Barren Beliefs: The Sterilization Campaign and Contraception in Peru

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Abstract

This paper examines the sociocultural ramifications of a government-mandated sterilization campaign which took place in Peru during the late 1990s. Subsequently, it depicts the contraceptive decisions of those living in the Department of Cusco, Peru, which was highly-targeted during the sterilization campaign. I argue that both male and female agency in contraceptive decision-making is impeded by structural, economic, and sociocultural constraints. These conclusions are based on interviews and participant observation conducted within the rural towns and villages, as well as the city of Cusco, located in the Department of Cusco. Informants included government medical clinic staff, private medical clinic staff, women of reproductive age, and men of reproductive age. Qualitative analyses centered on experiences with contraceptives and sterilization, measures of government control over contraception, cultural identity, and the economic necessity to employ contraceptive methods. Based on these results, I conclude that approaches to examining contraceptive use and sterilizations in the developing world must address the structural, sociocultural, and economic constraints that impact agency and ethics in the administering of temporary and permanent contraceptive methods.

Introduction

As I asked Elena to tell me about her family, she slouched back against the wall of the textiles shop inside a city hotel and dropped the thread from her hands. Tears had begun to form in the corner of her eyes. She explained how she had an intrauterine device (IUD) inserted after she gave birth to her first child because she and her partner were young and poor. Soon after, she suffered a violent infection from the IUD and followed the recommendations from the local town doctor that she give birth again to rid herself of the pain. After she gave birth to twins in the city hospital, she found out that the doctors had sterilized her. "I didn't know about it, but it's okay…" she sobbed, "I would not be able to have any more [children] anyways." Following the birth of the twins, her partner, previously a farmer, was hit by a train on his way to work and left without a leg. The accident also left him psychologically impaired. "He's in Lima now [years later] being treated, and we don't have much money," Elena said as she dried her tears and adjusted her traditional hat, which she wore only wore while working. The tourists in the hotel always liked to see someone "authentic."

Sterilizations, President Fujimori, and Halting Population Growth

In 1994, the International Conference on Population and Development enacted a Program of Action to ensure and emphasize reproductive health in the world. In the Program of Action, reproductive health was defined as each man and woman's right to have access to safe, affordable, effective, and chosen methods of family planning. The delegation of Peru was present at the conference and agreed to the terms in the Program of Action; yet the Peruvian delegates were also aware that their country was simultaneously grappling with high rates of poverty and infant and maternal mortality (Rousseau 2007).

Shortly after the conference, the Peruvian government began to combat these high rates of poverty and infant and maternal mortality by promoting the use of modern contraceptive methods, vasectomies, and tubal ligations (Rousseau 2007). Government records indicate that between 1996 and 1999, over 277,000 women were surgically sterilized, and most were indigenous people from the sierra (highlands) or the Amazonian regions (Leinaweaver 2005). Though the Peruvian government was credited for reducing its population growth rate to 1.7% in recent years, the courses of action the government has taken, in particular that of the sterilization campaign has created significant criticism and debate (Miranda & Yamin 2004).

Under the initial direction of President Alberto Fujimori, the Peruvian Ministry of Health targeted mainly the poor and marginalized of rural areas (which coincides primarily with women and men of indigenous Quechua descent) for sterilization and contraceptive use (Mosher 1998). Over the past ten years, the government's control over family planning and reproductive behavior has become a new aspect of Quechua life. While some, mainly the wealthier and educated, are satisfied with their new options of family planning, others have endured negative ramifications of such structural control over their bodies.

The campaign is protested as discrimination against "poor, rural women" who are seen as "objects of policy rather than as people who have rights and are entitled to participate in…policies affecting their health at all levels" (Miranda & Yamin 2004). Allegations that government health professionals used gifts such as food and clothing, threat tactics of cutting off government support, and repetitious pressuring of women and men to undergo permanent sterilization question just how much autonomy women in rural Peru have had over their reproductive decisions (Sims 1998; Vasquez del Aguila 2006). The government focused on sterilizations by enacting monthly quotas, incentives for medical personnel to perform sterilizations, and tubal ligation and vasectomy[1] "festivals," therefore "creating a climate unconducive to guaranteeing…freedom in decision-making" of family planning (Rousseau 2007). Such claims again illuminate questions of agency within the architecture of structural social inequalities in Peru.

