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The Political Economy of Maternal Health in a Medically Pluralistic Environment: A Case Study in the Callejón de Huaylas

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The Political Economy of Maternal Health in a Medically Pluralistic Environment:

A Case Study in the Callejón de Huaylas, Perú

by

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A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts
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with a Concentration in Biocultural Medical Anthropology
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and

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Abstract

This thesis examines maternal decision-making regarding prenatal care and childbirth in the rural, north-central Andes in the province of Carhuaz. Semi-structured interviews (n=30) and participatory action research workshops (n=7) were conducted with local women to elucidate how they conceptualize, experience, and negotiate the shifting landscape of prenatal care and childbirth practices and providers. Semi-structured interviews with obstetricians, midwives, and social workers (n=9) were also conducted to compare perspectives and identify disconnects in knowledge and practices existing between these two groups in order to facilitate an open conversation on how to jointly improve the maternal experience and reduce maternal mortality and morbidity in rural Peru, where these risks are significantly higher than in urbanized, coastal areas.

In the face of changing practices and the influx of biomedical ideologies, women are faced with competing and conflicting bodies of knowledge as well as varying concrete and symbolic values and consequences of their decisions, which they must navigate and evaluate in a dynamic environment. Issues of ethnic and gender discrimination and financial and social coercion arose as prominent forces structuring risks and constraining maternal agency. However, women also found ways to both resist and accommodate these challenges, demonstrating the intricate and on-going negotiations that occur throughout gestation and the maternal experience. The results of this investigation illustrate the various and nuanced ways in which macro-level maternal health policies are manifesting on the local level and impacting the lived realities of rural, Andean women.
Chapter 1: Introduction

Introduction

Every day, 800 women worldwide die from pregnancy or childbirth-related complications (World Health Organization 2012). Among women who survive these complications, nearly 20 million suffer from long-term physical and mental disabilities, including fistulas, uterine rupture, marital disharmony, and social isolation (Filippi, et al. 2006). These maternal complications are primarily direct obstetric complications occurring immediately before, during, or after childbirth and include hemorrhage (24 percent of maternal deaths worldwide), sepsis (15 percent), abortion-related complications (13 percent), pregnancy-related hypertensive disorders (12 percent), obstructed or prolonged labor (8 percent), uterine rupture (8 percent), and ectopic pregnancy (8 percent) (Bailey, et al. 2006; Paxton, et al. 2005).

Although the complications leading to the majority of these deaths are not readily predictable, they are largely preventable and/or treatable with prompt and adequate medical attention. However, ninety-nine percent of maternal mortalities occur in the developing world, where more than half of births are absent of skilled attendants who can play a critical role in not only birth assistance, but rapid identification and assessment of obstetric complications for referrals to secondary health facilities where emergency obstetric care is available (United Nations Children's Fund 2008). Moreover, the quality, availability, and accessibility of basic and emergency obstetric care vary widely around the globe, and rural, low-income areas face the most barriers in developing and implementing obstetric care facilities and services (Amnesty International 2013a; Paxton, et al. 2006). As a result of these shortcomings in regards to skilled
birth attendants and emergency obstetric care, maternal mortality is the single largest cause of death among women of childbearing age in developing countries (United Nations Children's Fund 2008). However, it is not only the absence of birth attendants that contributes to this high rate of maternal mortality, but also political, social, and economic forces that are structuring risk and constraining maternal agency. Social exclusion, gender inequality, and poverty are all common challenges in the lives of these women and play crucial roles in their chances of surviving pregnancy and childbirth.

In South America, Peru’s maternal mortality rate remains the second highest in the region, at an estimated 185 to 240 maternal deaths per 100,000 live births, despite considerable economic growth in the previous decade and a number of national programs directly targeting maternal health (Amnesty International 2013b; United Nations Children's Fund 2008). A closer look at the distribution of maternal mortality within the country reveals a serious disconnect between urban and rural rates of maternal death. In the capital city of Lima, the maternal mortality rate is 52 per 100,000 live births, while in Puno, a rural, southeastern, highland province, that rate jumps to a staggering 361 (United Nations Population Fund Peru 2009). In fact, the Peruvian Ministry of Health (MINSA) estimates a two-fold increase in maternal risk in rural areas as compared to urbanized zones (Amnesty International 2013a). To understand this striking disparity, the sociocultural, economic, and political nuances of Peru must be elucidated in order to reveal the ideological processes motivating national health policy development and implementation.

I was exposed to many of these nuances while working with local health promoters, health workers, traditional healers, and elementary school children on a day-to-day basis in Carhuaz, a rural province located in the north-central highlands of the Peruvian Andes, in the
summer of 2008. During this first experience in rural Peru, I discovered the dynamic nature of health and medicine in a community caught up in the unavoidable process of globalization, motivating my eventual return in 2012 to conduct the research for this thesis. Every day, the people of the Callejón de Huaylas are faced with decisions concerning different, and often clashing, systems of medicine, which are further complicated by the intense presence of poverty. Local beliefs in traditional medicine still hold strong, despite the government’s growing implementation of biomedical health practices. However, the politics of health are rapidly changing as the country confronts intensifying economic and political changes. As global forces change local environments, systems of belief, webs of meaning, and the daily lives of individuals, understanding these women’s decision-making processes and struggles for survival and accommodation is vital to reducing maternal mortality and improving overall health outcomes.

Thus, this research investigated the role of political, economic, and social forces in structuring maternal risks and barriers to maternal care and safe delivery in the province of Carhuaz. The main objectives of this research were:

1. to determine how rural, indigenous women make health-seeking decisions,
2. to elucidate the perceived barriers to safe delivery,
3. to identify preferred maternal care and delivery practices, and
4. to apply the knowledge gained from this study to propose local, culturally acceptable and accessible maternal health and delivery program improvements.

To meet these objectives, I employed primarily qualitative research methods during my research affiliation with the Center for Social Well Being, a local non-profit organization dedicated to enhancing active, democratic participation through community mobilization and advocacy to
influence local, regional, and national policies and programs to improve the lives and opportunities of the local community (The Center for Social Well Being 2011). Semi-structured interviews (n=39), participatory action research (PAR) workshops (N=7; n=69), archival research, and participant observation comprised the main methods of data collection. The result of these qualitative methods is a wealth of rich, ethnographic data that illustrates the kaleidoscope of influential factors and actors at play in maternal decision-making, helping to elucidate the process of maternal decision-making and its impacts on the maternal experience in Carhuaz province.

