

## Free Choice or Poverty Alleviation? Population Politics in Peru under Alberto Fujimori

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The government cannot reduce poverty efficiently if poor families continue to have on average seven children (Peruvian Prime Minister, *Gestión* 12-07-1995, cited in Aramburú 2002).

In 1995, the Peruvian government of Alberto Fujimori implemented a nation-wide 'family planning' promotion programme as a result of which, it was later revealed, poor, mainly rural and indigenous women were sterilized according to a quota system. Many were coerced, and some women died of unattended complications. These events have been investigated from a human rights perspective (CLADEM and Tamayo 1999, CLADEM 1998, Defensoría del Pueblo n.d.). This paper intends to widen the perspective by examining *how* it was possible that such neo-Malthusian-motivated politics were implemented in the second half of the 1990s, after the agreements reached at the Cairo Conference on Population and Development (1994) and the Beijing Conference on Women (1995) with regard to sexual and reproductive rights.

Birth control programmes directed at the poorest of the world are not new or unique to Peru. As a wide range of studies demonstrate, the poverty of – often – non-white masses has prompted the development of active population control strategies by national and international organizations and governments (Mamdani 1972, Jaquette and Staudt 1988, Kabeer 1992). Such politics have been justified with economic developmental, environmentalist, and medical arguments. Often, as the diverse studies indicate, underlying motives for these strategies were based on fears for poverty and racial degeneration with effects beyond national borders.

At a national level, the idea that populations could be 'moulded' into desired citizens has been present from the early twentieth century. As such, birth control programmes in the Third World in the second half of the twentieth century, underpinned by the assumed problem of overpopulation and poverty, have their roots in early twentieth century discourses and experiments in the fields of hygiene and eugenics (Stepan 1991). In Peru, these debates were directed at the 'Indian problem' and a fragmented national identity debated by *hispanistas* and *indigenistas*, in short, those who promoted a cultural and biological emphasis on the European heritage among Peruvians, and those who proposed an emphasis on an indigenous heritage (Hale 1996). In the 1930s and '40s, while eugenic theory had lost its intellectual appeal in most of Latin America and Europe, Peruvian physicians actively promoted eugenic ideas and policies through a state-sponsored eugenics society. These distinguished scientists were concerned with the 'quality' of the Peruvian population and the improvement of the race, while their efforts were grounded in a quest for modernity (Boesten and Drinot 2004).

As such, the field of 'population' is and has always been highly charged politically. At the same time, and this is often neglected by policymakers and demogra-

phers, the resulting quest for birth control concerns women's individual bodies and the control they have over their body, sexuality and reproductive choices (Caetano and Potter 2004). After decades of activism and debate, these two aspects of the 'problem' of population were, if not reconciled, at least discussed at the Cairo Conference on Population in 1994, followed by the Beijing Conference on Women in 1995 (Tamayo 2001). Reproductive health and women's rights were recognized as central to the success and effectiveness of population programmes. Nevertheless, sufficient space for ambiguity was left in the Cairo agreements for international cost-cutting and neo-liberalism, religious opposition to women's rights, and the 'Malthusian thinking [...] ingrained in development institutions, donor agencies and government departments', to overshadow population programmes throughout the world (Nair and Kirbat 2004). In Peru, this space was eagerly picked up on by the authoritarian government of Alberto Fujimori (1990-2000).

### **Population issues as a policy object**

Modern day concerns over population, after the decline of the social concerns formulated by 'hispanistas' and 'indigenistas' in the 1910s and 1920s and the eugenic movement of the 1930s and 1940s, were provoked by rapid demographic changes.<sup>2</sup> The Peruvian population grew from some six million in 1940 to more than twenty-five million in 2000. Improvements in healthcare caused a sharp mortality decline, while the fertility rate stood at an average of six children per woman in 1972 (Aramburú 2002). The urban centres, especially Lima, grew steadily as a result of internal migration. By 2000, seventy-three per cent of the population was urban, and fifty-four per cent of this population lived below the poverty line. Urbanization and economic and political changes led to new concerns over population growth among the poor.

As a result, in 1964, a group of public health researchers created a publicly funded institution, the *Centro de Estudios de Población y Desarrollo*. However, the political context was not right: aggressive U.S. involvement in birth control programmes in the Third World prompted several leftist governments of major developing countries to protest against 'U.S. imperialism' and the equation of population growth with poverty (Kabeer 1992). When, in 1968, a leftist military regime took power in Peru, it sided with those critical countries against U.S. involvement. The *Centro de Estudios de Población y Desarrollo* was abandoned and U.S.-made contraceptives were imported, but not massively. The 1970s saw an increasing interest for birth control methods among middle class women. Feminist organizations emerged, and demands for improved access to a wide range of birth control methods were voiced. This marked the beginning of a long and unfinished conflict with the Catholic Church and its representatives in government. Besides the problems of religious sexual morality and the political opposition against U.S. imported contraception, there was a problem of class: middle class feminist activists had relatively good access to contraception and reproductive health services compared to poorer women, and in particular, in comparison with rural indigenous women who were often cut off from healthcare services. Whereas the opposition to U.S. imported birth control methods faded in the 1980s, the Church's preoccupation with sexual mores and the problem of access to healthcare services for the poor remained an obstacle for the pro-birth control lobby.

