hacienda owners, politicians, engineers, and biomedical doctors (Bastien 2003; Blaisdell and Vindal Ødegaard 2014; Canessa 2012; Palaez-Barrios 2011; Wachtel 1994; Weismantel 2001).

Kharisiris generally attack when their victim is in a vulnerable state, such as walking alone at night, sleeping, or while travelling (Blaisdell and Vindal Ødegaard 2014; Palaez-Barrios 2011). If the victim is not already asleep, the *kharisiri* uses prayers or powdered human bones to put the victim to sleep (Blaisdell and Vindal Ødegaard 2014; Canessa 2012). Once the victim is asleep, the *kharisiri* uses various tools to extract

the fat from their body (Canessa 2012; Wachtel 1994). Although in the past, *kharisiris* were said to use knives to cut into their victims, their tools have advanced with technology. Present day accounts of *kharisiris* describe their tools as needles and syringes, or small machines such as watches, cameras, and tape recorders (Blaisdell and Vindal Ødegaard 2014; Canessa 2012; Palaez-Barrios 2011; Wachtel 1994). In some cases, *kharisiris* are said to be able to extract one's fat simply by looking at them, or from a great distance by using a laser (Blaisdell and Vindal Ødegaard 2014).

The victims of *kharisiris* are usually healthy adults, who are engaged in production and reproduction within the community, and generally not children or the elderly. By targeting adults, “*kharisiris* strike at the very core of social reproduction” (Canessa 2012, 179), thereby keeping their victims, their families, and their communities, “oppressed due to reduced economic productivity” (Blaisdell and Vindal Ødegaard 2014, 11). However, Wachtel (1994) alludes to an instance in Lima, Peru, in 1988 in which rumors had spread that children's eyes were being extracted while they were in school by armed non-indigenous men. He suggests that “the resulting blindness be a physical metaphor for the darkness in which the poor and illiterate are living” (Wachtel 1994, 86). The children are denied education and must live in metaphorical darkness, thereby inhibiting the future advancement of the community through education. This further supports the notion that *kharisiris* target the most productive members of the community, they are able to cause damage to the community as a whole. *Kharisiris*, therefore, not only oppresses indigenous communities, but they also profit from those communities' oppression.

Once the *kharisiri* steals the fat of his victim, the victim becomes increasingly weak and usually dies unless they are able to perform the correct rituals or replace the stolen fat or kill the *kharisiri* (Bastien 2003; Blaisdell and Vindal Ødegaard 2014; Canessa 2012; Palaez-Barrios 2011; Wachtel 1994). Even so, the chances of surviving a *kharisiri* attack are small, as explained by one of Canessa's participants in Bolivia: "But when it comes to *kharisiris*, when the fat has been removed you are just going to die...*Zas!* You just have to die when you have been '*kharisiried*'" (Canessa 2012, 176).

The *kharisiri* continues to hold a presence in the Andes into the present day and there are many documented cases of individuals having been punished or killed on suspicion of being a *kharisiri* (Blaisdell and Vindal Ødegaard 2014; Canessa 2012; Palaez-Barrios 2011; Wachtel 1994; Weismantel 2001). While historically *kharisiris* were specifically non-indigenous males, present-day renditions explain that indigenous men and women also have the potential to become a *kharisiri* as a result of the influences of modernization (Blaisdell and Vindal Ødegaard 2014; Canessa 2012; Palaez-Barrios 2011). Indigenous people who exhibit a sudden change in social status, have acquired many expensive items, pursue an education, or have adopted modern lifestyles as a whole and reject their indigenous past are suspected of being *kharisiris* (Palaez-Barrios 2011; Wachtel 1994; Weismantel 2001). Señora Margarita, a Bolivian woman, explains the increased threat of *kharisiris* to indigenous communities: "There are more nowadays, it is said, even among the young girls, the youngest girls, in the past, we did not hear like that, it is said, today there are more. Who can it be? ...Yes, young people, it is said, students, college students, university students, they could have been. They might have been

taught” (Palaez-Barrios 2011). The influences of non-indigenous cultures through urbanization, migrant working, and educational opportunities put even indigenous people at risk of becoming a *kharisiri*.

Greed of Biomedical Personnel

The cultural phenomenon of the *kharisiri* continues to contribute to the distrust of biomedical personnel, which discourages the indigenous use of biomedical services. Those in highland communities often perceive of biomedical doctors as *kharisiris* (Bastien 2003). Not only are biomedical doctors understood to be trained in surgery and therefore have the “know-how to extract fat” (Blaisdell Ødegaard 2014, 13), but many of their standard tools are also tools of choice for the *kharisiri*, especially the needle. In addition to this, it is also widely rumored that biomedical personnel perform various unnecessary procedures for their own monetary profit. For example, a woman in Bolivia, Doña Rosa, states, “The nurse wants us to keep having lots of babies so that she can vaccinate them. You see, the more she vaccinated, the more she gets paid” (Hammer 1997, 290). This statement exemplifies the perceived greed of the biomedical personnel. The nurse, perceived to be motivated by money, benefits from Doña Rosa’s and other indigenous women’s uncontrolled fertility in that the more babies the women have, the more money the nurse can make. Therefore, this nurse is interpreted as profiting at the expense of the indigenous women.

The belief that biomedical personnel perform unnecessary services for their own benefit and procedures is especially present when it comes to childbirth in the hospital.

Women who give birth in the hospital run the risk of having to undergo a cesarean section if difficulties arise. While other methods of biomedical assistance during childbirth do not necessarily conflict with indigenous Andean medical theory, the caesarean section goes against it in almost every aspect. During childbirth, a woman's body must be warmed because it is believed that the baby uses the mother's warmth. If the mother does not remain sufficiently warm, labor will slow and malevolent forces can enter the body more easily. During a cesarean section, metal tools are used, and because metal is humorally cold, exposure to it can bring harm to the laboring woman and child. Malevolent forces and evil spirits enter through the body's openings to inflict illness. Women in labor are considered to be "open" and therefore extremely vulnerable to these forces. By creating an incision in the woman, as is necessary to perform a cesarean section, she becomes further "open" and thus even more susceptible to illness (Bastien 1982; Bradby 1999; Torri 2011). Although it is considered a common and safe procedure within the biomedical system, a cesarean section is thus an extremely dangerous practice according traditional Andean medical theory.

The rejection of the caesarean section by indigenous Andean women is also the result of the actual and measurable danger of the procedure in the Andean region. As recently as 1999, Bolivian hospitals had a post-caesarean death rate of 49% over a ten-year period (Bradby 1999). This high death rate only adds to the fears that are already associate with childbirth in general, and while hospital birth has been promoted and accepted as the safer option to homebirth, the reality of death during childbirth, even during biomedical care, causes fear and avoidance of hospital birth and especially the

cesarean section. Here, Bradby describes the fears of Doña Emilia of Bolivia as she left for the first time to give birth in the hospital to her fifth child:

So, as she padlocked the doors of her house to go to hospital for the first time, her fears were not around the birth itself. Her thought, “Will I return or not?” referred rather to her fear of hospital, and in particular of the caesarean operation, with which she had already been threatened (1999, 287).

Doña Lidia clearly feared for her life, which was especially dependent on whether or not she would need to have a cesarean section. Despite hospital birth being promoted and perceived by Andean governments and biomedical personnel as safer than homebirth, the woman’s safety, as it is perceived through the indigenous medical system or through the biomedical system, is not guaranteed. In opposition to the fundamentals of traditional childbirth, mingled with notions and tales of folklore, and backed by significant rates of death, “to be subjected to the caesarean was, for her, and many women like her, to run the risk of death” (Bradby 1999, 287).

Another woman from Bolivia, who went to the hospital to give birth, was strongly recommended a cesarean section despite having no complications during her labor. In an interview with a researcher, she explains:

Did you have the cesarian section?

No. The baby was born and it was a normal delivery.