Although ex-President Alberto Fujimori is currently in jail and awaiting a trial for human rights violations and corruption charges, the Peruvian government has not relinquished its control over reproductive practices. Even as Fujimori is detained in Peru, his supporters vehemently protest his incarceration while others denounce him, recalling his alleged political killings and abductions. Some still whisper faintly of the hundreds of thousands victimized by human rights violations during his presidency (Romero 2007), yet the government control over reproduction reflects the persistence of Fujimori's legacy.

President Fujimori claimed that this program would "give women control over their own destinies;" (Burt 1998) however, in this research, I question the validity of such control over reproductive health and seek to demonstrate how government power, shifting identities, economic dependency, and sociocultural factors affect family planning decisions. Subsequently, I strive to present the barriers to achieving the guidelines on reproductive health set forth by the International

Conference on Population and Development in the city of Cusco, Peru and its surrounding rural villages in the Department of Cusco.

Sociocultural Identity in the Transitional Andes

The medicalization of family planning in rural Peru reflects one aspect of the cultural clashes between indigenous and western ideals which have been exacerbated due to the rapid changes currently gripping the central Andes. While some reports mark the persistence of rural poverty as a result of the Andean peoples "backwardness" and "passivity," others have emphasized that the Quechua people have in recent decades undergone considerable economic and social reorganizations (Zoomers and Salman 2003:5). Still, "to talk about Andean-ness without taking into account questions of power, is to overlook one of the crucial molding forces of its present shapes and transformations" (Zoomers and Salman 2003:6). In recent years, the societies in the Peruvian Andes have entered into a dynamic period of change characterized by neoliberal policies, globalization, communication technologies, and urban migration (Zoomers and Salman 2003). To understand the dynamics between these changes, urban migration, and the effects of rapid globalization on rural life, I chose to perform research in the city of Cusco and the rural villages in the Department of Cusco.

Two and a half million people in Peru align themselves with the Quechua culture (Borthwick 2006), often with a "tenacity" that "was, and is, remarkable" (Cadorette 1989). In Peru, indigenous colloquialisms and customs retain a substantial presence which provokes questions of pluralistic identities and varying degrees of sociocultural syncretism (van Dam and Salman 2003:27). With concurrent dispersals and contractions characterizing global systems today, the fluid concept of Andean identity is removed from its geographic locus and uniqueness. Subsequently, the modern systems have brought on new pressures and modes of viewing the self, kin networks, the outside world, and traditional practices.

Positioning Contraception and Reproduction

One such traditional practice among the Quechua that has been challenged by the infusion of external powers is reproduction. Reproductive behaviors provide an effective vantage from which to understand the broader social effects of transitional dimensions on Quechua life, since reproductive behaviors are an integral aspect of the structural and societal principles (Browner and Sargent 1996:219). Contraceptive use in reproductive behavior can only be fully understood when placed in the contexts of political and economic structures, and social and cultural practices among whom they are used (Russell and Thompson 2000: 7); but Cohen reminds us that the physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, and place in a global economy (Cohen 1995:78). Changes in reproductive behaviors, particularly noted in increased medicalization and control, are also seen occurring in times of political unrest (Coreil et al. 1996). Ultimately, Macklin asserts that "values associated with the use of contraceptives vary according to culture, religion, [and] ideology," and "what varies from circumstance to circumstance and from each individual are the factors of culture, religion, ideology, individual preference, socioeconomic status, and the choices afforded to each person" (Macklin 1996: 175).

Understanding the dynamics between shifting identities, sociocultural heritage, and structural control is imperative for grasping notions of agency and choice in family planning decision making. Illuminated through the current situation in the Peruvian sierra is the notion that reproduction is linked to material access, hegemonic social relations, and cultural ideals. Anthropology, through incorporating a "global lens," has enhanced its approach to the political economy and politics of reproduction to encompass the intersections of state interests, Bio-(Western)medicine, and religious groups "as they construct the contexts within which local reproductive relations are played out" (Ginsburg and Rapp 1991).