Moreover, the results of this research expand the current literature on maternal decision-making and its implications for maternal health and mortality in the Peruvian Andes, which has had a particular focus on southern Andean populations. This research also helps to develop the literature available on medical pluralism in Peru, its practice and meanings. This is particularly important in Peru, as there was a significant lack of anthropological research during the 1980s and 90s as a result of political instability and violence, which led to travel restrictions and the departure of many non-governmental organizations, international aid workers, and academic researchers. Thus, this research contributes to filling these gaps as well as examining the impacts of the influx of development efforts that entered the country post-conflict.

Regarding applied benefits, preliminary findings were returned to participating communities in the form of informational pamphlets prior to my departure, and local organizations are continuing with the research begun here. The issues that proved to be most important to the communities were abuse, discrimination, and violence in the health centers as well as restricted autonomy with regards to decision-making. Both the Center for Social Well Being and Las Mujeres Lideres de Shilla, the organization that formed out of this research, are
moving forward with addressing several of these issues. In the spring of 2013, members of the Center as well as the women’s group held community meetings in preparation for a presentation of the pamphlet to the local health centers. This outcome is the first step in the conversation to improve the maternal experience.

Additionally, final research findings, which will be returned to the community as well as the Center, identify local perceptions of barriers to healthy pregnancy and delivery and local preferred birthing practices, which will be crucial in the development and implementation of locally relevant maternal health interventions in Carhuaz province.

**Chapter Summaries**

This thesis focuses on maternal decision-making in the Peruvian Andes, considering not only the physiological aspects of maternal health, but also the sociocultural influences as well as the political-economic environment in which decision-making takes place. Chapter Two synthesizes relevant literature regarding maternal mortality, the influences of poverty, ethnicity, and gender in rural Peru, and current, national maternal health programs and policies. Additionally, this chapter provides background information on Carhuaz province and the three communities in which this research took place.

Chapter Three provides the theoretical orientation and methodological foundation of this study. As this investigation was framed within a political economic perspective and grounded in a community-centered approach, the political economy of health and participatory action research methods are the main focus of this chapter. Additionally, reflecting the changing medical landscape in the north-central Peruvian Andes, this chapter also reviews understandings of medical pluralism as they relate to health-seeking decision-making, which can serve both practical as well as symbolic functions.
Chapter Four presents sample demographics and the results of data collection and analysis. The results of this investigation focus primarily on the data collected through the semi-structured interviews with local mothers (n=30), utilizing participatory action research workshop findings (N=7; n=69) as well as maternal care provider (n=6) and social worker (n=3) interview data as complementary. The results chapter centers on the process of maternal decision-making and influential factors, such as restrictions to individual autonomy, issues of access and availability, perceived health benefits, and sociocultural influences. Chapter Four also discusses the perceived and experienced barriers to safe delivery as well as preferred maternal care and delivery practices.

Finally, Chapter Five discusses the implications of the results of this investigation both within the local context as well as broader contributions to the literature on the political economy of health, maternal decision-making, and structural violence in a medically pluralistic environment like the Peruvian Andes. The discussion chapter ends with the presentation of recommendations concerning potential avenues for achieving community-relevant maternal care and childbirth practices in Carhuaz province as well as methodological recommendations for similar efforts in different locations.
Chapter 2: Background: Literature Review and Research Setting

This chapter presents relevant background literature regarding maternal mortality and maternal health policies and programs in Peru together with information regarding the nation’s healthcare system. This chapter also addresses context-specific issues of poverty, ethnicity, and gender, which play important roles in rural, indigenous women’s access to healthcare and other resources as well as impacting their decision-making processes and available options. This section concludes with information on the province in which this research took place, Carhuaz, as well as the three participating communities, Marcará, Shumay, and Shilla.

Literature Review

Maternal Mortality and Morbidity

The United Nations’ Millennium Development Goals officially established the need to improve maternal health and significantly decrease maternal deaths worldwide as a necessary means for achieving a safer, healthier, more equitable global community. Consequently, maternal mortality now commonly serves as a meaningful measurement of development as well as an indicator of economic and gender inequality and health inequity (Diaz-Granados, et al. 2011; World Health Organization 2011). Since prenatal care and the presence of a skilled birth attendant during delivery have been shown to reduce maternal deaths by identifying and addressing complications as they arise, maternal mortality rates also function as an indicator of the availability, accessibility, acceptability, and actual utilization of health resources and facilities. As a result, it is through these evaluations that health-related development
interventions have attempted to improve maternal health and survival (Campbell and Graham 2006; World Health Organization 2011; Yamin 2007).

Maternal mortality is defined as the death of a women during pregnancy or within 42 days of delivery or termination of pregnancy (World Health Organization 2011). In Peru, more than 850 women suffer daily from pregnancy-related morbidity, and two women die every day from pregnancy, childbirth, and postpartum complications (Ministerio de Salud 2013). In an effort to curb maternal mortality and morbidity, the national Ministry of Health (MINSA) called for a strategic alliance in the early 2000s to promote biomedical prenatal care and institutional delivery for all pregnant women though community involvement, improved healthcare quality, and comprehensive healthcare coverage (Ministerio de Salud 2013). Yet, despite these efforts, risks of maternal mortality and morbidity persist in high numbers, particularly among rural, indigenous populations, demanding a more nuanced examination of maternal health and the maternal experience (Amnesty International 2009; Ministerio de Salud 2013).

Relevant literature has identified three major delays that are contributing to the high rates of maternal mortality and morbidity in rural Peru. These include: 1) the delay in the decision to seek care, 2) the delay in arriving at care facilities, and 3) the delay in receiving appropriate care once at health facilities. These deadly delays are closely related to the lack of availability of care in regards to the distribution of health facilities and proper staffing, equipment, medicines, and other resources, the lack of accessibility as a result of both infrastructural and economic barriers, and the lack of acceptability, both culturally and ethically (Bristol 2009; Campbell and Graham 2006; Fraser 2002; Fraser 2008; Gabrysch, et al. 2009; Vega 2006; Yamin 2007; Yamin 2008). The complications responsible for nearly three-quarters of all maternal deaths in Peru are hemorrhage, accounting for 45.7 percent, and pre-eclampsia and eclampsia, which are
pregnancy-related hypertensive disorders that can lead to complications, including seizures and maternal cerebral hemorrhage during delivery, responsible for 26.5 percent of maternal deaths (Sanchez, et al. 2008; Yamin 2007). Among women who survive these complications, nearly 20 million suffer from long term physical and mental disabilities, including fistulas, uterine rupture, marital disharmony, and social isolation (Filippi, et al. 2006). Although not easily predictable, evidence indicates that these complications are detectable and treatable with the presence of skilled birth attendants, referral networks, and the availability and accessibility of emergency obstetric care (United Nations Children's Fund 2008; Yamin 2007).