The first political attempts to broaden access to birth control methods after the

fall of the military regime in the 1980s were made during the Belaúnde government (1980-1985). The census of 1981 showed that the Peruvian population had grown by over three and a half million in less than a decade; that the fertility rate was still slightly above five children per woman; and that sixty-two per cent of married women, especially women in areas with the highest fertility rates, did not want any more children. The government set up a national population council and slowly family planning services were installed in public hospitals. These measures did not, however, reach the population in more remote communities beyond the urban centres. Nevertheless, the second International Conference on Population in Mexico in 1984 marked the final push in the formulation of a law on population and birth control (Aramburú 2002).

The 1985 National Law on Population guaranteed the rights of individuals to freely decide how many children they wanted. Shortly after he came to power, president Alan García (1985-1990) expressed his concern about population growth in relation to development (Aramburú 2002, Bonfiglio 1999, Arroyo 2002). For the first time, public opinion, including the political left and the Church, supported proposals to actively control population growth. The Church opposed modern methods to reduce the fertility rate but it promoted 'responsible parenthood' and natural birth control methods such as withdrawal and the female fertility cycle. As a consequence of fear for Church opposition, the 1985 legislation omitted voluntary sterilization and abortion, two medical interventions feminists wanted legalized. Despite the favourable climate to introduce birth control programmes, the government failed to introduce comprehensive changes in the healthcare services or in the provision of information beyond the urban centres (Arroyo 2002). While no radical effect was felt in the 1980s, the law nevertheless paved the way for more sweeping policies in the 1990s.

In sum, while developing countries around the world were involved in population policies through foreign-financed family planning campaigns, Peru's political and religious arena was not ready for widespread measures. Rumours of forced sterilizations executed by USAID or the U.S. Peace Corps in neighbouring countries reached Peru, and similar accusations were made within in Peru.<sup>3</sup> Thus action was not taken and birth control methods remained largely a privilege for those who could afford them, had access to adequate information, and to the actual products. The fertility rate dropped steadily among middle-class educated women as well as among urban migrants with less economic means, while the fertility rate among the rural indigenous population hardly decreased.

### **Fujimori and rapid fertility reduction**

When Alberto Fujimori came to power in 1990, the country was socially, economically and politically bankrupt due to rampant inflation and the devastating war initiated by Shining Path in 1980. To deal with these problems, Fujimori created an authoritarian-populist rule with a flavour of democracy. From the start, Fujimori used the rhetoric of social integration and emancipation. Nevertheless, despite his promises, the new president started his governing period with an economic shock, which stabilized the economy but also impoverished the population. Nevertheless, several economic and social achievements, not to mention dismantling Shining Path by capturing its leader Abimael Guzmán in 1992, earned him vast popular support. Fujimori also used his mandate to create a system of unprecedented con-

control over society. After a 'self' coup in 1992, the president and his secret service increased their control over the judiciary system, the military, the police, and large parts of the media (Cotler and Grompone 2000). The authoritarian but popular character of his regime contributed to the following events.

Fujimori followed up on Alan García's law on population by designing a *Programa Nacional de Población*. The goals of this programme were to reduce the growth of the population to a maximum of an annual two per cent growth by 1995 (which is in fact a negative growth); to promote a decrease in fertility from three and a half to three children per woman in 1995, to two and a half children in 2000; to improve maternal and child health; and to guarantee the freedom of choice and the reproductive rights of persons. Additionally, the population programme proposed to encourage the participation of women and their organizations in the economic, political and socio-cultural spheres on an equal basis with men (CLADEM 1998). Thus, the Fujimori government promoted birth control by explicitly emphasizing the need for equal access to contraceptives and reproductive healthcare for women of all classes. In 1992, urban women showed a fertility rate of 2.7 and rural women 5.9 children per woman. Accordingly, providing access to services for the poor and rural populations was emphasized from then on. After the introduction of the programme in 1990, the first reforms were made and international funding bodies were lobbied. However, in the electoral year 1995, the programme went ahead, but now supported by USAID money and a solid legislation.<sup>4</sup>

After being re-elected with a vast majority of votes, Fujimori incorporated voluntary sterilization into the law as an approved contraceptive method. This provoked a heated debate between the government and the Church, but the media in general supported the measure (Bonfiglio 1999). The Church tried to impose its own conditions. For example, the Church prevented the state from implementing liberal sex education in schools by opposing the spread of educational material that the Ministry of Health had issued in 1996. The then archbishop of Ayacucho and one of the most conservative and powerful Church authorities in Peru, Monsignor Juan Luis Cipriani, developed his own educational material, stressing *paternidad responsable* (responsible parenthood) and family planning based on abstinence and moral values. According to several accounts of this polemic between Church and government, the conservative programme became available to all; the Ministry's version – already revised – became available to teachers, but not to students (Sala 1996; Bonfiglio 1999, 136).<sup>5</sup> The influence the Church had on politics was in part determining the government's policies. However, Fujimori continued challenging the conservative sectors with the support of the international community and public opinion.

The international community welcomed the sweeping measures Fujimori proposed. In the same year that the law on voluntary sterilization was passed, the Fujimori government received millions of dollars and several thousand tons of food from USAID to support its plans.<sup>6</sup> Part of the money went to Movimiento Manuela Ramos, a Lima-based NGO, to implement a participatory programme to inform women on the use of birth control methods and empower them to become actively involved in the improvement of their reproductive health. The rest of the funds were used by the government to provide information campaigns and family planning services, including sterilization, without a fee. However, no improvements in the quality of rural healthcare services, such as the provision of a hygienic working environment, medical supplies or even beds, were provided. Instead, the govern-

ment improvised mobile medical services for rural areas; local rural doctors received orders to sterilize women in their areas according to a quota system and to 'ensure that all women accepted a contraceptive method after delivery' (Aramburú 2002).