So why did they want you to have a cesarian section?

I don’t know. I think it was because they wanted to practice or something, or for the money. I don’t know (Schuler, Choque, and Rance 1994, 215).

The doctors did not give the woman a reason for their recommendation of a cesarean, which led the woman to speculate that they would make a larger profit from the procedure than they would from a natural birth. However, she also mentions that the doctors may have wanted the chance to practice the procedure on her. This is evidence of

another perception surrounding biomedical practitioners, that biomedical doctors and medical students use indigenous patients as guinea pigs to gain surgical experience (Hammer 1997). In this scenario, the biomedical personnel are, once again, portrayed as greedy for a chance to either earn extra money or to gain knowledge by experimentation by performing an unnecessary cesarean section. Whichever their motive, the biomedical personnel would have benefited at the expense of the indigenous woman.

Not only are biomedical personnel portrayed as eager to profit from unnecessary procedures, but they are also seen as willing to perform additional procedures on individuals that are already being operated on. These procedures include removing (stealing) organs from their indigenous patients to sell on the black market, “one woman put it this way: ‘We have lots of things inside of us, here (referring to the abdomen); doctors might cut, damage or take out something we need.’” (Hammer 1997, 279). This reflects the distrust that indigenous patients feel toward biomedical doctors to perform a surgery honestly, and to leave their bodies intact.

Forced Sterilization of Indigenous Women

Unfortunately, the distrust related to additional and unnecessary procedures is based on actual events. In Peru during the late 1980s,

a select group of military officers wrote a document entitled “Coups Plan”[...] which argued that “the most important problem facing Peru is that its demographic trends since World War II have reached epidemic proportions. Population growth must be stopped immediately,” concludes the document, suggesting that the most “convenient” method toward this end is “the generalized use of sterilization among culturally backward and economically impoverished groups” (Burt 2016, n.p.).

This plan was put into practice during the dictatorship of Alberto Fujimori (1990-2000) in 1992. Laws to make sterilization legal in Peru were passed in 1994 (Kleiss, 2004), and between the years of 1996 and 2000, the controversial and unethical Programa Nacional de Salud Reproductiva y Planificación Familiar (PNSRPF) was implemented forcibly (Chanduvi Jana 2015). Under the guise of women's rights and increased access to family planning services (Pacino 2015), PNSRPF sought to promote economic growth and development and reduce poverty (Burt 1998; Pacino 2015; Rousseau 2007). As a result of the high rates of poverty and maternal mortality in the highlands, sterilization by tubal ligation for women and vasectomies for men disproportionately aimed at the people, especially the women, of these communities, "who often lacked information about reproductive technologies and had difficulty controlling their fertility" (Pacino 2015, 17).

In an effort to encourage sterilization, the Peruvian government purposefully withheld contraceptives and provided material incentives to women (Pacino 2015). Some women from poor communities "actively sought out the free treatments and traveled in order to receive them, and some women used the sterilization program as a way to get around cultural or religious aversion to birth control or to circumvent a male partner's resistance to limiting pregnancies." (Pacino 2015, 17). In addition to offering incentives to women to encourage tubal ligation, the government also persuaded doctors to perform the procedures by issuing quotas. "According to the Peruvian Medical Federation, Ministry of Health physicians were offered monetary incentives based on the number of sterilizations performed, and some doctors feared losing their jobs if they did not meet their "quota"" (Burt, 1998). The necessity to meet their quotas led many doctors to

engage in unethical tactics to coerce women into having tubal ligations (Kleiss, 2004). Doctors would often use bribery and threats to coerce women into tubal ligation. Doctors frequently bribed women with food subsidies and “false promises of free education for their children” (Kleiss, 2004) and of forgiven hospital expenses accrued from childbirth (Burt 1998). Similarly, doctors also threatened them that they would lose their food subsidies or that they would be fined if they had any more children (Boesten 2007; Brut 1998; Kleiss 2004; Pacino 2015). The doctors would even tell illiterate men that their wives required immediate surgery without giving details as to what the surgery was for, thereby misinforming and convincing them to undergo medical procedures that they did not completely understand (Boesten 2007; Kleiss, 2004; Pacino 2015).

Women who went to hospitals to give birth, either by choice or by persuasion, would undergo caesarean sections, followed by tubal ligation without consent (Kleiss, 2004; Rousseau 2007). Upon waking after a forced caesarean section, a woman found out that, not only was her baby dead, but she had been sterilized without her knowledge: “‘When I wanted to see my child, they told me he was dead,’ Espinoza said, trembling with emotion. ‘I said, ‘I want to go home now.’ The intern said, ‘She is very sad because her child died.’ My doctor responded, ‘You will have another child,’ to help calm me down. But I heard the nurse whisper, ‘No, she is ligated’” (Russell, 1998, 18).

Not only were the sterilization procedures performed without consent, but they were also often performed by poorly-trained medical staff in substandard and unsanitary conditions, frequently without anesthesia (Burt 1998; Kleiss, 2004; Pacino 2015). These conditions resulted in frequent complications and, because doctors did not always

conduct follow-up examinations to monitor the patient's recovery, many women were left with infections that lasted for months, and many died as a result (Burt 1998; Chanduvi Jana 2015; Kleiss, 2004; Pacino 2015).

During a period of four years, “nearly 300,000 women and 22,000 men, mostly from the Andean highlands, underwent forced sterilizations without receiving clear information about the procedures and without giving informed consent, resulting in a detrimental impact on their health as well as their family, social, and community life” (Chanduvi Jana 2015). The unethical nature of these policies is confirmed by the fact that many of the women who underwent forced sterilization included those who were childless or postmenopausal (Pacino 2015).

Cases of forced sterilization are evident not only in Peru, but elsewhere in the Andes and throughout the world. A Bolivian woman underwent a necessary cesarean, and unbeknownst to her, the doctor decided to either implant an intrauterine device (IUD) or perform a tubal ligation on her:

When I had the last baby and suffered so much, the doctor told me that I wasn't going to have any more kids. I wonder why he said that.... Maybe he 'cured' me [did something so that I wouldn't be able to have children]. They say that right after you have the baby is the best time for the doctor to 'cure' you. I wonder whether that's what he did to me (Schuler, Choque, and Rance 1994, 215).

Even after leaving the hospital, she does not know exactly what other procedures had been performed on her during her cesarean section. The only thing she is aware of is that she is no longer able to become pregnant. This recent manifestation of unconsented and forced sterilization has significantly influenced women's choices in seeking biomedical services during pregnancy and birth. Furthermore, actions such as these from individuals

in powerful positions continue to reinforce the stigma of these positions in regards to the *kharisiri*.

Summary

The negative experiences of indigenous women with biomedical personnel perpetuates the reluctance of indigenous women to seek biomedical services. These experiences are often the result of biomedical practices that conflict with indigenous medicine. Women report feeling antagonized and disempowered during biomedical services, in which they are scorned, violated, and neglected by biomedical personnel.

The historical exploitation of indigenous peoples of the Andes by non-indigenous groups and its personification in Andean folklore as the *kharisiri*, contributes to this negative view of biomedical personnel. Biomedical doctors, with their tools and knowledge for surgery, are often associated with the *kharisiri*. This association has been strengthened by the forced sterilization of indigenous women in the Andes, especially under Peru's Alberto Fujimori dictatorship. As a result of these occurrences, women further distrust biomedical personnel, and resist seeking biomedical services.

The relationship between indigenous women and biomedical doctors is only one of many factors that influence a woman's 'choice' of prenatal and childbirth care. In the following chapter, I discuss a handful of other contributing factors that influence this 'choice' to utilize indigenous Andean services or biomedical services and contraceptives, or a combination of both.