Prior research on contraception dynamics in Peru indicates that a couple's life experiences, contact with urban centers, availability and sustainability of contraceptives, economic status, and emphasis on cultural values play significant roles in the decision to use modern contraceptives in a Peruvian highland community (Tucker 1986; Kost 1993). While these factors persist, Peru has endured significant changes from intense government promotion of modern contraceptive use. Tucker's (1986: 308) analysis of the barriers to modern contraceptive use in the sierra was intended to further outside understandings of Quechua-speaking indigenous attitudes toward modern contraceptives and to "provide family planning programmers with insight into the attitudes and feelings of rural populations in general to modern contraceptives." Over twenty years later, this research echoes the same need for family planning programmers to understand how contraceptives are perceived and utilized, except now those administering contraceptives must understand the major cultural effects resulting from the influx of new economic systems and government imposition of modern contraceptives and sterilizations on the sierra region. Additionally, studies regarding control over maternal mortality rates "generally exhibit certain analytical limitations, notably their inadequate consideration of state policies" (Morsy 1995:163). Thus, the intentions, motives, results, and perpetuation of the government's promotion of sterilizations and modern forms of contraception must be examined to provide a more adequate view of the ramifications of politicizing reproduction.

Browner, in an analysis of women's reproductive activities, states that "reproduction…can be considered social in a Marxian sense," as it is done "within the context of explicit and variable material conditions" (2001:773). She expands by explaining that a woman does not simply "get pregnant" and "give birth." Rather, a woman does so within the milieu of unequivocal and dynamic access to resources, including opportunities for employment, and broader economic relations, class divisions, the quality of and access to healthcare, and the types of contraception that are available

(Browner 2001). Hence, reproduction is never void of social arrangements, control over contraceptive decision making, and access to contraceptive materials. In examining reproductive actions, Ginsburg and Rapp (1995:161) have argued for "[research] models that place the cultural and social dimensions of human agency and its structural constraints at the center of analysis." This particular portrayal draws from that model and seeks to demonstrate how sociocultural life and structural inequalities not only reveal the current state of reproductive activities, but also the dynamics of Quechua social and cultural identities.

Methodology

Ethnographic research was performed from June to August 2007 in two primary settings, various rural towns and villages and the city of Cusco in the Department of Cusco. The Department of Cusco is situated in Southern Peru and is heavily mountainous. Its population of approximately 1,000,000 inhabitants is split approximately evenly between the city of Cusco and small towns and villages.

Research was conducted in both Spanish and Quechua at the preference of the informants. Interviews entirely carried out in Quechua were assisted by a native Quechua-speaker to aid in translation. The research assistant also provided a means of building rapport within the communities because of her familiarity with the region. Targeted and snowball sampling (Bernard 2006) was used to gather data on four specific groups: government medical clinic staff (13%, n=4), private medical clinic staff (6%, n=2), women of reproductive age (50%, n=15), and men of reproductive age (30%, n=9). Data was also collected in informal, unstructured interviews and participant observation in rural and urban health posts and clinics, marketplaces, town plazas, and in homes. Semi-structured interviews with non-healthcare practitioners focused on overall awareness of and experience with modern contraceptives, knowledge and opinions of sterilizations, cultural

beliefs, religion, economic situation, and sexual and reproductive experiences. Semi-structured interviews in the medical setting centered on the types of contraceptives available, how the methods are administered, opinions of sex in the sierra, and government promotion of modern contraceptives. Interviews were recorded in full and transcribed if the informant agreed. I obtained informed consent from all formal interviewees. The University of Notre Dame Institutional Review Board approved this research methodology.

Notes were recorded freehand during participant observation and interviews and then formally recorded and reviewed at the end of each day. Notes were made on follow-up questions and emerging analytical themes (Bernard 2006). All comments were inductively coded, and salient quotes from interviews were noted for their thematic relation to contraceptive options and knowledge, sentiments of sterilizations, personal and public perceptions of contraceptive use and sterilizations, and the decision-making process to use or not use modern forms of contraceptives. Grounded themes have been extracted with the aid of Qualitative Research Software International nVivo program (version 7.0) and discussed with my research assistant and research advisors at the University of Notre Dame.

Dynamics of Contraceptive Use: *Control, Identity, and Necessity*

"No aspect of [reproduction] is a universal or unified experience, nor can such phenomena be understood apart from the larger social context that frames them" (Ginsburg and Rapp 1991).