Establishing quotas to sterilize women is already sufficient proof of the political motives of this programme: setting quotas seriously implies that the programme was not motivated by concerns about women's health, birth control, or even family planning; it was about national demographics in relation to economic growth. These goals were not set in an overpopulated area either; rather, they were set in inaccessible, poor and marginalized rural areas. In order to decrease the fertility rates in these scarcely populated rural areas, local healthcare personnel had to determine the number of 'women in fertile age' in their region, and sterilize a certain number of these women. Those workers who met their quotas received goods or money (CLADEM and Tamayo 1999, CLADEM 1998, *Defensoría del Pueblo* n.d.). Donated food was used as a stimulus for women to agree to sterilization. In fact, according to one newspaper, the offer of free sterilizations for the poor was made public in the harbour of Lima at the very moment when the Minister of Health received almost 20,000 tons of foodstuffs from USAID (*Expresso* 12 September 1995). Although the cited reports by Tamayo, CLADEM and the Defensoría del Pueblo differ about the extent to which the government forced sterilizations on women during the Fujimori period, all agree that it occurred. Fujimori's motives for these extreme measures were economic. They were not primarily intended to provide equal access to services for all, or to ensure the well being of women. As Carlos Aramburú, who was briefly president of the National Population Council in 1996, observed (2002), Fujimori's radical methods showed his personal interest in decreasing population growth through the most cost-effective method, sterilizations.

Newspaper articles in 1995 show how Fujimori sold his poverty-reduction strategy through population policies to the wider public: in a national newspaper, *El Comercio*, he claimed that he personally went to the Conference on Women in Beijing to support the 'important work of the women's movement', and to emphasize his 'dedication to the improvement of the position of the fifty per cent of the population which had been excluded [from full citizenship] for a long time' (Fujimori 1995). At Beijing, Fujimori – the only male head of state present at the UN conference – could not stress enough that women had the right to control their fertility and that he would be the one to guarantee this right for women of all classes. Thus, Fujimori won the hearts and minds of those Peruvians who were at his political left, the women's movement, and the international community, which was needed not only to provide legitimacy, but also the financial means to implement his plans.

Of course, the Church felt it was losing ground in the area in which it thought it was the sole authority. However, as the Minister of Health declared to a national newspaper, this time there were no disagreements with the Church, because the government was just 'giving in to the demands of the population to control their fertility according to their rights' (*La República* 16 August 1995). But Fujimori took it even a step further: the President accused the Church of impeding women from exercising their rights by saying in his speech to the World Conference on Women: 'I am convinced that in Latin America and in other parts of the world, the time has come to abandon, once and for all, the antiquated mental schemes which hinder the full development of women and, therefore, of humankind. This does not mean that we aim to attack any institution, but that we must promote a debate of

the highest ethical and human standards' (Fujimori 1995). In this way, Fujimori deployed international discourses of women's rights and appealed to demands for equality to justify the family planning programme (or rather, fertility reduction programme) directed at poor, rural and urban marginalized women, while shacking off any conservative objections to his policies.

When, in mid-1996, the Church denounced the existence of a systematic sterilization programme promoted by the Fujimori government, its accusations were dismissed: Fujimori claimed that the Church was a conservative force that did not support the freedom of women to use modern contraceptives. This was in line with his discourse at Beijing. Initially, human rights and feminist movements supported Fujimori's plans silently. However, from late 1996 onwards human rights movements and the national ombudsman, the *Defensoría del Pueblo*, joined the Church in its criticism. Because of an entanglement of interests and priorities, feminist organizations responded late and not very effectively to the policies (Barrig 2002, Petchesky 2000). By 1998, major international funding was withdrawn and the government was forced to seriously reform its population policies (Bonfiglio 1999, Aramburú 2002).

As a consequence of participation in the population programme, both the feminist *Movimiento Manuela Ramos* and USAID could be accused of complicity, although both denied any knowledge or approval of quotas or force. In an important article, feminist scholar Maruja Barrig recounts the sequence of events in the relation between the state and feminist organizations with regard to the revelations of the coercive practices (Barrig 2002). She highlights the lack of response of the feminist NGOs, the web of interests, and the apparent incapacity of taking a united feminist stand against the programme for fear of losing the little ground that women had gained in birth control issues. Interviews with personnel that worked for *Reprosalud* and its annual reports, suggest that *Movimiento Manuela Ramos* would not have agreed to a coercive sterilization project. However, the organization did not use the information available to them or the access to women and men in the rural areas where the programme was implemented to stop the programme either. The *autodiagnósticos* discussed below imply that the organization should have known what was happening, as women mention coercion and deceit used by the healthcare personnel. Instead of publicly and forcefully denouncing the events and withdrawing from the project, *Movimiento Manuela Ramos* handed the cases over to the human rights organization CLADEM. The position of *Movimiento Manuela Ramos* was to aim for 'changing from within', a position that compromises the critical role a feminist nongovernmental organization perhaps should have. As Petchesky observes, the tension between collaboration and critiquing that the NGO encountered in the issue of forced sterilizations, also highlighted that while *Movimiento Manuela Ramos* provides important public health services, it 'has neither the *authority* nor the *accountability* of a government agency' (Petchesky 2000, 38 [emphasis in original]). Despite the millions from USAID, *Reprosalud* was one of many local projects that could not surpass the existing fragmentation of projects (Guzmán Chaganaquí 2002, 197).<sup>7</sup> This lack of authority and accountability, added to the organization's loss of its activist role through its collaboration with an authoritarian government, made the *Reprosalud* programme, unfortunately, a lame duck institutionally.