Chapter 6: A Woman's 'Choice' in the Use of Biomedicine

Despite its widespread promotion by both governmental and nongovernmental organizations throughout Latin America, the availability of biomedical services and contraceptives continues to be limited for communities in the Andean highlands. It is apparent that many women in highland communities do wish to utilize biomedical services during pregnancy and childbirth, and to control fertility. However, the choice of women to utilize biomedical or indigenous medical services, or a combination of both, is deeply influenced by an array of factors, including political, economic, geographic, social, and cultural aspects, which often prohibit the actual freedom that is often associated with 'choice' (Bourquia 1995; Corrêa and Petchesky 2007; Hardon et al. 2012; Larme 1998; Torri 2013). In the following sections, I describe only a handful of these varied facts that influence indigenous Andean women's 'choice' of care during pregnancy and childbirth, as well as their choice of fertility control methods.

Political Influence on the Availability and Use of Biomedicine

The trend through Latin America to decrease maternal and infant mortality rates has led to an emphasis on biomedical birth within a biomedical hospital or clinic and the use of biomedical contraceptives. To encourage women to go to hospitals and clinics to give birth throughout

Latin America, there have been efforts in the health sector to officially recognize diversity and some policies and programs have partially incorporated cultural adaptations with regard to language, practices, and beliefs (returning of the placenta, respect for the delivery position, incorporation of traditional medicine, etc.) (Camacho, Castro, and Kaufman 2006).

An example of these efforts to promote biomedical services and facilities over traditional midwifery and homebirth is the birth care policy created by Peru's Ministry of Health in 2005, Vertical Birth with Intercultural Adaptation (Guerra-Reyes 2009). Among other things, this policy addressed many of the biomedical practices that conflicted with the traditional medical system, namely by modifying the birth environment within biomedical facilities. Some of the changes made to accommodate women were using a warm and full covering hospital gown and decreasing the frequency of dilation checks to reduce discomfort; using small electric stoves in the labor and delivery rooms to keep a hot temperature; making it permissible for more than one person to accompany the laboring woman during the birth process; allowing vertical birth positions with the use of birthing stools and floor mats for normal births; allowing the laboring woman to eat and drink, including consuming traditional labor concoctions; switching from metal framed beds to wooden framed beds in order to reduce the amount of humorally cold, and thereby harmful according to indigenous Andean medical theory, metals in the room; and giving the placenta to the family so that it could be disposed of properly (Guerra-Reyes 2009). Although all of these efforts had been implemented in a pilot site visited by Guerra-Reyes initially, she states that when she returned in 2007, they had all been discontinued because they were perceived by biomedical authorities as unnecessary and undesired by their patients, despite patients indicating otherwise.

As understood by governments and non-governmental organizations, one of the major factors contributing to women not seeking biomedical care is geographical distance. Women in the Andean highland communities must travel great distances to the nearest city in order to obtain biomedical services, often without a form of reliable transportation (Guerra-Reyes 2009; Hammer 2001; Zug 2013). For this reason, government-funded and private maternal waiting houses were created at various pilot sites in Peru as an effort to encourage women from rural highland communities to travel to biomedical facilities to give birth. As of 2013, the maternal waiting houses near health posts in Huancayo, Peru, were still in use, although many of the indigenous influences, such as ropes suspended from the ceiling to aid in vertical birth, had been abandoned (Zug 2013).

Contraception has become more readily available in Bolivia, Ecuador, and Peru since the mid-twentieth century. This was largely a result of international development efforts adopting the guiding principal towards population that “linked economic development with smaller populations and families” (Pacino 2015, 15). In Peru and Ecuador, family planning programs were developed and implemented by government health ministries as a response to the pressure of international health agencies in the late-twentieth century. These programs were also supported by the Catholic church in Peru as “part of a broader education plan to the duties of responsible Catholic parents for the betterment of families and the nation” (López 2008, 52) and as a means to ease poverty rates. Women in Peru and Ecuador are generally able to receive education on family

planning and contraceptives in community schools, Catholic parish clinics, and health posts (Hammer 1997; López 2008; Pacino 2015).

Although the Catholic presence in Peru did not adopt a “hard line against girth control” (López 2008, 54), the opposite occurred in Bolivia. The strong presence of the Catholic Church in Bolivia has historically led to the minimization of programs that focus on reproductive health, especially in the rural population. As a result of the Church’s influence, biomedical birth control methods were illegal in Bolivia until the mid 1980s. In the 1990s, the Bolivian Ministry of Health began to succumb to the pressures of international health agencies to participate in the research and development of family planning programs (Hammer 1997; Pacino 2015), which led to reproductive health programs that addressed fertility control with the goals of improving the health of rural “low priority” populations. The Catholic Church continues to be an obstacle to reproductive health programs throughout Bolivia, and the church-run health posts are known to suppress information about family planning and contraception, thereby making it even more difficult for indigenous women to obtain (Hammer 1997).

Using Biomedical Services for Prenatal Care and Childbirth

In some areas of the Andean highlands, biomedical services are more readily available than in others as a result of their proximity to urban centers. In these areas, women who are able to afford the services often seek biomedical services in addition to indigenous medical care. For instance, the Hambi Juasi health post in Otavalo, Ecuador, offers both indigenous and biomedical approaches to prenatal care. The health post

employs biomedical obstetricians as well as indigenous midwives, allowing women the option of seeking either or both types of prenatal examination. In the case of this particular health post, the biomedical prenatal exam is subsidized, and thus free to women, while the indigenous exam is available for a fee of \$5. Despite the economic incentive for women to only be examined the biomedical obstetrician, many women opt to be examined by indigenous midwives, or both practitioners for various reasons (Torri 2013).

The women who frequent this health post, utilize both medical systems in order to obtain a more holistic diagnosis. These women view the prenatal services of midwives and obstetricians as fundamentally different from one another, and therefore often seek the combination of both to ensure the most thorough care (Torri 2013). On one hand, biomedical doctors are utilized for “the specific service of scientific procedures, ultrasounds, and pills” that are heavily reliant on the use of technology (Torri 2013, 404). Biomedical personnel use technology to monitor the heartbeat and progress of the fetus and prescribe vitamins and supplements to pregnant women. Women also take advantage of visits to the obstetricians for the opportunities to learn about the prevention of sexually transmitted diseases and papillomavirus cancer.

On the other hand, midwives at the health post, as elsewhere across the Andean region, perform the services of the indigenous Andean medical system, including the prenatal massage, and treatment for the displacement of the uterus, which occurs when a woman carries heavy loads, falls, or has a humoral imbalance (Torri 2013). To illustrate why women utilize the services of both medical systems, one woman stated:

Traditional midwives know the exact position of the baby inside the womb, how it is growing... the doctors can only do an ultrasound and say whether the child is doing well or not.... on the contrary, the *partera* [midwife] only by touching the belly is capable of understanding how the baby is doing (Torri 2013, 402).

Although obstetricians and midwives both examine the fetus, their methods result in different sets of knowledge. Thus, by utilizing both services, women are given the satisfaction of holistically knowing the state of their pregnancy through the methods of two medical systems.

Women may also seek out a hospital birth for the additional assistance and perceived safety that is available through the biomedical system (Bradby 1999). During a traditional home birth, women commonly seek assistance in facilitating the labor and hastening the birth. This assistance comes in the form of warming herbal teas and broths, and massaging the back and abdomen, which manually helps to push the baby out (Bradby 1999).

This concept of assistance during childbirth extends to biomedical methods. Women often choose to go to the hospital for assistance during birth, which includes medications that speed up the birth process or dull pain, and for the care given by biomedical personnel. Although originally skeptical and fearful of giving birth in the hospital, Doña Emilia of Bolivia “was enthusiastic about the “good attention” she had received” (Bradby 1999, 288), despite having given birth unattended. However,

she saw no contradiction in going to hospital and giving birth alone, because the attention she was seeking was to do with what happened after the birth of the baby. This is in line with traditional thinking of birth as in two stages, or as two births—the birth of the baby followed by the birth of the placenta. (Bradby 1999, 296)

Doña Emilia “was happy doctors arrived just after birth to pick up the baby” (Bradby 1999, 294) because she expected assistance for the second birth, the birth of the placenta. With the assistance of biomedical personnel, who facilitated and sped up the birth of the placenta and shortened the duration of blood loss, Doña Emilia was exposed to danger for a lesser period of time. The assistance of biomedical personnel is thus desired by some indigenous women because of their practices that speed the process of the second birth (Bradby 1999).