A skilled birth attendant is defined by the World Health Organization (WHO) as an individual “trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns” (Harvey, et al. 2007). Peru maintains the greatest disparity in South America between rich and poor regarding access to skilled birth attendants, with less than 20 percent of the lowest economic quintile reporting births assisted by a skilled attendant, and the second lowest quintile reporting nearly 80 percent of births being attended (Yamin 2007). In fact, the Peruvian regions reporting the lowest rates of attended births (below 30 percent) are Amazonas, Cajamarca, Huancavelica, Moquegua, and Puno, which are all located in the highlands and jungles of Peru where indigenous populations are significantly higher than in coastal areas (Yamin 2007). Moreover, in the case of obstetric complications and emergencies, without the presence of a skilled attendant linked into a referral network, which is necessary for transfer from home or local level health facilities to regional-level, comprehensive care hospitals, access to lifesaving emergency obstetric care is limited.
Basic emergency obstetric care is defined by the WHO, United Nations Children’s Fund, and the United Nations Populations Fund as a package of six medical interventions required to treat the previously mentioned seven major direct obstetric complications responsible for the majority of maternal deaths. These interventions include: 1) the administration of parenteral antibiotics, 2) oxytocic drugs, and 3) anticonvulsants, 4) the skills for manual removal of all or part of a retained placenta, 5) removal of other retained birth products, and 6) the availability of vaginal birth assistance. Comprehensive emergency obstetric care includes the previous six interventions as well as blood transfusions and surgical capabilities for performing Cesarean sections (Paxton, et al. 2005; World Health Organization 2009).

Although there are no national data available regarding the distribution and accessibility of emergency obstetric care facilities in Peru, a proxy measure for these resources can be found in the distribution of general health facilities, which are disproportionately concentrated in more urban, coastal areas where rates of maternal mortality and morbidity are markedly lower than rural, Andean areas (Yamin 2007). To understand this gap in available healthcare services, it is necessary to examine the social and economic context of Peru and its impact on the politics of health.

*The Effects of Poverty, Ethnicity, and Gender on Access to Healthcare*

Despite Peru’s impressive economic growth in the earlier half of the previous decade, with rates that reached up to nine percent before the global economic downturn (CIA 2011; World Health Organization 2005), over half of the almost 30 million people living in Peru continue to live in poverty and just under a quarter live in extreme poverty (Fraser 2002; World Health Organization 2005). Examining the distribution of poverty within the country, there is an obvious disconnect in the urban-rural wealth distribution, with three-quarters of the rural
population living in poverty, and over half of them living in extreme poverty. In contrast, just under ten percent of the urban population does (Intitut Internacional de Governabilitat de Catalunya 2005).

Additionally, roughly 47 percent of Peru’s population is indigenous, defined by the primary use of an indigenous language (Trivelli 2006), 75 percent of whom live in rural areas (Minorities at Risk Project 2011; Yamin 2007). The most recent data analyzing poverty rates with regards to ethnic background found that in 2000, 62.8 percent of indigenous households in Peru were living in poverty compared to 43 percent of non-indigenous households. With respect to extreme poverty, 22.2 percent of indigenous households were living on less than a dollar a day as compared to 9.5 percent of non-indigenous population (Trivelli 2006).

Clearly, indigenous populations in Peru are not equally experiencing the benefits of economic growth and development in comparison to their Hispanic and urban counterparts. This inequality is rooted in a legacy of ethnic discrimination and sociocultural shifts away from indigenous identity towards more Western models of appearance and language, modernity, and progress. In Peru, dominant power has historically been associated with the rejection of indigenous identity, which the Peruvian elite associate with backwardness and resistance to modernization (Méndez G. 1996). Gonzalo Portocarrero states, “Peruvians tend to reject all that is indigenous and to believe we are all the more valuable the more white and Western we appear” (2007:223). Consequently, indigenous individuals, identified by their language use, appearance, dress, location of residence, and/or cultural practices have faced significant and persistent exclusion socially, politically, and economically. They are disproportionately represented in rural areas and experience a significantly higher incidence of poverty, which
highlights the political and economic challenges faced by indigenous, Andean highlanders, resulting in fewer personal and public resources to draw from for healthcare.

The distribution of biomedical health facilities across the country reflects obvious structural inequalities related to access and availability that establish *de facto* discrimination against ethnic minorities and the economically disenfranchised. There is a greater concentration of health-related resources in wealthier, urban areas, particularly along the coast, while rural areas with large indigenous populations have significantly fewer health facilities and personnel (Yamin 2007). In regards to health personnel, in 2009, the countrywide average density of healthcare workers per 1,000 inhabitants was 9.2 doctors, 3.3 nurses, and 9.5 obstetricians. However, 53.2 percent of doctors, 40.2 percent of nurses, and 41.47 percent of technicians and nursing assistants are concentrated in Lima, where approximately one-third of the population resides (Alcalde-Rabanal, et al. 2011).

Moreover, an examination of per capita government funding by region reveals a significantly higher concentration of public spending in urban and coastal areas such as Lima, Tacna, and Arequipa as compared to rural mountain and jungle regions like Ancash (where this research took place), Huancavelica, and Amazonas (Yamin 2007). In fact, according to the most recent national census of indigenous peoples living in Peru, nearly 60 percent of the indigenous communities surveyed did not have access to any sort of health facility whatsoever (Amnesty International 2013a). Additionally, in 2008, the Ombudsperson’s office found that the majority of health facilities with the capacity to handle obstetric emergencies 24 hours a day were located in urban areas, and most rural areas did not even have health facilities capable of providing emergency obstetric care, let alone operating 24 hours a day (Amnesty International 2009).
These struggles are further compounded in the lives of rural, indigenous women as the effects of gender inequality coalesce with economic disenfranchisement and ethnic discrimination, which disproportionately impact women as opposed to men, as men are afforded more opportunities to adopt aspects of Western identity such as formal education, Spanish fluency and literacy, formal market labor, Western style clothing, and urban exposure through migrant labor (Alcalde 2010; Hendrickson 1995). In regards to education, a fundamental component of individual empowerment and agency, girls living in extreme poverty in Peru attended school at a rate of 80 percent that of their male counterparts (Yamin 2007). In 2004, nearly 40 percent of women living in the Peruvian Andes had not completed primary school, and an additional 17.4 percent had no educational background whatsoever (Yamin 2007). While the functionality of formal education and the clear threats to continued non-Western lifestyle patterns and linguistic traditions are crucial related topics that merit discussion, within the greater political system and economic market, this lack of educational opportunities has serious consequences, including high rates of adult female illiteracy, women monolingual in Quechua, reduced economic opportunities, and overall greater political and economic exclusion.