The role of USAID in the population programme is not less problematic. Considering its history of involvement in Malthusian-motivated population pro-

grammes, USAID's role in the Peruvian programme is suspicious. Although USAID denied knowing about the quotas, it agreed with Fujimori's ambitious demographic goals in the first place and even emphasized in the grant agreement that services should deliver a 'minimum threshold of quality offered to the greatest number "at-risk" people' (cited in Hartmann 2002, 268). This makes one wonder if the Reprosalud project was not a politically correct blanket in which to smother aggressive demographic objectives in the first place. However, the Reprosalud project was apparently designed by new USAID departmental leadership keen on promoting women's rights, and was initially met with resistance within the higher echelons of the organization (Coe 2001, 8). The funding of both elements of the population programme – a highly participative, community and rights-based element and a highly top-down, aggressive demographic policy – illustrate the contradictions within the Cairo agreements and the continuous tensions between reproductive health and population control agendas. Of course, USAID did not admit to knowing about the quotas when the accusations of forced sterilizations became sufficiently substantiated in 1997, but it issued further research into the matter and withdrew its funding for that programme element.

### **Andean women and fertility control**

We have seen with which arguments and goals the Fujimori government wanted to introduce birth control among poor women. However, instead of empowering women and improving healthcare, the state forced poor urban and, especially, rural women to use contraceptives, or rather, to be sterilized. This policy could be read as indicating that there was a clash of interest between the wishes of the state and the wishes of women: as if women did not want to control their fertility and were therefore forced by the state. However, as I suggest below, the opposite was true.

Before the initiation of the population programme, as observed by the *Encuesta Demográfica y de Salud* 1991-1992, the majority of Peruvian women found that two children was the ideal number to bear. However, the national fertility rate was four children per woman and the rural areas showed an average number of slightly more than six children per woman despite the fact that most women did not want any more children (FLACSO 1993, 83; Aramburú 2002). Such numbers are supported by the amount of illegal abortions executed in Peru: according to the feminist organization *Flora Tristán* at least thirty per cent of all yearly pregnancies were aborted. Many abortions were carried out by non-professionals, others were self induced, leading to many complications and high maternal mortality rates (Flora Tristán and DEMUS 2000). Subsequent surveys among indigenous women show that they found the physical complications of having many children a burden on their bodies (FLACSO 1993, Aroyo 2002, Aramburú 2002). Thus, we can assume that a majority of women wanted to use birth control methods.<sup>8</sup>

Despite the wish of many rural women to reduce and control their fertility, few rural women used modern birth control methods. The majority used methods such as herbs, prolonged breastfeeding, withdrawal and the rhythm method (FLACSO 1993, 83). Despite the increase in healthcare facilities and the formal incorporation of family planning services in the local healthcare centres during the Fujimori period, women and men did not seem confident in using modern contraceptives. We can illustrate this by examining the autodiagnósticos, or auto-ethnographic reports, in which women discuss their reproductive health.

### *Movimiento Manuela Ramos and autodiagnósticos in Huancavelica*

Autodiagnósticos are a participative way of determining people's problems in developing areas. Through the autodiagnósticos, people identify their needs and demands by analysing problems in their local context. These particular autodiagnósticos I used were made by women in Huancavelica and facilitated by Movimiento Manuela Ramos between 1996 and 1999 as part of the national family planning programme.<sup>9</sup> Ironically, this information, which was formally meant to support the design of the governments' policies, can now help us to further examine why these policies went so wrong.

Despite the polemic surrounding the Movimiento Manuela Ramos project as implemented in the second half of the 1990s, the project contains a wealth of information on perceptions of reproductive health in Andean communities. The autodiagnósticos show the sometimes-contradictory experiences of 'traditional', or local, knowledge versus 'modern' biomedical knowledge concerning healthcare and reproduction. These contradictory experiences seem to contribute to the difficult relationship between men and women and between healthcare personnel and their patients. These difficult relationships, in turn, are grounded in socio-cultural misunderstandings that are entrenched in racism and sexism towards rural indigenous women. This broader context, I suggest, explains why it was possible for medical personnel to use coercion in family planning programmes.

#### *Huancavelica*

Huancavelica is a province and a department with a capital of the same name, situated in the cold and arid heights of the Andes at approximately 3500 metres. It is one of the poorest regions of Peru. People mainly live from raising cattle, producing wool, and from producing some agricultural products such as potatoes, corn and *quinua*, a cereal used as a food staple. The communities and the provincial capital are linked mainly by unpaved roads, public transportation or private cars are available only to a group of traders, authorities and NGO workers; the roads between the provincial capital and the other departments are poor and often inaccessible due to flooding. The history of Huancavelica is, in addition, a violent one: in the colonial period Huancavelica was the centre of mercury production at high cost for the local population in terms of labour exploitation (Contreras 1982). Bordering the department of Ayacucho, it was also one of the main areas of conflict between Shining Path and counterinsurgency forces from 1980 to 2000.