Government Control Over Reproduction

Approximately seventy-five percent of Peru's population receives medical care from public health clinics run by the Ministry of Health (MINSA-Ministerio de Salud), yet due to inadequate human and financial resources, most citizens lack quality medical care (Rousseau 2007). There are currently no government-mandated standards for medical care (Rousseau 2007). Clinics in the

department of Cusco are easily recognizable by their distinct pale blue color and were often overcrowded with the wide age ranges from infants to the elderly. Lighting remains dim in the waiting area where all patients, regardless of their reason for attending, must wait to visit with a medical practitioner. Among the small offices within the clinics is an Obstetrics and Gynecology section, demonstrating how the once-natural processes of reproduction among the Quechua have been medicalized and situated within the biomedical realm.

Every informant interviewed was aware that a sterilization campaign took place. Although some could only say they heard that such procedures were being performed, others cited multiple people in their social networks who had been sterilized. Aside from overtly forced sterilizations, contraceptives have been reported to be administered covertly in hospitals and secondary schools. A recent secondary school graduate stated that MINSA representatives who came to her school every three months "gave out injections saying it was for illnesses, but the injections were just another way of sterilizing." Another woman informed me that the medical post gave out medicine for headaches, which she later discovered to be birth control pills. One woman stated that nurses at the government clinics gave her consultation on injections and birth control pills while she was visiting the clinic for an unrelated illness. Furthermore, women are required by law to give birth in a hospital or they face a hefty fine which is often impossible to pay (Rivas 2006), leading their health decisions at parturition to be at the will of the government healthcare practitioners. Documents in government hospitals are written in Spanish, leaving those who speak, read, and write only in Quechua without full knowledge to give complete consent (Rivas 2006). One woman cradling her third child in a large marketplace in Cusco expressed her desire to follow the "traditional and familiar" practice of giving birth in her home, but because of the large fine and the inaccessibility of a government birth certificate outside of the hospital, she gave birth in a government hospital. She explained that she currently receives contraceptive injections, despite the fact that she believes they

cause her strong headaches and discomfort. After further inquiry into why she chose that method, she explained that the doctor at the government hospital where she felt forced to give birth would not give her a birth certificate for her child unless she agreed to receive contraceptive injections.

No current instances of forced sterilization were reported in interviews; however, government-controlled health clinics demonstrated a strong propensity towards advertising and administering surgical sterilizations and other modern forms of contraception (particularly birth control pills and contraceptive injections). One government nurse at a MINSA clinic in the city of Cusco explained, "Well, the only methods we offer are ones approve by the Ministry of Health like condoms, the Copper T (an intrauterine device or IUD), birth control pills, injections, and nothing else."

Six out of six government clinics I visited outwardly displayed a large poster of contraceptive methods offered. Although the poster indicated that the clinic offers consultations regarding natural methods (such as the rhythm method), interviews with medical personnel reflected only a promotion of barrier and hormonal methods to contraception, including IUDs, condoms, birth control pills, and contraceptive injections. Furthermore, one MINSA nurse explained that "the Ministry of Health hasn't given us the materials to give to women to record their menstruations," therefore demonstrating the lessened structural support for natural methods of contraception. While inquiring about contraceptive methods in a MINSA clinic in a rural town, I observed a "Sterilization Room" (*Sala de Esterilización*). At first, the medical practitioner at the clinic denied the use of the room, but upon asking him what advice he would give to a "young mother of two children," he stated that he would try to persuade her to undergo a tubal ligation explaining that "it only takes fifteen minutes – thirty max!," that she "would not feel any pain," and that "life would be better if she stopped having children."

Paraphernalia promoting contraceptive use among the indigenous is plastered all around the clinics. Ironically, a mural outside of one clinic where the nurse had informed me that I could undergo the moderately-risky tubal ligation surgery in fifteen minutes showed an indigenous woman holding a child with the caption "Maternity: Healthy and Safe, the Right for Every Woman." Inside the clinics and on the placards shown in family planning demonstrations by MINSA personnel are scenes depicting cartoons of a frazzled, single woman in indigenous garb crowded by young, crying children juxtaposed with a modernly-dressed man and woman with two children smiling with their arms around one another in front of a large home. MINSA personnel were said to use such visual aids in talks (*charlas*) at secondary schools and inside the clinics.