In terms of female agency over health matters, forty percent of women in the rural Andes report that they do not have sole or even joint control over decision concerning their own health, as compared to 22 percent of their urban counterparts (INEI 2011b). From experiences in and around Carhuaz province, this appears, in large part, due to a lack of independence in female health decision-making as a result of the linguistic barriers present in traditionally Quechua-speaking communities, whose hospitals and other public health facilities are staffed almost exclusively with Spanish speakers. Thus, women must sacrifice personal autonomy and privacy and rely on the assistance of bilingual family members or friends, who are typically men, as they
have higher rates of formal education, during which they learn Spanish. Otherwise, they encounter significant barriers in accessing care or avoid it all together. In fact, 2011 census data in Peru show that 45.5 percent of women do not seek any medical attention when they encounter a health problem, illustrating the low utilization of health services (INEI 2011b).

Healthcare in Peru: Insurance Reform and the Healthcare Landscape

To tackle some of these challenges rural, indigenous women face, the nation has implemented national health insurance-related reforms to address the affordability of health care and financial independence. Peru’s public health insurance program underwent extensive reform in the earlier part of last decade with the implementation of Seguro Integral de Salud (SIS) in 2002, though gaps in coverage and service availability persist (Alcalde-Rabanal, et al. 2011; Yamin 2007).

Implemented under the presidency of Alejandro Toledo, Seguro Integral de Salud is composed of five major plans, A-E, which cover children ages zero to four and five to seventeen, pregnant women, childbirth, and postpartum care, emergency services for adults, and adults in extreme poverty as well as a varying list of special groups, whose inclusion has often been influenced by political interests, including victims of political violence, local health promoters, shoe-shine guild members, and taxi drivers (Alcalde-Rabanal, et al. 2011; Ewig 2010). Universal insurance coverage became a national political priority in 2006 with the formation of the Political Accord in Health (Acuerdo Político en Salud), which was formulated in conjunction with CARE, the United Nation’s Population Fund, and the National Democratic Institute in Peru. Subsequently, in 2007, SIS was expanded to offer a partially subsidized option through which low-income individuals could receive healthcare coverage at lower rates (Alcalde 2010).
The inclusion of childbirth coverage has increased the frequency of institutional delivery, with a rise from only 24 percent of births in rural areas occurring in health facilities in 2000 to 2012 data showing 58 percent of rural births occurring at a biomedical facility (INEI 2012). However, while Plan C of SIS continues to mandate the free provision of prenatal care, high risk delivery coverage, and postnatal care to women living in districts with rates of poverty at or above 65 percent and on a sliding-fee scale in less impoverished areas (Yamin 2007), patients are still asked to pay for medicines, lab tests, and medical supplies up front, posing continued financial barriers. This is due partly to a lack of reinforcement of the SIS mandates, but also because the public insurance program is seriously underfunded, with a total expenditure of only 5 percent of gross domestic product designated for the health system, only 54 percent of which goes to the public system (Francke 2013). In fact, it is estimated that in 2007, Peru spent around 200 USD per capita per year on social spending, including health expenditures, while the regional average was 666 USD per capita per year (Economic Commission for Latin America and the Caribbean 2010).

Moreover, in 2004 and 2005, the country’s public health system underwent decentralization, and the administration of health facilities as well as implementation of health policies shifted from the national level to regional governments in order to improve local responsiveness and increase efficiency (Ewig 2010). However, poor funding, continued disorganization, weak regulation, and a poorly defined relationship between the regional and national level have resulted in continued gaps in coverage and access, particular in rural areas (Francke 2013). In 2010, former President Alan Garcia implemented another expansion of SIS through a framework law establishing Universal Health Insurance (Aseguramiento Universal en Salud [AUS]) in an effort to fill remaining gaps in coverage. However, to date, little progress has
been recorded, and without sufficient, dedicated funding, these efforts risk the same shortcomings (Francke 2013).

Furthermore, while SIS provides health insurance coverage in an effort to address the financial barriers to health services, it does not address the challenges of availability of facilities and personnel or how healthcare services are delivered. Nearly half of Peru’s population is indigenous, and associated traditional, culturally rooted models of health and medicine continue to exist in both the home and informal health sector. The nation’s health initiatives have scarcely addressed this issue in their reform efforts, largely finding indigenous conceptualizations of health and medicine as barriers to modernization rather than avenues for integration and collaboration. However, within the domain of maternal health, a handful of local, vertical programs and projects have made efforts at understanding and incorporating culturally-relevant maternal care practices. Thus, the following section discusses both socioculturally-concerned maternal health policies and programs as well as the national initiatives and mandates that have overlooked these fundamental factors in pregnancy, birth, and wellness.

Current Maternal Health Policies and Programs

National efforts in the expansions of healthcare access and coverage have been accompanied by targeted, vertical programs aimed at improving maternal health outcomes, particularly in regards to morbidity and mortality measures. As mentioned earlier, the Millennium Development Goals had a major influence in prioritizing maternal health and gender health equality as global health concerns at the turn of the millennium as did the 1994 International Conference on Population and Development. These global initiatives stimulated national efforts in Peru to improve health outcomes, particularly among women and children. However, it should be noted that these efforts were largely motivated by Western ideologies of
health and wellness as well as neoliberal efforts that encouraged cost-effectiveness and decentralization and privatization of health facilities, which have resulted in persistent gaps in coverage and access (Ewig 2010).