The workers (*promotoras*) employed to implement the Reprosalud project in Huancavelica were indigenous to the region and most had studied at the recently established local university. As community workers for Movimiento Manuela Ramos, they travelled far in the department to meet with local women's organizations in *talleres*, workshops, to empower the participants and to support them. The promotoras provided the participants with information on illness related to reproduction, on pregnancy and giving birth, on birth control, on rights and laws, on leadership, and on violence in the family. Before the courses started, the participants were supposed to make autodiagnósticos: under the guidance and direction of the promotoras, the participants formulated what they found problematic in their reproductive lives. When permitted to do so by the participants, the promotoras tape-recorded these autodiagnósticos, and if not, they took notes. Large parts of the

cassettes and notes were transcribed after which the autodiagnósticos were analysed and summarized by the promotoras of Movimiento Manuela Ramos. The promotoras also reflected critically on their own work, their way of interviewing and directing, and the questions they asked or failed to ask. The promotoras translated the reports into Spanish while key concepts were also given in Huancavelicans' first language, Quechua. Using these autodiagnósticos as the source of information, I provide a narrative in which Huancavelican women from communities to which I travelled in 2001 look at their experiences with reproductive health. These accounts are, of course, subjective, and have been transposed several times from one reader and language to another. Nevertheless, such an exercise provides us with a glimpse into (some) women's views on why they would or would not use modern birth control methods. While governments have acted as if poor women do not want to or cannot manage to reduce the number of children they give birth to, this analysis suggests that there are other problems that serve as impediments in the exercise of women's basic right to control their own body.

### *Fertility and notions of womanhood*

The autodiagnósticos of Huancavelica indicate that there is a central obstacle that women encounter in controlling their fertility, which is the socio-cultural value attached to having many children. Women's status is linked to their fertility, as well as to men's status. Older women may see bearing twelve children as God's imperative and the ideal number for every woman. However, the younger generation seems more sceptical about these divine duties (Movimiento Manuela Ramos 2003a). Most women indicated in their autodiagnósticos that having 'too many', that is, more than the desired number of two or three, was a burden on their household economy, on their time, on their marriages, and, especially, on their physical well-being. Nevertheless, it seems that not everyone in the communities accepted such notions.

This partial shift in socio-cultural notions about womanhood and fertility seems to have been an incentive for husbands to oppose women's use of modern contraceptives. Some husbands seemed to be concerned about losing control over their wives' sexuality, and associated modern contraceptives with infidelity. In the autodiagnósticos, women said that if they wanted to use modern contraceptives, husbands might accuse them of wanting to be with another man, or in Quechua, *cacha warmi*, being an unfaithful woman. Notions of gender roles impose a strong relation between motherhood, decency and the reproduction of the group. Women are seen as the 'guardians' of traditional life and the use of modern contraceptives threatens the traditional order.<sup>10</sup> If women transgress those boundaries of acceptable behaviour by wanting to use modern contraceptives, resistance can be expected. Male jealousy – and domestic violence in relation to jealousy – is a realistic consequence (Harvey 1994, 75; Boesten 2006). Yet, according to the autodiagnósticos, as formal surveys confirm, both women and men accept the use of traditional herbs or natural methods to prevent or postpone pregnancy (FLACSO 1993, Ferrando 2002). The accepted use of methods such as withdrawal or the female fertility cycle, suggest that participation of the male partner in controlling fertility is preferred over women's use of modern contraceptives.

In the autodiagnósticos, some women said that their husbands would be prepared to consider modern birth control if it was extensively explained to both of

them. Women's desire to understand and use birth control methods, while the husband was not involved in the process, made men apparently suspicious about their wives' sexual behaviour. New programmes in *pueblos jóvenes* in Lima where men are incorporated in family planning programmes confirm the positive effect of informing men and women alike. Men are willing to attend workshops on family planning so long as they are part of the process.<sup>11</sup>

### *Mixing myths*

The beliefs, contradictory knowledge, and misunderstandings concerning birth control that circulated among women who participated in the autodiagnósticos are indications of the lack of access to information that people had. For example, some women said that they knew about the menstruation cycle and tried to use it for birth control. However, they also indicated that this was unsuccessful. There are various reasons for this: first, some women indicated that conception is related to the union of blood. Thus, during menstruation '*la barriga está abierta*' (the belly/body is open) to fertilization. The openness of the female body causes pregnancy; the child will then live the first months on the maternal blood, which is why menstruation stops. Of course, this is in contradiction with bio-medical notions of conception and fertility. However, another reason that appeared in the autodiagnósticos, is that women cannot use the rhythm method '*porque no conocemos*', (because we do not know it). According to the social worker who participated in drawing up the autodiagnósticos, women might get confused by the sporadic information given by healthcare workers and what they know traditionally about their bodies. Another reason women in Huancavelica gave for not using the menstrual cycle-method is '*porque no nos viene nuestra sangre*' (because our blood does not come). The women said that they did not get the time to use the method, as they would be pregnant again before they had the chance to control their menstruation. Other women said that if they use the method, they would have intervals of one to two years between childbearing.

In the autodiagnósticos, modern methods such as pills, injections, or sterilizations were subject to a wide range of uncertainties and doubts. Women indicated that sterilization would change the woman's attitude, make her quarrel with her husband, and 'burn' (*quemar*) the body. Pills and injections would also burn the body. Obviously, this would make the woman sick; cancer, heavy bleedings, extreme loss of weight, and a bad temper appeared most often as symptoms. Among the results from intervening in fertility issues that they feared, were deformities in children or the birth of twins due to the use of birth control. The stories seem generated by a general fear of the unknown as incomplete information (although not necessarily wrong information, as many contraceptives have side effects and are not 100 per cent safe) was mixed with more traditional beliefs and projected onto the new. Healthcare personnel failed to inform their clients properly about the side effects of different contraceptives, appropriate individual usage, and the possible consequence of sterilization. This led to a clash between two belief systems. For example, according to the autodiagnósticos some people believed that if a woman 'stands' in a rainbow while menstruating, or looks at or carries a cat while pregnant, her child would be born deformed. Modern contraceptives become part of such traditional beliefs. Because women bear responsibility for reproduction, their

behaviour, including the use of modern contraceptives, becomes the sole reason for anything bad that happens to the newborn.