The Husband’s Role in a Women’s ‘Choice’

Although men understand contraception to be a woman’s responsibility, they play an extremely important role in the woman’s choice or ability to use contraception. In many health posts in the Andean highlands, unless they have means of being economically independent, a woman must have her husband’s permission to acquire biomedical contraceptives. For instance, in Markita, Peru, women cannot obtain contraceptives from biomedical personnel without the presence and written authorization of her husband (Maynard-Tucker 1986). Women in rural Andean highland communities also fear being accused of having extramarital affairs if their husbands discovered that they are using biomedical contraceptives (Camacho, Castro, and Kaufman 2006; Maynard-Tucker 1989; Schuler, Choque, and Rance 1994). One woman in a Peruvian community expressed, “Men like to keep us pregnant because they are jealous” (Maynard-Tucker 1989, 222), demonstrating women’s perception of the way men control them. Although in some areas, such as Wila Kjarka, Bolivia, there is little evidence to

support the notion that men seek control over their wives' fertility and there is no evidence that men believe that contraception would lead to the promiscuity of their wives (Canessa 2012). In other areas such as Markita, Peru, men demonstrate the opposite, claiming that "contraceptives are bad because the wife can fool the husband" (Maynard-Tucker 1989, 223). Although the use of biomedical contraceptives therefore can trigger a struggle in authority between ascribed gendered responsibilities, a woman generally relies on her husband's judgement:

It is clear that the use of modern methods designed for and practiced by women challenges men's authority, and implies a break with women's traditionally subordinate position, promoting feelings of insecurity among husbands.... Women are not quite prepared to challenge their husbands' authority. Women feel that men know best because they have more schooling, they speak Spanish better, and they are more aware of modern life because they often travel outside the community. Most of all, women need their husband's indispensable economic support for the well-being of their children, as they themselves have but a few opportunities to find work and earn cash (Maynard-Tucker 1989, 223).

Although a woman's health and wellness and that of her family are a woman's responsibility as an element of her role as mother and caregiver, her subordinate position to her husband gives her little authority to make decisions regarding their use of biomedicine for reproductive health and fertility control (Camacho, Castro, and Kaufman 2006). Many men work outside the communities and are more likely to receive an education; therefore, they are seen by women to have more understanding of what are considered modern concepts, including the biomedical system. Furthermore, biomedical services, although subsidized in some countries, require monetary payment. Because men are generally the breadwinners in the family, a woman must rely on her husband's

income and gain his permission to use his money for specific biomedical services or contraceptives that are not subsidized depending on the location.

The husband's role in seeking biomedical services is reinforced at the health clinics, where their authorization can be requested for their wife to receive certain types of contraception (Camacho 2006; Hardon et al. 2012; Maynard-Tucker 1086). The husband also has influence and authority over the choice of care during times of obstetric emergencies (Camacho, Castro, and Kaufman 2006). For instance, when Emilia of the Peruvian Andes went into labor for her second birth, her husband ultimately made the choice for Emilia to give birth in a hospital.

She [Emilia] and her husband [José] were alone when she went into labor, and José, frightened by the memory of his mother's death in childbirth, bundled her into his blue Volkswagen taxicab and took her to the hospital (Allen 2002, 197).

Biomedical birth has been promoted as the safer option to homebirth in the Andean highlands (Bradby 1999). Motivated by a fear of his wife dying during childbirth, José chose to take Emilia to the hospital despite Emilia's preference to give birth at home.

The authority of a husband over his wife therefore influences the type of care or fertility control method women that women 'chose' (Corrêa and Petchesky 2007). This 'choice' is greatly influenced by husbands and even often decided upon by a husband on behalf of his wife. However, as stated previously, a husband's authority over his wife is only one of many factors that contribute to determining the type of care women seek during pregnancy and childbirth and the methods of contraceptives that women use.

The Biomedical Personnel's Authority in a Women's 'Choice'

Biomedical personnel also play a major authoritative role in women's choice of medical care. Many women are coerced by doctors to give birth in biomedical facilities or are forced into methods of fertility control. Biomedical personnel often persuade indigenous women into using biomedical services available at health posts (Bastien 1987; Bradby 1999; Finerman 1989; Hardon et al. 2012; Zug 2013). For instance, in Ecuador, the government-sponsored hospitals distribute food to women who attend lectures about hygiene and nutrition and participate in infant health screenings (Finerman 1989). This situation has also occurred in Bolivia, where biomedical facilities run Mother's Clubs to encourage the use of biomedical services (Bastien 1987; Bradby 1999; Pacino 2015). The original basis of the clubs was a means of improving infant and child mortality rates by focusing "more closely on women as childbearers" and to "persuade women to come for antenatal check-ups in the Medical Post and to give birth in hospital" (Bradby 1999, 289). These clubs were designed for women with young children and hold regular meetings at which lectures on health education are given and rations of food for children and pregnant women are distributed. "Mother's Club strategy is seen as an attempt to achieve the cooperation of women with this birth policy through the advance of 'gifts' in the form of food aid for their children" (Bradby 1999, 289). In addition, these clubs were run with the assistance of NGOs, which often act as mediators between the state and local communities regarding access to healthcare services, nutrition, education, and economic development (Pacino 2015). Participation in these club meetings is generally a way for nurses and doctors to informally pressure pregnant women to give birth in the hospital

and reinforce the fears associated with home birth. These clubs are only one example of the top-down approaches to increasing the hospitalization of childbirth as it trickles down from international organizations and into government policy, which is played out with the aid of governmental and nongovernmental organizations (Bradby 1999).

There are a variety of reasons that women go to the hospital to give birth, the most common among rural and migrant women being fear of death during and just after childbirth. The reality of death in childbirth is reflected not only in published maternal mortality rates and efforts throughout Latin America to decrease these numbers by encouraging biomedical birth, but also in the rituals of traditional childbirth and in the accounts of women who go to the hospital out of fear of death. As Doña Emilia of Sucre, Bolivia, so openly puts it, women go to hospital to give birth “because at home, if the birth doesn’t go right, we die” (Bradby 1999, 289).

Biomedical doctors use this fear as a means to manipulate women into giving birth in the hospital. Doña Emilia describes how her doctor “made her” go to the hospital because “she would be ‘too damp’ (*muy humeda*) [Sp.] at home” (Bradby 1999, 293). In this instance, the doctor uses indigenous medical theory to further persuade Doña Emilia to go to the hospital. During a homebirth according to indigenous medical theory, many factors can contribute to complications, including an imbalance of the humors. If the woman’s body is too damp, she can lose too much blood, which can be fatal. Doña Emilia further justifies her safety in giving birth in the hospital with the fact that “one lost blood for a shorter time there” (Bradby 1999, 289). This notion was reinforced after she gave birth and

the doctors and nurses pressed down on her stomach after the birth and squeezed the blood from her uterus into a tray, as if they were “wringing out a wet cloth.” This meant that her blood flow was more or less over the day after the birth in hospital, and in turn this meant a lot to her (Bradby 1999, 288).

Although she would have lost the same amount of blood if the doctors and nurses had not “wrung” her out, the mere fact that the period of time over which Doña Emilia lost blood was significantly shortened and controlled allowed her to be vulnerable to illnesses and death for less time. Being “too damp” and losing too much blood, along with the possibility of complications put women at risk during childbirth. These risks can be minimized or eliminated all together by traveling to the biomedical clinic or hospital, thereby decreasing the chance of death during childbirth.