Although not initially implemented in the region of Ancash, the PARSalud program (Proyecto de Apoyo a la Reforma del Sector Salud), which was established in 1999, aimed to support the modernization and reform of the national health system. Among its goals was the improvement of maternal and child health, which became a main focus of the program in 2002 with the specific promotion of institutional delivery (José Díaz and Jaramillo 2009; Yamin 2007). PARSalud initially aimed to address the primary causes of maternal mortality, which include pre- and postpartum hemorrhaging, hypertensive disorders, and obstetric emergencies requiring Cesarean through this push for institutionalized delivery. However, given the overwhelming nature of tackling all of these challenges, which would include a demand for increased trained personnel, particularly for Cesarean sections, as well as broad-level improvements in infrastructure and technology to address hypertensive-related complications and other obstetric emergencies, PARSalud ended up focusing specifically on the prevention of postpartum hemorrhaging through the standardization of the administration of oxytocin to control postpartum bleeding (José Díaz and Jaramillo 2009). By promoting institutional delivery, PARSalud intended to catch all women at risk of postpartum hemorrhage for treatment with oxytocin. However, data from 2002 to 2005 demonstrate that national rates of institutional delivery fluctuated from approximately 50 to 70 percent, with an overall decline to about 60 percent in 2005 demonstrating continued low utilization of biomedical services (MINSA 2005).

Moreover, this emphasis on institutional delivery and oxytocin administration through PARSalud had little impact on the availability and accessibility of emergency obstetric care
facilities. The available literature on emergency obstetric care in Peru primarily evaluates the availability, accessibility, and quality of these services in the southern Andes, particularly in the region of Ayacucho, a rural, largely indigenous area. From 2000 to 2005, CARE conducted the FEMME project (Foundations for Enhanced Management of Maternal Emergencies). Although national and international funding had improved the availability of maternal health facilities and resources in this region, community use was still low, leading CARE to conclude that this continued low utilization was linked with issues of poor quality care, cultural unacceptability, and inefficiency of services (Kayongo, et al. 2006; Taskier 2010).

Partnering with already established local and regional health facilities, CARE and the FEMME project sought to apply a human rights approach to improving the quality of available care as well as expanding coverage networks in Ayacucho. Accordingly, the project focused on staff training and increased valuation of their skills to develop provider commitment and pride, quality of care improvements, specifically in regards to patient-provider interactions and the use of traditional birth practices, the strengthening of referral systems to ensure continuity of care, and the engagement of the local community through community constituted committee oversight and mobilization (Kayongo, et al. 2006). Increased work motivation through improved training resulted in the creation of two 24 hour, on-call physician shifts that can now provide emergency obstetric care 24 hours a day, seven days a week. Additionally, the project helped identify traditional birth practices adaptable to the biomedical environment, such as the use of birthing chairs for vertical birth. As a result, the department of Ayacucho was able to increase the met-need for emergency obstetric care from 30 percent to 84 percent of pregnant women during the five-year course of the project (Taskier 2010).
The FEMME project also led to the development of evidence based guidelines for the management of emergency obstetric complications, which were later passed to the national government, eventually becoming the official, national emergency obstetric care protocol (Taskier 2010). However, no literature is available on the extension of these emergency obstetric care policies and improvement strategies to other parts of Peru, particularly in the north and central Andes where little research on maternal mortality and health has been conducted. Despite the evidenced success of these efforts and the official acknowledgement and validation of the emergency obstetric care protocol, the program has not been replicated in other rural, economically disenfranchised areas and its policies have not been nationally applied in spite of a very apparent need for them.

Another avenue for the improvement of maternal health outcomes in Peru has been the development of mamawasis, which are “waiting houses” launched by MINSA in an effort to bridge the gap in locally available maternal health services. Mamawasis are located near health centers and hospitals that are, ideally, equipped to handle obstetric emergencies, and women are invited to stay in the waiting houses as their anticipated delivery date approaches, allowing them to remain near a health facility that can provide birth assistance by a skilled attendant and emergency obstetric care, if needed (Fraser 2008). Moreover, the mamawasis allow for family to stay with the expectant mother, staff employees who speak local, indigenous languages, and also accommodate some culturally appropriate birth practices, such as vertical birth (Amnesty International 2009; United Nations Population Fund Peru 2009).

Although the mamawasis have been shown to be effective in increasing access to maternal care and improving rates of utilization, with rural rates of birth attendance increasing from 24 percent in 2000 to 48 percent in 2007 (Fraser 2008), Amnesty International (2009) has
noted that the distribution of these facilities throughout the country is uneven and inadequate. Further, Amnesty International’s 2009 examination of these facilities found that, despite policy recommendations, a large proportion of the mamawasis were built near health facilities that were not equipped to provide the required level of maternal care, especially in rural, low-resource areas. Addressing these shortcomings is crucial for the effective implementation of the waiting houses in order to bridge the current gap in accessible and available emergency obstetric care and skilled birth attendants, transportation barriers, and cultural appropriateness and acceptability of maternal care services.

State-funded social support programs aimed at the nation’s economically disenfranchised have also prioritized improving maternal and child health outcomes, including Juntos, the nation’s conditional cash transfer program, established in 2005 by former president Toledo. Juntos provides beneficiaries 100 soles per month (approximately 30 USD) to mothers in extreme poverty (an income of less than 30 USD per month), regardless of family size or marital status (JUNTOS 2013). The program’s mission is to reduce poverty and break the intergenerational cycle of persistent destitution through the provision of conditional cash transfers aimed at supporting increased rates of education and improved healthcare use and outcomes. In order to receive these funds, children under five are required to attend regular medical check-ups, children ages 6-17 have a required school attendance of at least 85 percent, and pregnant and breastfeeding mothers must attend pre and postnatal check-ups (Perova and Vakis 2009).

Similarly, Vaso de Leche, a state-funded nutrition program primarily targeted at children zero to six and pregnant and breastfeeding mothers, as well as government provided insurance, SIS, were reported by participants to require women to seek biomedical prenatal care and deliver
in a biomedical institution in order to receive benefits. Women reported that if they do not meet either of these requirements, they are threatened with removal from social assistance programs and state insurance for anywhere from several months to permanent exclusion. Although such requirements were not encountered in the literature or official program documents, they may be present on the local level, particularly in the environment of the country’s decentralized health system. Undoubtedly, the provision of these funds and other benefits can have a significant impact on the economic stability of recipient households, effectively doubling their monthly income in the case of Juntos. However, similar to other findings regarding maternal health-targeted development efforts (Smith-Oka 2009), the conditions tied to these funds endorse biomedical healthcare and formal education as though they are universal goods, without regard to the social, political, and cultural implications of these shifts.