*'Maltrato' by the healthcare personnel*

Looking back, we might conclude that the lack of information and the consequential uncertainty about modern contraceptives was mainly due to the ill treatment by healthcare personnel. Local healthcare personnel did not inform the partners equally about birth control, but imposed methods on women without much explanation. For example, women in Huancavelica said that the *posta de salud* gave them contraceptive pills for the treatment of headaches. One woman said that at the healthcare centre personnel had inserted an IUD (intrauterine device) after she had given birth. She claimed that she only found out when she went to the hospital complaining of pain. Both claims suggest that the healthcare personnel believed that these women would not have wanted or been able to control their fertility if this had been discussed with them. Instead, the healthcare personnel took the easiest option: imposition. As we will see below, this example reflects a common practice, as registered by various NGOs, regarding the hierarchical and untrustworthy relationship between client and healthcare providers. The lack of constructive discussions about certain beliefs of both women and healthcare personnel encourages, on the one hand, suspicion on the part of targeted women and men, and disrespect and discrimination on the part of healthcare workers, on the other. This situation contributed to what became the scandal of forced sterilizations based on the government's quota system.

The Latin American and Caribbean Committee for the Defence of Women's Rights, CLADEM, was the first to publish an investigation of Fujimori's quota system. According to their report, researched by the feminist lawyer Giulia Tamayo, personnel used many tricks to win the consent of women for sterilization. Birth control campaigns promised attention by 'specialists from Lima' and free health treatments for the whole population. Food and clothing were also promised. Another tactic, not to convince women, but to round them up, was to organize food distributions and then 'capture' women. When they protested, threats of imprisonment, fines, and not treating any members of the family ever again were made. Pure physical force and confinement were the last resort that healthcare personnel used. The government even ordered healthcare centres in marginalized areas to 'make sure that women who come for delivery or abortion walk out with a sufficient method to prevent future pregnancies' (as cited in CLADEM and Tamayo 1999). In practice, this led to women walking out sterilized without even knowing it.

Whereas the national and international press claimed that between 1995 and 1999, 200,000 women were forcibly sterilized, this is difficult to prove. Although, according to the Ministry of Health, 277,793 women were sterilized in that period (Gianella 2004), it is likely that of these thousands 'only' a proportion was forced and another group would have been manipulated (including the possibility of bribery) into getting sterilized. A number of the women have, of course, wilfully agreed to be sterilized, even if the procedures were not thoroughly explained to them. However, even for those women who were happy with sterilization free of financial cost, the inadequate services represented a problem: at least seventeen women died and many were left permanently disabled as a result of badly executed sterilizations (Defensoría del Pueblo n.d.). The *postas de salud* in rural areas often

lacked the necessary equipment and knowledge to actually carry out the operations, the clinics did not meet hygienic standards, and women received no appropriate care. The difficulty of grasping the full effects of the National Family Planning Programme and the extent to which this was a well organized, fully planned campaign to sterilize a vast number of poor indigenous women is further hampered by the existing prevalence of violence and abuse against this section of the Peruvian population.<sup>12</sup>

Although we do not know the statistical details, we do know that thousands of women were coerced into being sterilized according to a quota system implemented by local healthcare personnel that complied with the government's demands. Why? First of all, just as the targeted women, healthcare personnel were tempted through a system of reward and punishment. The *posta de salud* or hospital that met the established quotas received computers and other useful equipment from the Ministry of Health. Individual professionals received bonuses when they met personal quotas of four to six sterilized women a month. Not participating could mean losing one's job (CLADEM and Tamayo 1999). Tamayo's report includes photocopies of letters from the Ministry of Health to local healthcare centres to support these claims. A doctor in La Mar, a province in Ayacucho bordering the province of Huancavelica, told me that: 'it was an authoritarian situation; we could not oppose it. We went out to find women who we could sterilize'.<sup>13</sup>

However, healthcare personnel acted in relative freedom and did not need to be convinced with violence or deceit. Therefore, complicity of personnel can partially be explained by the structural character of aggressive and even violent behaviour towards women in the healthcare system. Independent of the population programme, women in Huancavelica as well as in Lima said that doctors and nurses humiliated them constantly. In 2000, women in the district of Pamplona Alta in Lima drew up an impressive list of the humiliating treatment they received from healthcare personnel.<sup>14</sup> The first CLADEM report included other charges about humiliating remarks about women's sexual behaviour, their stupidity, their marginal position and their weak legal position. Urban poor and rural women claimed to feel discriminated, or rather *maltratadas* – abused – by healthcare personnel. The above-cited doctor in La Mar remembered that: 'these women are ignorant. We just bribed them; they consented to sterilization if we gave them money for their basic needs'.<sup>15</sup>

Racist attitudes of local healthcare providers were the cornerstone of the implementation of coercive family planning programmes. How else would a doctor, often born and raised in the region and educated at a provincial university, be able to force pills, IUDs and even sterilizations upon the local population? Only a profound disdain for this same population can explain it: the belief that indigenous women and men were not capable of understanding birth control methods. They seemed to believe that men did not want birth control and that women were too ignorant to understand how to use it. At the same time, healthcare personnel seemed easily convinced of the necessity for poor families to use contraception in order to stop further reproduction among certain social groups.