Although biomedical personnel are often persuading women into using biomedical services and contraceptives, they also have the authority to deny women the use of these services. For instance, Paolina of Markita, Peru, had access to biomedical contraceptives through her husband’s drugstore. She had tried the pill and Depo-Provera, but ultimately decided she wanted to undergo tubal ligation:

During her last delivery, by cesarean section, she asked the doctor at the hospital to perform a tubal ligation. The doctor refused, saying, “Your child might die, you are too young to get sterilized, and I know that you will want another child later” (Maynard-Tucker 1989, 220).

Despite the fact that many doctors have performed tubal ligation on women without their consent, this particular doctor refused to perform the requested operation on Paolina (Kleiss, 2004; Rousseau 2007). Therefore, despite the ability to make a choice regarding her reproductive health, Paolina’s well-thought out request was denied through the authority invested in the biomedical doctor.

The Desire to Control Fertility

Having a large number of children is generally not desired in the Andean highlands (Canessa 2012; Pacino 2015). In Andean society, value is placed on a man's ability to acquire resources and money, not his virility. Therefore, having a large number of children is not a symbol of a man's status. Instead, in the rural communities of the Andean highlands, a smaller family is a symbol of modernity and progress toward economic development, akin to new roads and cell phones, the ideal family size being four healthy children (Canessa 2012). This association between smaller families and progress and modernity are evidence of the argument that correlates population control with economic development, which was adopted by many governments in the late twentieth century. This is reflected in the trends in fertility rates in the region, which have decreased drastically since 1960. According to The World Bank, the fertility rate of Bolivia has decreased from 6.7 births per woman in 1960 to 3 births per woman in 2014; in Ecuador it has decreased from 6.7 in 1960 to 2.5 in 2014; and in Peru it has decreased from 7 in 1960 to 2.5 in 2014.

In the Andean highlands, fertility control is essential to control family size, preserve resources, and achieve the symbol of modernity that is associated with a smaller family. In the economically poor communities of the Andean highlands, "people are very aware of the cost to the household of too many children as well as the burden of children who will not be productive" and "It is very rare for people to speak of the joys of having children" (Canessa 2012, 129-130). One woman in Wila Kjarka, Bolivia grieved: "I am in great sorrow. I wish [my children] would all die; I wish they would die I say. They

make me very angry; they make each other angry. I only have boys and they are always fighting” (Canessa 2012, 129). Limiting the size of one’s family is necessary and desired in the Andean highlands as a mean of limiting financial burdens and in stimulating the ideas of modernity.

Despite the common desire to have fewer children, contraception is not openly discussed between husbands and wives in the Andean highlands. Women are expected to remain “innocent” (Maynard-Tucker 1989, 222) about the topic of sex and, therefore, it is a prohibited topic of conversation (Canessa 2012; Schuler, Choque, and Rance 1994). This communication barrier leads to feelings of insecurity, distrust, and jealousy surrounding contraception between couples, which often cause arguments and suspicious accusations (Maynard-Tucker 1989).

In the rural communities of the Andean highlands, fertility control is seen as a woman’s responsibility:

Women are expected to “take care of themselves,” which means somehow avoiding pregnancy, generally by using the rhythm method or some other form of abstinence. Women who cannot manage this are criticized. Women are criticized not only for not having any children, but also for having too many children or having them too early or too close together. Such women are described as breeding like bunnies or like hens laying eggs, or having children that look like *zampoñas* [Sp.] (musical instruments made of a row of bamboo stalks that diminish in size) or *salteñas* [Sp.] (little meat pies) coming out of the oven. One woman observed: “People always criticize you. It seems like everything [you do] is wrong. They criticize you if you have no children, they criticize you if you have lots of children—everything [you do] is bad (Schuler, Choque, and Rance 1994).

Women who have too many children are scrutinized by peers, biomedical personnel, and policy makers for not being able to control their fertility, while those who do not have children are reprimanded for not fulfilling their responsibility as reproducers and mothers

(Allen 2002; Camacho, Castro, and Kaufman 2006; Llanque Channa 1972; Hammer 1997; Larne 1998; Schuler, Choque and Rance 1994; Torri 2011). Just as other female reproductive concerns are seen as the responsibility of the woman, so too is controlling fertility. However, economic, geographical, and cultural factors limit a woman's overall access to and choice in using biomedical contraception.

Natural Methods of Fertility Control

As biomedical contraceptive options are not widely available or affordable in the economically poor rural Andean communities, there are several typical methods of limiting family size in the rural Andean highlands, such as through abstinence or periods of abstinence, withdrawal, herbal teas, and abortion (Canessa 2012; Maynard-Tucker 1989). One of the more extravagant methods of fertility control involves the improper disposal of the placenta, which according to indigenous medicine, will diminish a woman's reproductive ability:

Women attempt to control fertility by the practice of throwing the placenta into the river after childbirth instead of burying it in the fields as is customary. While not everyone agrees this is an efficacious method, women who have given birth to only two or three children are commonly said to have disposed of the placenta in the river or waded in the river to cool their ovaries so that they will not be able to conceive (Bourque and Warren, 1981).

While improperly disposing of the placenta after birth is not a very commonly practiced method of birth control, there are several methods that people in the Andean highland communities practice regularly, such as abstinence, abortion, or infanticide.

Abstinence from sexual intercourse is a common way that women control their fertility. An Aymara woman from Peru explains how she and her husband are able to practice abstinence with the help of her husband's complacent attitude and separate beds:

I didn't get pregnant [after the first child] because my husband isn't demanding—he leaves me in peace.... He's a good man.... He just comes home and goes to sleep. He has his own bed and I have mine, apart.... [If I don't want to have sex], he doesn't get annoyed, he just goes to sleep (Schuler, Choque, and Rance 1994, 217).

Practicing periods of abstinence when a woman is most fertile, referred to as the rhythm method, is a popular choice of birth control because it costs nothing and is perceived as more “natural” than other methods (Maynard-Tucker 1986; Maynard-Tucker 1989).

However, because indigenous medical theory deduces that women are most fertile while menstruating because menstrual blood is required to form a baby, the periods of abstinence that are practiced through the rhythm method take place during menstruation and resume a few weeks later, making this method ineffective at preventing pregnancies (Maynard-Tucker 1989).

Oftentimes, the method of abstinence relies on the woman's “ability to control her partner, or to evade his attempts to control her” (Schuler, Choque, and Rance 1994, 216).

One woman relays her difficulties in discouraging the advances of her husband:

My husband knows the calendar method by heart. He marks off the days, and when I'm free [not fertile], he wants to have sex all the time. I can't. You know you get tired of it Sometimes we fight about it—I don't want to be with him and he gets cross and sulks but he'll get over it I don't need [modern contraceptives] because I'm fine with this method (Schuler, Choque, and Rance 1994, 217).

A woman must find ways to avoid the sexual advances of her husbands. A common tactic to discourage a husband's advances is for a woman to sleep surrounded by her young

children (Schuler, Choque, and Rance 1994; Bourque and Warren, 1981). However, despite the difficulties of discouraging her husband from intercourse, many women in the Andean highlands heavily rely on abstinence as their primary form of birth control.

Post-Conception Fertility Control Methods

However, as biomedical contraception methods are not easily available, the majority of women must rely on post-conception birth control methods, which include abortion and infanticide (Hammer 1997; Hammer 2001; Canessa 2012).