Moreover, as Yamin (2007) notes, the fundamental issues of many of the prominent shortcomings, including the availability, accessibility, and acceptability of national health services have not been properly addressed in these health reforms. Further, the majority of these efforts have focused on communities located in the southern Andes, leaving a noticeable lacuna in data concerning northern highland women’s experiences with and perceptions of biomedical maternal care. In order to address maternal mortality and morbidity throughout the country, it is necessary to expand the scope of research and the available literature. Thus, this research, which was conducted in the north-central Andean province of Carhuaz, helps to address this dearth in the literature and expand on its applicability to various settings in Peru.

**Research Setting**

Peru is located on the western coast of South America, bordering Ecuador and Colombia to the north, Brazil and Bolivia to the east, and Chile to the south. The country is composed of
three major ecological zones: the deserts of the Pacific coast, the Andean highlands, and the Amazon region to the east. These major ecological zones create significant infrastructural challenges and represent markedly different concentrations of wealth, ethnic populations, and public facilities and provisions.

Carhuaz is a province in the Callejón de Huaylas, a valley located in the Central Andes between the Cordillera Blanca and Cordillera Negra in the Ancash region and is located at an elevation of 2,632 meters above sea level (See Figures 1 and 2). The three participating communities, Marcará, Shilla, and Shumay, are located within Carhuaz province, with Marcará and Shilla as district capitals, and Shumay as a neighborhood within the Marcará district (See Figure 3).

Figure 1: Map of Peru Segmented by Region with Ancash Highlighted
The district of Marcará is located at an elevation of 2,757 meters and is situated 27 kilometers away from the regional capital of Huaraz and 7.5 kilometers to Carhuaz, the provincial capital. Within Marcará district, the communities of Marcará and Shumay participated in this research. Marcará, the center of the district, is a community of about 1,285 people belonging to approximately 369 households (INEI 2007). Shumay, a more rural community of Marcará district, has a population of 576 individuals belonging to 193 households. Although there were notable differences in the built environment of these two communities, such as the use of housing materials (adobe versus bricks), the presence of dirt versus paved roads,
and local fresh markets, the narrowest available demographics are on the district level. Thus, for the purpose of background information on these two communities, as well as Shilla, data will be presented on the district level.

In the district of Marcará, the primary economic activity is agriculture (63.5 percent), including large and small-scale agriculture, gardening, hunting, and forestry, and 36.1 percent of the population lives in poverty (INEI 2007; INEI 2011a). Overall, among adults aged 15 and older, 32.2 percent are illiterate. Examined across genders, there is a marked difference between rates of illiteracy among men (15 percent) as compared to women (47.2 percent). Of the population over five years old, the overwhelming majority (77.2 percent) reported learning an indigenous language in childhood, likely Quechua, though this specific data was not collected, which serves as a marker for ethnic identity (INEI 2007).

Regarding access to healthcare, there is a health center located on the main road that runs through the Callejón de Huaylas, which traverses the community of Marcará. The health center is a 15-20 minute walk from the community of Shumay. Only about one-third (31.5 percent) of the population has official health insurance coverage, primarily provided through the state health insurance program, SIS (77.5 percent) (INEI 2007; INEI 2008). The remaining 68.5 percent of the population that is uninsured must pay out of pocket for healthcare expenditures, though at certain public hospitals, healthcare services are offered on a sliding scale.

The district of Shilla is located further north in the Callejón de Huaylas, 45 kilometers from Huaraz and 10 kilometers from Carhuaz. However, Shilla is at a notably higher elevation of 3,014 meters, increasing the difficulty of travel between it and Carhuaz and Huaraz as a result of rough mountain terrain. Moreover, until late 2012, the road to Shilla was not paved and was littered with rocks and other obstacles and vulnerable to landslides, particularly during the rainy
season, which lasts from about late November through April. As the community of Shilla is the center of the district, there is a health center located within walking distance. However, 75 percent of those living in Shilla are uninsured, and of the 25 percent who are insured, 87.6 percent are covered by SIS (INEI 2007; INEI 2008).

Similar to Marcará, the primary economic activity in the district of Shilla is agriculture (71.5 percent), and nearly half of the population (49.4 percent) lives in poverty (INEI 2007; INEI 2011a). Forty-two percent of adults 15 and older are illiterate, and illiteracy is nearly three times more common among women (60.9 percent) as opposed to men (20.5 percent). Moreover, nearly the entire population over five (97 percent) reported learning an indigenous language, again, likely Quechua, in childhood. This information demonstrates the predominance of indigenous ethnicity and associated cultural practices in the community.

In light of the previously discussed literature regarding the effects of poverty, ethnicity, and gender on access to and availability of healthcare in Peru, understanding the maternal experience within these three participating communities can help to further elucidate our understanding of maternal decision-making among economically and socially disenfranchised women. Thus, this thesis focuses on the political economy of maternal mortality in a medically pluralistic society with a specific focus on the roles of poverty and ethnic and gender discrimination in constructing barriers to accessing appropriate maternal care and constraining female agency. Accordingly, the following chapter discusses the theoretical framework and methodology of this research.
Chapter 3: Theoretical Orientation and Methodology

The following chapter details the theoretical orientation employed in this project, namely, the political economy of health in a medically pluralistic environment. This chapter also includes information regarding data collection and analysis methods as well as the participatory action research framework that facilitated community engagement with, and eventual ownership of, the research process and outcomes.

The Political Economy of Maternal Health in a Medically Pluralistic Environment

Many recent maternal health interventions in Peru, particularly those in rural areas of the country, have proven largely ineffective in improving the maternal experience despite their concerted efforts at addressing the major challenges of availability, accessibility, and acceptability (Yamin 2007). To understand these shortcomings, it is necessary to examine Peru’s high rates of maternal mortality from a political-economic perspective by looking at the macro-level forces shaping national health policies while also taking into consideration the mechanisms of structural violence that constrain maternal agency (Baer 1982; Baer 2003; Crandon 1986; Maternowska 2006). Examining maternal mortality from this perspective highlights the health consequences of social inequality (Singer 1995), which Carey emphasizes are “created by social relations at the local level which are shaped in turn by larger scale political-economic and sociocultural forces generated by the rest of Peru and beyond” (1990:272).