This brings us to a more problematic aspect than 'just' a cruel government that sets quotas. Stories of abuse based on gender, class and ethnic discrimination emerged not only in relation to healthcare personnel and family planning programmes, but likewise in relation to education, foodstuff distribution and state programmes to eradicate domestic violence (Oliart 1999, CLADEM 1998, Boesten

2003 and 2006). Authoritarianism and the abuse of power reproduce a long-existing hierarchy based on gender and race (Manrique 2002, Barrig 2001). In the case of birth control programmes, the personal interest that Fujimori had in combating poverty by preventing population growth engendered obedience among local medical authorities, which, in turn, was an incentive for authoritarian behaviour and abuse of power at a local level.

Inequality thus operates at several levels and serves distinct purposes that often intersect. For the doctor in La Mar, it was education that distinguished him from his patients. This doctor was himself from the southeastern highlands of Puno. He proudly introduced himself as being of Aymara-speaking indigenous descent. He also said to be happy to serve in a Quechua-speaking region as he claimed to love the culture in the area. However, after four years in the La Mar area, he did not yet speak the language. Although he lamented his inability to communicate with the population he did not seem to find this lack of communication a problem. This doctor claimed he was dedicated to the indigenous populations, but defined himself as an educated, state-appointed doctor among a poor and 'ignorant' population. In the end, as the educated doctor who possessed the 'truth' of biomedical science, he did not believe in the rationality of his patients and thought that indigenous women and men were not capable of understanding birth control methods. Powerful vis-à-vis the population but powerless vis-à-vis the higher authorities, this doctor and his personnel complied with the demands that the central government made on them.<sup>16</sup> His testimony shows the paternalistic and hierarchical application of medical practices in a culture where biomedical knowledge often contradicts local knowledge about the body and reproductive health.

Ethnicity and gender are palpable pillars of inequality, which have influenced the prejudice and miscommunication between healthcare providers and users. Healthcare workers tend to view Andean women as ignorant and promiscuous, which they see as justification for the stress on the need for birth control. Strikingly, among many couples in Andean communities, the idea of promiscuity is the exact opposite, in other words, a woman is viewed as promiscuous when she shows interest in using modern contraceptives, not if she conceives many of her husband's children. These contradictory attitudes once again show the need for mutual understanding and a constant questioning of assumptions about reproductive health among both users and healthcare workers. As Bonnie Shepard, programme officer for the Ford Foundation who was in charge of its sexual and reproductive health programme in the region during the years 1995-1999, concluded: 'In the traditionally vertical context of the bio-medical setting, both providers and users are prisoners of unspoken assumptions and corresponding roles in a paternalistic system' (Shepard 2002).

### **Concluding remarks**

There was a contradiction between the rhetoric that Fujimori used to justify his population policies, which focused on women's 'right to choose', and his actual goal: rapidly reduce fertility rates among poor people. Poor women were coerced into using birth control methods. If the goal was to empower women, then the opposite was achieved: women were treated as subordinate people. The emancipatory rhetoric was efficiently deployed as a smoke screen for what was actually going on. We can conclude that the government's policies had little to do with the em-

powerment of women despite its laws and rhetoric. Discourses of poverty and development steeped in an emancipatory rhetoric led to an increased emphasis of women as mothers of the poor. In practice this led to poverty reduction through the implementation of forced 'birth control' directed at poor – and mainly indigenous – women. Although an openly racist position towards the designated population 'problem' was never expressed, the areas, methods and goals of Fujimori's population programme leave little doubt about the hidden prejudices that sustained those policies. As such, parallels could be made between late twentieth-century population policies and early twentieth-century anxieties about the predominantly indigenous, 'backward', and poor character of the Peruvian population (Boesten and Drinot 2004).

Because women give birth, they are perceived as responsible for the number and the 'quality' of the children they have. Often men are overlooked in reproductive health matters, and are rarely held responsible for the conception of (too many) children. In general, governments and concerned international organizations aimed policies to control national birth rates at women, not at men. Although this responsibility is projected onto them, women are paradoxically not always perceived as capable of managing their own sexuality and are therefore often excluded from controlling their own fertility. As the analysis above confirms, the relationship between healthcare providers and low-income women is per definition unequal and abuses of power are at the core of such relations. Moreover, men sometimes attempt to control women's sexual behaviour in order to maintain a certain power inequity within marriage and the family. Male anxieties about women's use of modern contraceptives are reinforced by their exclusion from the family planning process. Such socio-cultural processes are in urgent need of scrutiny and need to be linked to those practices considered universal and modern in formal policies. A more inclusive policy would, of course, not only benefit the women and men involved, but improve gender relations in general, and likely lead to the desired decrease in the national fertility rate.<sup>17</sup>

This discussion about exclusion and abuse might suggest that the majority of Peruvian women have no control whatsoever over their own fertility. However, conversations I had with women in rural and urban areas about fertility control suggest that women do employ strategies of control we hardly ever see documented. Several women explicitly said they had used or would have used the sterilization campaigns to stop becoming pregnant. For some women, the campaigns close to their homes were a solution to the many pregnancies they did not want and which proved difficult to control with more traditional methods. This is supported by the persistent evidence of a desired fertility rate of two to three children per woman. Sterilization, as well as IUDs, also seemed a good method with which to avoid the opposition of husbands against using modern contraceptives such as pills, injections, or condoms. Women thought that they could keep sterilization or an IUD a secret.<sup>18</sup> We cannot know to which extent women have used the sterilization campaigns according to their own desires; we can only conclude that we need to examine the ambiguities of women's agency. It seems that there may have been a double layer in the accusations of practices of coercion in the sterilization campaigns. Although this does not undermine the fact that quotas were set and coercion was used, it does suggest an even more complex – and perhaps worrying – situation.