Unwanted pregnancies are often discussed discreetly in the Andean highlands as “late periods,” which are caused by ailments of the *madri* (Canessa 2012, Hammer 2001; Morgan 1997; Schuler, Choque, and Rance 1994). In order to cure these ailments and stimulate the flow of menstrual blood, women often seek to induce abortion by performing extra-strenuous tasks, “accidentally” falling, and taking herbal emmenagogues, abortifacients, or in exceptional cases, visiting a pharmacist in the nearest town (Canessa 2012; Hammer 2001 Schuler, Choque, and Rance 1994). As in much of the world, in the Andean highlands, “induced abortion is one of the most important methods of fertility control” (Luker 1975, 2). As Canessa recalls, “In the words of a friend, ‘When you have too many children, you must cure yourself. You must take some medicine, and you just need to expel the fetus... You drink, and then it comes out.’” (2012, 129). Another woman, who already had eight children, describes her many unsuccessful attempts at inducing a miscarriage when she became pregnant again:

I cried, especially these last few times. I thought about what people would say about me [if she had yet another child], how they would look at me. I always

wanted to miscarry—that's why I carried loads of potatoes, thinking that this would make me lose the pregnancy. I did everything—fell, so that the baby would die. I used to travel to my hometown ... to bring back potatoes, and I would fall out of the back of the truck, and people would say to me that I was pregnant and now I had hurt myself, I would miscarry. But nothing ever happened (Schuler, Choque, and Rance 1994, 218).

This woman feared the stigma associated with having a high number of children. Women who have many are criticized for not being able to control their fertility. The woman in the above quote was not able to control her fertility pre-conception, and therefore, sought to induce a miscarriage to avoid the scrutiny from her peers or others that is associated with having a large number of children. However, despite her many efforts to cause a miscarriage, she was not successful.

Within the indigenous Andean medical system, a pregnancy, especially an unwanted pregnancy, is viewed as a barrier to the body's well-being because while a woman is pregnant, her vital fluids are redirected to support the growing fetus. By inducing abortion and terminating the pregnancy, a woman is able to flush out the unwanted substances, thereby restoring the uninhibited flow of fluids (Hammer 1997; Hammer 2001). Women are also able to protect their fertile potential by practicing post-conception birth control rather than preventative contraception because it is thought that by intentionally interfering with a woman's ability to conceive, it may cause her irreversible infertility. Thus, the general concept of contraception goes against indigenous medical understandings. Fertility is essential for a woman not only for reproduction of the family, but also for her reproductive potential, as it affects the crops, herds, and her ability to produce goods and earn and income (Hammer 1997).

While abortion is a common form of birth control, it is not a topic that is openly discussed. Women discuss unwanted pregnancies in the terms of menstruation beginning late, which is treated with the goal of resuming menstruation:

By maintaining a state of ambiguity about abortion (and also in many cases about sex and fertility regulation), women expose themselves to repeated, self-inflicted damage to their physical and emotional health through a succession often unsuccessful measures to get rid of unwanted pregnancies. Maintaining this ambiguity may also contribute to the persistence of negative social perceptions of induced abortion, despite its being extremely common (Schuler, Choque, and Rance 1994, 218).

The dangers of abortion are well known to both indigenous Andean men and women. Men in the Bolivian Andes, for instance, insist that any method of birth control is damaging to a woman's health, however, abortion is especially dangerous because an induced abortion does not often go as planned, causing injury or death to the woman (Canessa 2012; Luker 1984). The dangers that are associated with abortion, as well as the condemnation of the practice by the Catholic church (Nations et al. 1997), contribute to it being discussed discreetly and ambiguously in the Andean highlands, and although it is admitted by men and women to be a form of birth control, men especially deny that it occurs within their community (Canessa 2012):

Perhaps because we were in the shadow of the church or simply in the center of Sorata negotiating stringy mozzarella, they were all keen to demonstrate to me that they were not party to the dubious customs of which I may have heard. Yet they showed detailed familiarity with the practice of abortion, even if all these incidents occurred "in the past" or somewhere else (Canessa 2012, 133).

In this instance, Canessa's informants acknowledge abortion as a fertility control method, although they distance themselves from it by claiming that the practice occurred outside

of their community or outside of the present time. This distance is also maintained when discussing the practice of infanticide.

Another form of regulating family size in the absence of contraceptive methods is infanticide, which is generally achieved by neglecting the baby, not adequately feeding it, failing to provide medical care, leaving it out on a cold night, or by smothering it (Canessa 2012; Schepper-Hughes 2009; Schuler, Choque, and Rance 1994). When infanticide does occur, it is culturally most likely to take place during the period of time before the naming ceremony. Unnamed babies are still considered fetuses, and therefore newborns are, in a sense, nonhuman as they are completely unsocialized, have no speech, and no name (Canessa 2012; Morgan 1997; Larme 1989). Therefore, infanticide is considered a late abortion and often follows previous unsuccessful attempts to terminate the preceding pregnancy (Canessa 2012; Schuler, Choque, and Rance 1994). Infanticide is used especially in cases when a baby is very ill or has a physical defect because caring for a severely handicapped or sick infant puts an extreme strain on the family's already limited resources (Canessa 2012).

The topic of infanticide is generally a sensitive one, and although there is evidence that indicates it does occur in the Andean highlands, it is extremely common for people to deny that it happens within their communities (Canessa 2012). Instead, indigenous Andean men and women distance themselves from the practice of infanticide as it being a practice of the past (Canessa 2012).

Perceptions of Biomedical Contraception

There are very few options for biomedical contraceptives available to people in the rural Andean highlands and those that are available prove inconvenient, expensive, and difficult to acquire. The biomedical methods that are available to women in the Andean highlands include condoms, contraceptive pills, contraceptive injections, intrauterine devices, and tubal ligation. Although women and men in these rural communities emphasize their desire for biomedical contraceptives, factors such as economic expense, access to contraceptives and information, communication with users of biomedical contraceptives, a woman's husband's approval or her level of economic independence, side effects, and social implications present barriers to their use in actuality.

The lack of reliable and effective natural methods of birth control can lead women to desire the available biomedical contraceptives. A woman near Otavalo, Ecuador, who has easier access to biomedical contraceptives explains the reason that she prefers biomedical contraceptives over other methods:

After my third child, I asked the *partera* [midwife] if she could indicate me some effective contraceptives methods...She said that I should have drunk some plants every day and had some vagina washing after the intercourse...It did not work and after few months I got pregnant with my fourth child. That is why I decided to ask a nurse or an obstetrician regarding the contraception...I think that their approach is more scientific and effective (Torri 2013, 404).

This woman did not get the results that she desired from the birth control methods that were prescribed to her by the midwife. This caused her to seek out biomedical contraceptives, which she has found to be more effective at preventing pregnancy.

However, while this participant has relatively easy access to biomedical contraceptives, women in the rural communities of the Andean highlands do not share this luxury.

In the rural Andean highland communities, one must travel to the nearest health post or urban center to acquire biomedical methods of contraception, which can often be a long, expensive, and possibly dangerous journey. The biomedical contraceptives that one may find available at a health post or urban center include birth control pills, condoms, tubal ligation, and some intrauterine devices (IUDs) (Hammer 2001). Many of these methods, when available, are considered unsafe according to the indigenous medical system, shunned by the Catholic church, or are simply too expensive (Canessa 2012; Hammer 1997). When a woman does choose to use a biomedical contraceptive method and makes the journey to the health post, she is not guaranteed to get the service from biomedical practitioners or the results that she had hoped for. One woman recounts the difficulties she had in obtaining her contraceptive injections despite making the extra effort to keep track of dates and travelling to the health post faithfully:

I went for one year, and for one year I did not bleed; but then I became pregnant. It didn't work: I had the injections in vain; and now I have my daughter...She is eight months old now. I went. You cannot make a mistake; you cannot go too early or too late. You must go on the right day. I went, but the attendant wasn't there. I had to go the next day and then she gave me the injection, but it didn't work. They say that you cannot make any mistake (Canessa 2012, 129).

Despite her punctuality and commitment to receiving the contraceptive injections, this woman's birth control failed for reasons outside of her control. It was the poor service of the biomedical personnel at the health post that contributed to the failure.

A woman may have a 'choice' (Corrêa and Petchesky 2007) in using a given form of biomedical birth control, however, this 'choice' is once again influenced by cultural, social, economic, and geographical factors. One of these various influences on a woman's 'choice' to use biomedical contraception is the way it is perceived through Indigenous Andean medicine.