High in the Andes, these subtle and covert forms of control resonate well with the Foucauldian framework of the "gaze" of the medical clinic and the "surveillance machinery of the Panopticon" (Armstrong 1997:25, Lock 1993). This gaze is evident in the advertisements, the instructive posters, and in the establishment of power of the medical practitioners over the newly-classified patients. The notion of contraception, and that of natural methods of family planning, has shifted away from locus of the home where one informant deemed that a knowledge of herbs is "just as natural as learning the alphabet." Instead, the source of information and access to state-approved and modern contraceptive methods is found in the posts, clinics, and hospitals. Thus, the government takes coercive measures through such advertisements to control indigenous thoughts and actions on reproduction.

A Note on the Practice of 'Illegal' Abortions

Counter-intuitively, abortions in Cusco also contribute to structural control over reproduction. Although abortions in the predominantly Catholic country are illegal, the government does little to stop their occurrence in Cusco. Abortions, though strongly culturally undesirable because of the physical and emotional risks associated, are reported to be used frequently by young

adolescents[2]. Multiple informants identified a specific neighborhood in the city of Cusco where abortion clinics are abundant. While visiting the neighborhood in the late evening, I entered into the "24-hour clinics" that advertised "consultation on contraceptive methods." In one particular locale, a nurse offered me an immediate abortion without any reservation moments after I had walked in (albeit for the average cost of 150USD). The nurse's immediate enthusiasm demonstrates that these clinics have a clear and well-known purpose and it is obvious that both the cliental and practitioners of the clinics on this particular city block see abortion as a primary service. In spite of the high cost, there is little structural action to prevent or discourage the use of abortions and many young women are reported to take advantage of such services. In a sense, the government controls reproduction and births through the off-hand permissiveness of abortions in Cusco.

Identity and Choice in Family Planning

Amid the five-star hotels, internet cafes, and cars buzzing around Cusco, longtime traditions have been retained in the public and private lives of many of the people. For example, Catholic lawyers and teachers living in the heart of the city cited frequent private offerings of water and food to the Pachamama (Mother Earth) in hopes that she would bring blessings of stability and good fortune. Hence, despite the institutionalization of external structures, such as the Catholic Church and business corporations, the actions and identities of the Quechua are often grounded in the ideals of pre-conquest culture.

This cultural clash is well-depicted in the age-old Quechua tradition of the "Yawar Fiesta" or "Blood Festival." In this ritual, the social conflict between the indigenous and the upper-class *mestizos* is exemplified in a fight between an Andean Condor and a bull (the condor representing the Quechua and the bull, those of Spanish descent)[3]. Even in tourist postcards today, the caricatures of condors are featured in power struggles over caricatures of bulls. This clash between old and new

establishments, and the more-powerful and the more-powerless permeate through newspaper selections, religious festivals, sexual relationships and reproduction. A woman from Lima currently residing in Cusco explained that "the Quechua people have their own religion. They believe in the Pachamama as much as they believe in the Virgin Mary!"

The concept of marriage itself has multiple dynamics and is rooted in pre-conquest culture. In rural villages, lifetime cohabitation or long period of cohabitation prior to a formal marriage is more frequent than legal or religious marriages. Despite opposition from the Catholic Church and the State, the ancient practice of "sirvinacuy" also known as "tikunakuspa," or a commonwealth marriage in which partners may reproduce prior to marriage persists today (Powers 2000). Thus, marriage, partnerships, sexuality, and child bearing are all affected by tradition and heritage.

Along the same theme, my informants expressed that "the fertility of a woman directly affects the fertility of the land," and "good fortune for the land comes from healthy menstruations and births." Additionally, sex and giving birth is described as "as normal as eyes and noses," and "just a natural part of life." Therefore, those born congenitally sterile are thought to live "sad" and "lonely" lives. One informant described sterile people to be "like ashes that blow away in the wind…they have no one and no one to help them cultivate their fields." Conversely, having children is said to "be the best thing [one] can do in life." In this agrarian society where fertility is inextricably linked to fruitful harvests, and barrenness tied to desolate fields, the cultural and societal position of a sterilized person is greatly affected.

In a similar light, having children is a means of establishing a societal position of adulthood. Fecundity for men is a sign of virility and dominance over their partner, or as one male informant stated, "Sex and having a lot of children is a sign of a man's power and control." Furthermore, more children allow for a stronger labor force working in family farmlands (*chakras*). For this reason, men felt threatened by contraceptives because it gave women more control over conception.