The unfortunate result of this episode in Peru's history has unleashed a back-

lash in sexual and reproductive health and rights, and regrettably, this has been supported by one of the most important international donors in population issues, USAID, for the U.S. has returned to a pro-life religious-conservative position in population matters. In Peru the existing pro-life religious-conservative community could not have been given a better opportunity to campaign against the further liberalization of women's sexual and reproductive rights than the abuse of the mid-1990s. We can only hope that in the future the conditions for these excesses will become history, and that governments will start taking reproductive health and rights both seriously and judiciously.

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## Notes

1. I thank Maruja Barrig, Betsy Hartmann, Paulo Drinot, and two anonymous reviewers for their suggestions and comments. The analysis presented here is, of course, my responsibility.
2. There is a vast literature on early twentieth-century deliberations with regard to what was called the 'Indian problem'. In order to avoid an inevitably incomplete list of references, I refer to the most comprehensive book that addresses these issues in relation to eugenic and Malthusian concerns (Stepan 1991). Boesten and Drinot (2004) elaborate further on the parallels between early twentieth-century discourses and late twentieth-century practices.
3. 'Necesidad de una política democrática de población', *¡Viva!* 1 (4) 1985, 22.
4. Aramburú stresses that the first sterilizations as part of the programme were carried out in 1993. If so, this was done illegally, as the law on voluntary sterilization had not yet been adopted (Aramburú 2002, 8).
5. The guides included the possibility of homosexuality as a sexual preference and voluntary sterilization as a birth control method. However, the government 'revised' the sex education guides during 1996 after strong opposition from not only the Church but also from conservative politicians.
6. In 1995, the Peruvian government received US\$ 12 million from USAID and in 1996, US\$ 16 million. According to Bonfiglio, the World Bank was also favourable to the family planning programme and financed educational campaigns as the population policy was helping to combat poverty (Bonfiglio 1999, 134).
7. A similar experience involved UNICEF, which had a project in Cusco and Cajamarca concerning reproductive health, strengthening the capacity of healthcare personnel and participation of the

- community and cultural adaptation of services. According to Alfredo Guzmán Chaganaquí (2002) the state did not make use of the important experience of this project.
8. Fujimori used such knowledge to underpin the legitimacy of his policies when faced with opposition.
  9. Several *autodiagnósticos* elaborated by Movimiento Manuela Ramos were analysed by Carmen Yon Leau (2000), and then, in 2003, separately by department (Movimiento Manuela Ramos 2003a, b, c, d). Various of my observations based on the *autodiagnósticos* of Huancavelica are obviously also to be found in Yon Leau's book and in the separate booklets. The four *autodiagnósticos* from Huancavelica that I use here are copies of the originals drawn up by the local office of Movimiento Manuela Ramos: *Autodiagnóstico Club de Madres 'María Parado de Bellido'*, Matipaccana, Yauli, Huancavelica, November 1996; *Club de Madres 'Virgen del Rosario'* Pallalla, Acoria, Huancavelica 1998; *Club de Madres 'Sor Ana de los Ángeles'*, Churcampa, Huancavelica, 27 April-1 May 1999; *Club de Madre 'Virgen de Fátima'*, Centro poblado menor de San Juan de Cearhuacc, zona Chopcca, Yauli, Huancavelica, 6-10 July 1999. Although villages, dates and personal experiences can differ, the experiences concerning reproductive health among women in rural Huancavelica are very similar. Therefore, I have decided not to refer to particular dates or villages when quoting or observing experiences of women that are repeated by women in the different *autodiagnósticos*.
  10. This is consistent with studies that examine women's perceived roles as the main bearers and reproducers of tradition. See for example *Allpanchis*, Vol. 25 (1985) where the role of women in the Andes is examined, and Radcliffe (1999), Stephenson (1999), Barrig (2001).
  11. According to the promotoras in the Casa de Bienestar, Movimiento Manuela Ramos, in Pamplona Alta, Lima, 2001. New programmes are set up that target men, for example by Calandria. Interview with Tommy Ravines, Calandria, July 2005, Lima.
  12. The Truth and Reconciliation Commission confirmed in 2003 that the chance to become a victim of violence in Peru is directly linked to one's social status, i.e., race, geographic location, and socioeconomic position. The conflict between Shining Path and the counterinsurgency forces produced 70,000 victims, of which eighty per cent were of indigenous decent.
  13. Interview held in La Mar, identity concealed, January 2003.
  14. Meetings at the Casa de Bienestar, Pamplona Alta, supervised by local representatives of Movimiento Manuela Ramos.
  15. Interview held in La Mar, identity concealed, January 2003.
  16. A possible parallel should be made to the teachers in Oliart's study: both Oliart's teachers and these doctors are authoritarian and often dominant in relation to the lesser educated, even though they seem to reproduce the humiliating circumstances and treatment they themselves received when they (or their parents) were in the position of their now students/patients (Oliart 1999). Patterns of abuse in the healthcare services, independent of the population programme, are documented in CLADEM 1998.
  17. Similar conclusions of the incompatibility of biomedical and local beliefs concerning the body and reproductive health were drawn in a study conducted in Jamaica by Elisa J. Sobó (1993). On the necessary inclusion of men in issues regarding fertility, see: Carla Makhoul Obermeyer (1999) and Peter Sternberg (2000).
  18. Group discussion with first generation Andean migrants in a settlement of Pamplona Alta, Lima.

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