Although not formally a disease of poverty, maternal mortality is undoubtedly affected by socioeconomic inequalities, political disenfranchisement, and power differentials, and
structural violence is an undeniable factor in the death of mothers. As coined by Galtung (1969), structural violence refers to the systematic manner in which social structures, such as racism, sexism, and classism, are institutionalized within a society in such a way that it results in the legitimized suffering of some members. Looking again at the glaring disparity of maternal mortality rates between Lima and Puno, one can see an obvious disconnect between urban and rural health outcomes, which is linked with the availability, acceptability, and utilization of maternal care services, which prevent marginalized women from obtaining the prenatal and obstetric care they seek as health facilities are disproportionately concentrated in wealthy, more affluent sectors of society and reflect biomedical models of health (Yamin 2007). This lack of continuity is directly influenced by economic inequality, particularly within the framework of neoliberal economic policies in which health is a marketable commodity, and is further compounded by social exclusion as dictated by ethnic discrimination and gender inequality.

Unfortunately, as various case studies reveal, health policies aimed at reconciling structural inequalities often end up constructing complex, fragmented, and contradictory healthcare systems that are struggling with the unintended consequences of seemingly benign health policies and programs. While some individuals enjoy improved access to quality care, others are exposed to increasingly difficult health challenges, social delegitimization, and stigmatization (Abadia-Barrero 2004; Castro 2004; Fassin 2004; Smith-Oka 2009). For example, in Peru, during Alberto Fujimori’s presidency in the 1990s, the country underwent large-scale health care reform, which had a particular focus on maternal health, reproductive health, and women’s rights as informed by the 1994 International Conference on Population and Development. Although the availability of tubal ligations was presented along with other family planning methods as avenues for women to regain autonomy over their bodies and fertility,
particularly as women no longer needed spousal consent for the procedure (Alcalde 2010), these reform efforts were marred by the implementation of systematic sterilization campaigns aimed at meeting government-set quotas seeking to control birth rates. A number of these sterilizations were often coerced or conducted without full consent, and aimed predominately at poor, disenfranchised women, compounding the legacy of fragmentation and discrimination in Peruvian society (Amnesty International 2004; Coe 2004; Yamin 2007).

Undoubtedly, the social exclusions constructed and compounded as a result of new health policies are further exacerbating existing health disparities as well as reinforcing social and structural inequalities. This is in large part due to the fact that these health policies reflect global, and arguably Western, ideologies, rather than local realities. As mentioned earlier, neoliberal ideologies dictating health policy construction, such as the underlying assumptions of the purported efficiency of market-based medicine, informed consumer responsibility, and the medicalization of life events, including pregnancy and birth, are transforming health from a basic human right to a scarce commodity, affordable to a very small percentage of the global population (Armada and Muntaner 2004; Atkinson 2002; Parker 2000). Accordingly, health-seeking decisions are not based solely on health maintenance efforts, but also influenced by political and economic factors.

Yet, although the framework of political economy often focuses on the individual as a victim stripped of agency, this is not wholly the case. This is clearly illustrated within the context of pregnancy and childbirth, which are biological events contextualized in sociocultural environments that dictate related beliefs, practices, and procedures. Thus, in addition to these political and economic factors framing pregnancy and childbirth, and the decision-making surrounding these events, socially and culturally rooted factors also play important roles.
Accordingly, pregnancy and childbirth must be understood as biosocial experiences situated in a kaleidoscope of intersecting practical and symbolic domains (Jordan 1983).

Moreover, in a medically and ethnically plural society such as that of the Peruvian Andes, it is necessary to understand that the utilization of different medical traditions also carries a symbolic significance that is often idiomatic of differing social, political, and economic realities and ethnic identities (Baer 2003; Crandon-Malamud 1991). Early anthropological investigations into medical pluralism sought to determine what constituted and delineated co-existing, yet separate medical systems and how they functioned (Press 1969; Stoner 1986). During this period, Chrisman and Kleinman (1983) developed a model to demonstrate the overlapping sectors of health maintenance, which included the popular sector, made up of health care performed by family members, social networks, and the sick person, the folk sector, which included care provided by informal, and sometimes illegal, practitioners, and the professional sector, comprised of biomedical and professionalized alternative health systems, such as Traditional Chinese Medicine and Ayurvedic Medicine (Baer 2003; Chrisman and Kleinman 1983).

Eventually, as the framework of critical medical anthropology matured, anthropologists began to approach medical pluralism from a political economic perspective in order to examine how power inequalities operate within medically plural systems, recognizing the social and hierarchical patterns reflected in medically plural environments (Baer 2003; Crandon-Malamud 1991; Miles and Leatherman 2003). Thus, more than simply the co-existence of objective medical institutions, it was recognized that “medical pluralism flourishes in all class-divided societies and tends to mirror the wider sphere of class and social relationships” (Baer 2003:44),
allowing for concurrent use of separate medical systems for a variety of both practical and symbolic purposes.

Moreover, as Douglas discusses in *Natural Symbols* (1970), and Scheper-Hughes and Lock elaborate on in *The Mindful Body: A Prolegomenon to Future Work in Anthropology* (1987), the body is more than a biological organism; it is also a social artifact, symbolic of its interactions with nature, society, and culture. As such, health and sickness respectively serve as models of embodied social harmony and conflict, particularly in transitioning economies where the influx of the market economy often exacerbates socioeconomic stratification and inequality. Therefore, while the body exists on an individual, phenomenological level of personal experience and identity expression, it is also a social body, representational of social harmony and discord. Medical dialogue and diagnosis serve as metaphors for social relations, and treatment-seeking behavior is emblematic of social identity (Crandon-Malamud 1991; Miles and Leatherman 2003). Accordingly, health and illness are more than simply functions of biology, and medical decisions are motivated by more than neoliberal conceptions of rational, cost-effective analysis.

In the Peruvian Andes, the contemporary biomedical system exists concurrently with popular and folk sectors of medicine, and utilization of these different systems overlap (Baer 2003). This diversity is a reflection of the ethnic diversity in the area. As discussed earlier, the Andes are home to a large majority of the indigenous populations of Peru, most notably Quechua and Aymara speakers (INEI 2011a). This presence of alternative systems of medicine creates a medically plural environment generating the possibility of adopting various systems as a mechanism through which varying social identities can be negotiated and established (Crandon 1986; Miles and Leatherman 2003).
Moreover, in examining the growing presence, and in some cases dominance, of biomedicine, it is important to note that it is not simply its curative value that fuels its ascendancy, but also its links with the rapidly expanding capitalist economic system (Baer 2003). Accordingly, what is hegemonic is not biomedicine itself, but the capitalist system and the power structures facilitating its expansion, thus firmly grounding maternal health-seeking decision-making in a political-economic framework. So as macro-level economic shifts transform local livelihoods, such as the transition from subsistence agriculture to the market economy, marginalizing traditional ways of life, medicine and health-seeking decision-making become effective mechanisms through which individuals can express resistance, allegiance, and identity. “Thus choices between alternative medical resources and shifts in medical ideologies are made at least as much for social and political reasons as they are for advances in technological knowledge” (Crandon-Malamud 1991).