A female informant stated that "men think a woman is more beautiful when she has a child on her back," and "it bothers men when [women] don't have kids." Furthermore, many men cited fears that female contraceptive use would lead to a lack of children, infidelity, and would ultimately weaken any control the man has in the relationship. One man strongly proclaimed "the only women who use those modern methods are bad women who cheat on their husbands."

A middle-aged male informant with five children listed and described in detail every modern contraceptive method, told of his support for Fujimori's promotion of family planning in Peru, and expressed his disapproval for parents who have multiple children. When asked, "Why do you support family planning but have five children?" he stated,

> "Well, what am I going to do? I can't take it back [having five children]. But here's the truth; I can be frank, right? I was certainly jealous. I always had to leave town for work and my woman would say, "You leave and go to your other woman!"…It's because of the jealousy that I had so many kids. And it's not only when [women] are jealous, we go to the bar and drink and we're *machistas* like that, and maybe we dominate our women…but women always think that we have another woman, right? That's what they think."

According to this man, he continued to impregnate his partner to prove his control and suppress his and his partner's fears of infidelity. A female informant expressed fears for her pregnant sister by saying, "I know she doesn't have money to take care of her baby." Her explanation is that "her husband is jealous and because of the jealousy, she got pregnant." Thus, allowing a man to retain control in a relationship through children was at times more important than the costs of childrearing, and women often lack agency in that decision.

When women do practice modern family planning, the use of modern contraceptive methods such as injections and birth control pills is associated with additional physical and emotional changes besides infertility. With the modern methods, women reported weight gain, weight loss, skin changes, nervousness, headaches, heart palpitations, intense hot or cold bodily sensations (see Bastien 1985), and irritability. Some women using an IUD even complained of "bad

respiration and a taste of iron in the mouth." Additionally, women reported fears that IUDs are abortifacient, or that "the baby gets pierced by the sides of the IUD."

For this reason, many women experiment with multiple forms before settling on one method whose side-effects they feel they can be most easily managed. For example, doctors at a rural medical post prescribed contraceptive injections for a woman who found an IUD to cause lower body pain and birth control pills to cause headaches. She described her experience with injections by stating, "When they give the injections, we don't menstruate. We don't see our blood and our bodies get hot." Because each injection lasts for three months, she learned to balance the heat incurred by a build-up of blood in her body by ingesting "cooling herbs" regularly which remedy her internal "shock" from the injections. However, this process of balancing side-effects is challenged during times of environmental or climate distress due to the interconnectedness of the body and the land. Therefore, "women can't handle taking contraceptives when there are mudslides or when the river is high. They are too nervous." Again, this example demonstrates the Quechua body-environment collaboration. The use of modern contraceptives must then be considered in the contexts of Quechua perceptions of the linkages between body and land, which is particularly important for those who have been sterilized and cannot return to a fertile harvest or *life*.

Men and women who have been sterilized "no longer feel strong enough to help their families work in the fields" (Rivas 2006). *Every* informant who spoke of personal experience or the experiences of kin who had undergone sterilization noted social and physical changes after the operation. A young rural woman explained that "nowadays, the women who had their tubes tied are sick. They're not well…their entire lives have changed." She also explained that a doctor coerced her father into being vasectomized and that, "It's really weighed on [him]. Since then, his character has changed so much…He has changed into a crazy man…he is weak now. He mistreats my mother and hits her with rocks." While working in the fields, one man pleaded with his peers by

saying, "Men like me, please don't go to the hospital. They'll castrate you there like they did to me." The fields, town plazas, and homes provide venues where the experiences of sterilizations can be discussed among kin. Much of the fear over sterilizations and modern contraceptive methods stems from the adverse experiences with sterilizations and contraception as described by kin.

Hemorrhaging, weight gain, and lower body pain are the most frequently reported physical problems associated with tubal ligations, while emotional attributes include insanity, anxiety, hostility, and crippling fears of cyst and tumor formations. Vasectomized men are cited with a lack of alcohol tolerance or alcohol abuse, raging tempers, and anxiety as their "testicles little by little become like stone," and "ushpa," (dust). Hence sterilizations and modern contraceptive use are never isolated, private affairs; rather, the outward character changes and frustrating physical transformations endured carry lasting and vulnerable social labels.