Biomedical contraceptives that fit indigenous Andean medical heory

The use of condoms, in theory, has been incorporated into the indigenous Andean medical system. Their function is explained within this system as preventing insemination by diverting the flow of semen (Hammer 1997). However, although condoms are generally available at health posts, often at no cost, they are not a commonly used form of contraception for several reasons. Firstly, men understand contraception as the woman's responsibility and will therefore not use them when having sexual intercourse with their wives (Canessa 2012; Hammer 1997; Maynard-Tucker 1986). Instead, men report using condoms as a tool to avoid venereal diseases when having sexual intercourse with prostitutes rather than as a form of contraception Maynard-Tucker 1986).

Condoms are also inconvenient and difficult to obtain because they generally require a trip to an urban center or health post (Canessa 2012; Hammer 1997; Maynard-Tucker 1986). Once at the health post, the procedures to obtain the condoms are a cause of embarrassment to men:

Men are given condoms free of charge, but they often do not return to the health post for a new supply. The registration procedures and regulations cause them embarrassment and shame. It is culturally unacceptable for a man to ask the

obstetrician (a female who knows the whole village) for a new supply of condoms and to have to sign a register booklet for his wife. The men often fear that this situation could lead to damaging village gossip, in which sexual conduct is commented on with malice (Maynard-Tucker 1986, 313).

The social implications of condoms are not confined to the health posts. In this case, the procedures that a man must go through in order to obtain the condoms can provide unfavorable evidence to fuel negative gossip throughout the community. Even within the home, a man does not escape the pressures and potential stigma that is attached to the use of condoms. The household is often crowded with family members, which allows for little privacy during sexual intercourse, causing men to be less motivated to use condoms during intercourse for fear of being stigmatized within the community (Maynard-Tucker 1986). Finally, alcohol negatively impacts the desire to use condoms as contraception because “most men’s drinking habits make this method impractical” (Marynard-Tucker 1986, 313).

Another method that has been adopted and explained through the indigenous Andean medical system is tubal ligation, or female sterilization. Although this method does involve surgery, which is not generally approved of through indigenous medical theory, it is usually performed after difficult hospital births that require cesarean sections (Hammer 1997). Therefore, as the woman’s body has already been opened by the doctor during a necessary procedure, the additional procedure of a tubal ligation is acceptable. The concept of tubal ligations is akin to the doctor making a woman infertile; in the indigenous Andean medical system, infertility can be caused by several reasons, one of which is by having an “inverted womb,” in which the womb is positioned upside down. An inverted womb can occur either naturally or by biomedical surgery, and causes the

fetus to not be able to “sit” properly in the womb, and thus falls out (Hammer 2001).

Therefore, tubal ligation is explained as a procedure in which the doctor “turns the womb upside down,” making it impossible for the woman to become pregnant (Hammer 1997, 115).

Biomedical contraception that does not fit indigenous Andean medical theory

Oral contraception is explained through indigenous medical theory in the same ways that other biomedical pharmaceuticals are explained, which makes it a less desirable method of contraception because it may be harmful to a woman’s health.

Through the indigenous Andean medical system, pharmaceutical drugs are understood to be toxic substances that alleviate immediate symptoms and, if administered wrongly, can cause illness or death. Therefore, taking a pill daily, as is required with oral contraceptives, not to alleviate any symptoms may cause a buildup of the toxin in the system, which can lead to damaging vital organs (Hammer 2001).

The intrauterine device is a biomedical method of contraception that is fundamentally contradictory through the theory of indigenous Andean medical system. According to the indigenous Andean medical system, the IUD, by its nature as a foreign object that is inserted into the body, can obstruct the normal movements of internal fluids and organs, which can lead to both physical and emotional illness (Hammer 1997). For instance, the IUD is believed to cause temporary insanity, which can only be cured by removing the device. Women also worry that the device will become stuck inside the body or, in the event that they do become pregnant, it may get lodged inside of the forming baby’s head (Hammer 1997.) The IUD is also believed by indigenous men and

women to cause damage specifically to the liver and is commonly linked to cancer (Hammer 1997; Maynard-Tucker 1989; Schuler, Choque, and Rance 1994). In the same way that oral contraceptives are linked to birth defects, the IUD is also blamed (Maynard-Tucker 1986).

Misinformation about Biomedical Contraception

The huge amount of misinformation and confusion surrounding these methods fuels their perceived dangers, which make women skeptical and unwilling to use them. As with other forms of biomedical contraception, oral contraceptives are not well explained to indigenous women, who consequently do not understand how to effectively use the method. This lack of information also results in misinformation and confusion surrounding the pill:

Pills are given with minimal explanation, so that most respondents do not understand the proper way to use them. Women often start taking their pills on the wrong date, forget to take them for a few days, or quit in the middle of the cycle because they “do not feel good.” They also tend to forget to return to the health post every month for a new supply (Maynard-Tucker 1986).

When women are not educated on how to correctly take oral contraceptives, the method becomes significantly less effective due to user error. This has led to fears and concerns that, despite taking oral contraceptives, a woman may still become pregnant and the resulting child will be born with deformities, birth defects, or stillborn (Hammer 2001; Maynard-Tucker 1986).

Dissatisfied users of biomedical contraception talk about the negative effects with other women, while women who are using biomedical contraceptives successfully do not

tend to discuss or praise the method to other women, but instead they keep their contraceptive use a secret for fear of embarrassment and to avoid becoming the target of gossip that associates contraceptive use and infidelity (Maynard-Tucker 1986).

Therefore, information about the negative qualities of a contraceptive method spread at a much higher rate than the positive ones. One woman describes the exhaustive amount of contradictory information that exists about various contraceptive methods:

Both the women who get them (IUDs) and the women who don't get them say that they cause cancer. They are objects that we shouldn't have in our bodies, that damage our bodies and give us headaches.... Lots of women say that they make you thinner or fatter, or that they make you want to vomit. But other women say that they're fine, so I wonder what really happens.... They say the pills affect the nerves and the liver and the heart, but I don't know because I haven't used them. They say that injections affect the nerves, that the spiral [IUD] can cause cancer. That's what I've heard and I believe it" (Schuler, Choque, and Rance 1994).

Negative side effects especially lead indigenous Andean women to either stop using or never begin a particular method of contraception because the woman would be voluntarily using a method that makes her ill. Becoming ill means that a woman will not be able to carry on with her work and responsibilities. Thus, the side effects of biomedical birth control methods are evidence that these methods make women ill (Maynard-Tucker 1986).

Therefore, the negative experiences and misinformation spreads more quickly than positive experiences and accurate information. This contributes to the misuse or reluctance to begin using biomedical contraceptives in the Andean highlands. Although women in these communities have a clear desire to control their fertility, the lack of accurate information and availability of biomedical contraceptives denies woman this ability (Hammer 1997).

Summary

Although biomedical services and contraceptives are heavily promoted and encouraged by the governments of Bolivia, Ecuador, and Peru, and nongovernment organizations in the region, these services and contraceptives remain largely inaccessible and unavailable to women in the Andean highlands. In order to obtain these services, women often have to travel great distances to the nearest urban center that has a biomedical facility. Furthermore, many women are simply not able to afford these services, despite subsidies available in some areas.

Cultural factors also act as a major barrier that can interfere with women obtaining biomedical services or contraceptives. The woman's expected submissive role to her husband prohibits her from making decisions regarding biomedical services. Oftentimes, the choice to utilize biomedical services or contraceptives is left to the husband.

Although there are several types of biomedical contraceptives that are officially available in the Andean highlands, they are not widely used by women of the rural communities because they are considered unsafe according to the indigenous medical system. The methods that are considered safe and agree with indigenous medical theory can be difficult to acquire. Furthermore, despite the method of fertility control used, women often receive no information or misinformation about the method. This often negative misinformation contributes detrimentally to the use of biomedical contraceptives.