Necessity to Use Contraceptives

Prior to the Fujimori era of massive distribution of contraceptives and government-mandated sterilizations, women preferred to ingest a series of herbs at particular times during their menstrual cycles to control family planning. Depending on a partner's compliance, this method's use was described in conjunction with coitus interruptus and/or the calendar (rhythm) method. Knowledge of these methods, particularly the herbs, is widespread; yet natural forms of contraception are highly unreliable. Firstly, the herbs provide no actual hormonal or barrier methods secure enough to consistently prevent conception. Coitus interruptus is often ineffective due to a lack of knowledge of pre-ejaculation. The calendar method is often undermined by the popular cultural norm of heavy drinking, leading men to desire and demand sexual intercourse. Furthermore, the fact that many men migrate from rural towns to the city of Cusco for weeks at a

time to sell goods disturbs sexual patterns in the calendar method. Hence, natural methods in the Quechua context are often unpredictable and inconsistent.

Because of such inconsistencies, women feel the necessity to employ more secure contraceptive methods to control their number of children. Contrary to a sense of power incurred in men by having multiple children, most women with whom I spoke who have multiple children (~ > 4) are ashamed and considered "unable to take care of themselves." Women, for the most part, are unable to overtly control their partners' sexual preferences and drives. Since men are against the use of contraception for the issues of control and jealousy, contraceptive use was sometimes cited as secretive.

Such secretive measures are taken especially when poverty leads to the impossibility to care for another child. One young mother of two explained that she tried to discuss contraceptive use with her husband,

> "But he doesn't want me to use any method. He told me that only whores are sent to get these things done. He can say what he wants, but I don't want another child. I went by myself to get the Copper T without him knowing. A year after, I had the Copper T put in, he asked me, "Why aren't you pregnant?" So I said, "I take care of myself naturally when my period comes." I need money. I told him, "It's a lot easier if you get a vasectomy." And he told me, "I don't know how that would be. Maybe the doctor will hurt me!" He says he doesn't want to do anything. For me, it's not good to have a lot of children. In order to have kids, we should have jobs and at least a house. I don't have secure work… and no social security."

Many impoverished women expressed similar sentiments, most frequently that of "I just *can't* have any more children!" and, "Life is very difficult and there isn't any money to put the kids in school." Additionally, many women expressed concerns that it would be impractical for their husbands to use methods such as condoms because of potential misuse or forgetfulness, and male displeasure of the sex with a condom. Overall, women place more trust in themselves to use contraceptives than in their partners.

There is little contestation that cultural values influence an individual's decision-making. Yet in the same vein, the influence of culture should not be viewed as trumping other factors that shape decision-making in reproduction. Macklin (1996: 173) elaborates this point by stating that "behavior regarding contraceptives is actually determined by a combination of government policies, the practices of individual health care providers with whom she comes in contact, and the degree to which she has freedom from control by her sexual partner(s); and…the social and economic class to which a woman belongs, rather than cultural values, is what shapes the extent to which government policies and providers' actions affect a particular woman's use of contraceptives". Despite the overall undesirability of using modern contraceptives and fears over sterilization, structural constraints in Peru have warranted the necessity of their use. Traditional forms of contraception are reported as unreliable and many families stated that they cannot afford to care for additional children.

The rising costs of education, clothing, and food make caring for additional children extremely difficult for many couples. The issue is only exacerbated in the decline in communalistic practices and the placement of more neocapitalist ventures in Cusco, especially with the rising competition in the tourism industry. The institution of rapidly changing economic situations in Cusco is forcing women and men to turn to often undesirable means of family planning, therefore placing an already vulnerable group in a more adverse situation.

Conclusions

If "informed consent" is considered the "hallmark" of high-quality contraceptive programs (Russell and Thompson 2000:10), then the current situation in Peru warrants an evaluation of the agency individuals have outside of economic, political, and social pressures to make informed and desired family planning decisions. Grasping a view of the sociocultural ramifications of the

sterilization campaign and subsequent uses of modern contraceptive methods is best achieved through an examination of the dynamic nature of Quechua identities, political hegemony, longstanding cultural beliefs, and economic constraints. Government control over reproduction over the last ten years has now been internalized into Quechua life and while some are satisfied with their access to contraceptive methods, many already vulnerable lives have been negatively affected by such structural exertions of power. For many, the use of modern contraceptives is providing a means to obtaining material and economic need, but often comes at the cost of a change in one's social identity and family life.

The example from the Department of Cusco, Peru offers a look into how outside physical control of reproduction affects both societal and cultural factors. Russell and Thompson state, "Contraceptives…have profound ramifications for human social organization and relationships, and the study of contraception and the issues surrounding it puts into high relief those aspects of human social life, politics and economics, that both forge the compact between 'people' and 'contraceptives' and are influenced by it" (2000:17).

The knowledge and availability of modern contraceptives is now widespread and the government has performed hundreds of thousands of sterilizations; yet the rapidity of the campaign has neglected to account for its effects on sociocultural expenses, perceived health effects, future family planning decision-making processes, and the violations on human rights. Adding to the trying situation in Peru is the sensitivity of rapidly-changing reproductive activities in the already-existing dynamics of indigenous life in the neocapitalist world. Tucker, in her 1984 fieldwork on barriers to modern contraceptive use in rural Peru, proposed that "family planning programmers need to recognize the social constraints imposed by gossip, the damaging rumors that undermine acceptors' [of modern contraceptive methods] motivation, and the discrepancy in attitudes and beliefs between husbands and wives" (1986). In addition to the difficulty of considering the factors

examined by Tucker are the major sociocultural ramifications from an intense exertion of governmental constraints and the effects of a society quickly becoming engaged on a global scale.

For this discussion, it is helpful to return to Cohen's previously mentioned assertion that reproductive practices are inextricably woven into the larger political, economic, and sociocultural fabrics. Adding to the complexity is the fact that the state of contraceptive use and the effects of sterilizations are contextually-dependent, dynamic, and often placed into the lofty concepts of transitional societies, negotiating identities, and agency within local and state structures. The overt sterilizations of the past and the covert measures to control reproduction in the present in Peru demonstrate the use of hegemonic force over what are considered the ideals of a vulnerable social group. Thus, current issues for reproductive health in the Peruvian sierra are directly tied to structural powers, lasting cultural factors, and Quechua social identities.

The example of contraceptive use and mass sterilizations in Peru demonstrates complexities of longstanding cultural clashes, ethical matters of choice in reproductive behavior, the power and poignancy of government control over reproduction and the transmission of alternate medical practices in a culturally-sensitive area. Due to the dynamic nature of the processes of contraceptive distribution and use as well as the state of sterilizations, it is imperative to discuss how an anthropologist with little to no constraints over personal agency in contraceptive decision-making should approach these issues in application. In essence, the anthropologist treads a fine line between providing ethical assertions and acting in a manner of which many Western feminists have by "speaking on behalf of…'the oppressed Third World'" with an overly-romanticized view that is solely rooted in historical narratives, as such viewpoints have been taken to be conservative, pronatalist, and overall ethnocentric (Briggs 1998).

To provide a more adequate discourse on how contraceptive use and sterilizations affect the lives of women *and* men, the anthropologist must ask 1) Who is promoting, funding, advocating, and

requesting contraceptive materials? 2) What contraceptive choices, if any, are available? 3) What external factors (i.e. economic constraints, the desire to have more sexual freedom) influence the use of contraceptives or sterilizations? 4) Are the contraceptives administered and the sterilizations performed with full knowledge and consent? And, 5) Who benefits and who is harmed by the practices? Such questions will be best answered with direct testimonies of the women and men, free from the presuppositions and ideals of the outside anthropologist. It is then that an evaluation of reproductive rights and subsequently the larger social processes inextricably tied to them can be gathered. Such analyses of reproductive behavior will illuminate the local and global entities and the state of the lives shaped at their junction.

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1Commonly referred to as "getting one's tubes tied," a tubal ligation is a female operation to tie the fallopian tubes closed and permanently prevent pregnancy by blocking the passage of ova to the uterus. A vasectomy is a male operation in which the vas deferens is either cut or tied, permanently preventing the transport of sperm from the testes.
2 Human subject safety requirements by the benefactors of this research at the University of Notre Dame did not allow the participation of anyone under the age of eighteen in this study.
3 See *Yawar Fiesta* by José María Arguedas. Arguedas (1911-1969) grew up in the Peruvian Sierra and became a novelist and short-story writer of indigenous life.

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