Thus, even though women often wish to utilize biomedical services during pregnancy and childbirth, or obtain biomedical contraceptives, they face many factors that make utilizing these services difficult.

Chapter 7: Conclusions

This thesis has demonstrated the ways that a woman's gendered roles and responsibilities are formed based on the associations and constructions of her body in Andean highland society. The reproductive functions of the woman's body are an important component to her overall health and wellbeing. Women often seek biomedical services for prenatal and childbirth care and biomedical contraceptives as a means to ensure their physical and social health. However, they are frequently met with not only economic and geographical, but especially with social and cultural obstacles to their ability to obtain them. This thesis has analyzed some of these social and cultural barriers that indigenous women in the Andean highlands come across in their pursuit of biomedical reproductive healthcare services and contraceptive methods.

The Female Body and Gender as Constructed in the Andean Highlands

In the Andean highlands communities, the role of women is directly linked to the reproductive abilities of her body. Her body is understood to be associated with the fertile and reproductive powers of Pachamama, and therefore, she is expected to take on a submissive role as mother and reproducer of children. As an extension of her nurturing and fertile role, women also are responsible for the production of crops, and caregiver of her family and of animals.

The reproductive functions of the female body and the associated prescribed gender roles place women in a state of chronic weakness, and ill health both physically and socially. In the indigenous Andean medical system, the female body is predisposed to illness as a result of its physiology and its reproductive functions. Thus, the health and strength of women is perceived to decrease as she ages. The ascribed roles of mother and caregiver ensure that women are expected to dedicate their lives to bearing and rearing children, which causes women to be in a constant state of social illness, in that they are confined to the home, enduring poor socioeconomic circumstances.

Not only is a woman's body a danger to the woman herself, but it also has the potential to harm her environment or, should she be pregnant, a growing fetus. In order to prevent this harm, a woman must manage the state of the body and avoid specific behaviors. It is only through menopause or the use of contraceptives that a woman can be 'cured' and thus 'liberated' from her lifetime role as a bearer of children.

The perception of the female body and the ascribed female gendered roles and responsibilities contribute to the ways indigenous women approach reproductive healthcare, whether it be indigenous medicine or biomedicine. There are, however, many more cultural, social, economic, and geographic aspects that influence a woman's choice to seek or utilize various healthcare services or contraceptives.

Negative Experiences and Perceptions of Biomedicine

Many factors contribute to the negative experiences of indigenous women and biomedical practitioners. Indigenous women feel mistreated and violated when they

undergo biomedical services. These feelings are often caused by the differences in authority during prenatal examinations or during childbirth between the indigenous medical and biomedical systems. The authoritative role of biomedical personnel and the passive role of the woman during these biomedical procedures conflicts with the more active role of the woman during their indigenous medical ones.

Visiting biomedical facilities for prenatal care or for childbirth often causes anxieties for indigenous women. The biomedical personnel frequently reprimand both the woman's state of health, her choice of healthcare, and indigenous medical practices in general. Furthermore, during birth in a biomedical facility, women are often left alone for long periods of time and at the moment of birth, and are unable to dispose of their placenta properly according to cultural beliefs, which causes them to feel lonely, neglected, and uneasy. Women also discuss the intrusiveness of biomedical vaginal exams, which violate their cultural views of modesty.

These exams are especially vulgar when they are compared to the methods of a midwife, who is able to determine the same information by feeling the woman's stomach and monitoring her pulse. The negative experiences with biomedical personnel, contribute to the negative stereotypes associated with them. Indigenous groups in the Andes have a long history of being victimized and exploited by outside groups and individuals of power. The tensions of this trend have been personified in the fat-stealing creature, the *kharisiri*. The association of biomedical personnel with the characteristics of the *kharisiri* are reinforced through their behaviors. However, the mass forced-sterilization of indigenous men and women throughout Peru between 1996 and 2000

under the regime of President Alberto Fujimori as well as other instances of unconsented sterilization has emphasized feelings of distrust towards biomedical personnel. All of these factors and events continue to reinforce the negative stereotypes that are attributed to biomedical personnel, and create a strong reason for women to not seek biomedical services during pregnancy or childbirth.

Influences on a Woman's 'Choice' to Use Biomedicine

Despite the negative perceptions of and experiences with biomedical personnel, indigenous women of the Andean highlands sometimes express the desire to seek biomedical prenatal and childbirth care and biomedical contraceptive methods. While governments and NGOs have been increasingly promoting biomedicine over the last few decades as an effort to reduce maternal and infant mortality rates, actual access to these services continues to be restricted for indigenous women for various reasons.

While geographical location and economic means factor greatly into a woman's ability to obtain biomedical services for prenatal or childbirth care, or biomedical contraceptives, there are also many cultural barriers that influence her choice and ability to seek these services. In her submissive gender role in Andean society, a woman must obey the wishes of her husband. Therefore, her husband plays a major role in the decision to seek biomedical services or contraceptives. This authority of a husband over his wife's reproductive health choices is often reinforced through requirements of his authorization for his wife to obtain certain services or contraceptives.

Biomedical personnel also carry a great amount of influence over women's choice of healthcare. They often pressure women to give birth in biomedical facilities or use contraceptives. Conversely, the biomedical doctor also has the authority to deny services or contraceptives to a woman who is seeking them.

The biomedical services and contraceptives do not all necessarily fit into the indigenous Andean theory of medicine. Many methods of contraception, for instance, either go against the principles of indigenous medicine or are associated with accounts of negative experiences and misinformation, which makes them less desirable. However, despite the many and various barriers to obtaining biomedical prenatal and childbirth care and contraceptives, indigenous women of the Andean highlands show a strong desire to utilize them.

Reflections

The efforts to promote to use of biomedical reproductive healthcare by incorporating indigenous medical practices seem to have been largely abandoned. In some cases, however, such as the Hambi Juasi health post in Otavalo, Ecuador, the incorporation of the two medical systems has been successful. Women who visit this clinic have a choice in receiving either biomedical or indigenous prenatal examinations, or a combination of the two. In addition, the women also have access to biomedical contraception and access to information regarding reproductive health.

On the other hand, many maternal waiting houses in Huancayo, Peru, that had incorporated indigenous methods of childbirth, for instance, are still in use, but they now

solely utilize biomedical methods despite an expressed desire from women to have access to indigenous birthing methods.

Because women do express this clear desire for the availability of indigenous medicine as well as biomedicine and biomedical contraceptives, all of these should be made more readily available in the Andean highlands. By this, I mean that they should not only be physically and geographically available and accessibly, but also financially available to women in poor communities.

When it comes to addressing reproductive healthcare in the Andean highlands, and elsewhere in the world, cultural factors such as patriarchy or indigenous medical interpretations of biomedical services or contraceptives that prevent women from seeking out or utilizing these services must also be taken into deep consideration. Furthermore, by making access to reproductive healthcare education readily available, more comprehensive, and not by devaluing indigenous beliefs in the process, many of the misconceptions and misinformation that exists around biomedical services and contraceptives can be largely diminished.

Most importantly, I think that reproductive healthcare should not be completely controlled by various overarching authorities, including governments churches, or even NGOs. Although these entities have a great deal of influence on the accessibility of reproductive healthcare as well as how it is implemented, they should work together with the needs and desires of the people they govern. At the risk of sounding overly optimistic, instead of continuously adopting top-down approaches to reproductive healthcare—or any topic—I feel that grassroots movements create more effective and long-term change.

While I do not necessarily have an answer to how this complicated topic should be handled, I do believe that extensive consideration should be given to the themes presented in this thesis in addition to those presented elsewhere, and that biomedicine and indigenous medicine can be incorporated into one another and made easily accessible on all levels in order to provide what Andean women describe as a more holistic approach to reproductive healthcare.

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Biography

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