Therefore, in understanding the processes behind maternal health-seeking decision-making, it is necessary to consider the influence of practical as well as symbolic motivations on both the macro and micro level. Thus, a political-economic perspective couched in an ethnographic framework is an ideal approach to elucidating a holistic understanding of maternal decision-making during the biosocial processes of pregnancy and childbirth.

**Participatory Action Research Framework**

Moreover, in order to ensure that the data collected during this research would be useful in facilitating the development of relevant and appropriate maternal health interventions and that treatment of the issues uncovered during this fieldwork would transfer to the community after my departure, a portion of this research’s methodology was composed of participatory action research (PAR) methods. PAR is an inductive, collaborative approach to research that allows...
themes and patterns to emerge from the local community, rather than from external forces and forms of knowledge. Motivated by Paulo Freire’s *Pedagogy of the Oppressed* (1993) and informed by the compiled works found in *Community-Based Participatory Research for Health* (Minkler and Wallerstein 2003), I believe that the organic, democratic, and emancipatory nature of PAR is ideal for developing community-appropriate maternal health interventions in the rural, north-central highlands of Peru from a local perspective and generating ownership of future health projects. Rather than informants, participants are collaborators in a shared, democratic learning experience that seeks to elucidate the nuances of the local experience.

Although PAR is ideally conducted by local community members for the local community, the role of the anthropologist as co-learner and co-researcher can be potentially useful for a number of reasons, particularly in the face of multilevel actors and forces. Anthropologists’ function as facilitators of communication is crucial in affecting how global policies become local realities. Through case studies, maternal histories, and ethnography, anthropologists humanize what would otherwise remain bare, statistical analysis, serving as mediums for the voices of the marginalized and disenfranchised. Moreover, as partial outsiders, anthropologists bring an alternative perspective that critically examines the dynamic forces constructing individual as well as group agency, and analyze power structures, the institutionalization of gender and ethnic discrimination, the production of poverty and socioeconomic inequality, and the manner in which these deepening inequalities affect people’s health and health care options, bringing into question multiple levels of social structures. In conjunction with local perspectives and continual evaluation, PAR can potentially maintain multiples levels of focus and an acute awareness of how these levels interact with each other.
As will be discussed in further detail below, in one of the participating communities, this approach helped facilitate the organization of a spontaneous women’s group aimed at combatting domestic violence and discrimination and abuse in the local health post. Although I assisted the group in their formation and development, the participating women guided the process, and, in conjunction with the Center for Social Well Being and several other local authorities, they are continuing to work on a variety of issues uncovered during the initial research, thus demonstrating continued community interest in and ownership of the research and outcomes in accordance with PAR objectives.

**Methods**

**Data Collection**

This project required field research conducted over four months, and the timeline was divided into a series of three overlapping phases composed of multiple methods. Based on the research questions and theoretical frameworks, the following data were collected (See Table 1 for corresponding phases, methods, and target populations):

1. local women’s perspectives on and experiences with pregnancy and their birth narratives,
2. their perceptions of the different medical traditions available for maternal care,
3. their preferred delivery practices, and
4. their opinions on barriers to safe delivery;
5. biomedical and traditional medicine practitioner’s maternal care experiences and their opinions on barriers to safe delivery;
6. local conceptions of ethnic identity, gender, and class;
7. current rates of maternal mortality and their causes;
(8) the presence of local health facilities, appropriate equipment, and trained staff; and
(9) national maternal health interventions.

The primary methods for data collection were qualitative, including participant observation, daily recording of field notes, open-ended interviews, semi-structured interviews, PAR workshops, and archival research.

<table>
<thead>
<tr>
<th>Research Objective</th>
<th>Methods</th>
<th>Target Population</th>
<th>Data Collected</th>
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<tbody>
<tr>
<td>1) To determine how rural, indigenous women make health-seeking decisions</td>
<td>Participant observation, open-ended interviews, semi-structured interviews, and PAR workshops. [Phases 1-2]</td>
<td>- Women who have previously given birth (Interviews n=30) (Workshops n=69)</td>
<td>-Women’s perspectives on and experiences with pregnancy and delivery -Women’s perceptions of traditional and biomedical delivery methods</td>
</tr>
<tr>
<td>2) To elucidate the perceived barriers to safe delivery</td>
<td>Participant observation, open-ended interviews, semi-structured interviews, PAR workshops, and archival research regarding maternal mortality in the district. [Phases 1-2]</td>
<td>- Women who have previously given birth (Interviews n=30) (Workshops n=69)</td>
<td>-Women’s perspective on and experiences with pregnancy and delivery -Women’s opinions of barriers to safe delivery -Practitioners’ opinions on barriers to safe delivery -Practitioners’ experiences with delivery -Background information on regional maternal health policies</td>
</tr>
<tr>
<td>3) To identify preferred delivery practices</td>
<td>Participant observation, open-ended interviews, semi-structured interviews, and PAR workshops. [Phases 1-2]</td>
<td>-Women who have previously given birth (Interviews n=30) (Workshops n=69)</td>
<td>-Women’s preferred delivery practices</td>
</tr>
<tr>
<td>4) To apply the knowledge gained from this study to propose local, culturally acceptable and accessible maternal health and delivery program improvements</td>
<td>Preliminary data analysis in the field and meetings with the Center for Social Well Being and Las Mujeres Lideres de Shilla [Phase 3]</td>
<td>-Center for Social Well Being Director, Dr. Patricia Hammer -Las Mujeres Lideres de Shilla</td>
<td>-Distribution of deliverable to community stakeholders</td>
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Table 1: Research Plan
Phase One

Phase One of the research took place during the first month of fieldwork and consisted of building rapport with the local community and reestablishing and extending contacts at maternal care providing health facilities and with local traditional practitioners through my relationship with the Center for Social Well Being, a non-profit organization. Functioning as a research affiliate and representative of the Center at both professional site visits and casual meetings, such as local festivals, I engaged in informal, open-ended interviews that guided the adaptation of relevant and appropriate interview guides. During this initial phase, I also began recruiting participants for in-depth interviews through chain-referral sampling, and later cluster sampling during the PAR workshops, in order to identify female participants who had previously given birth (n=30). Inclusion criteria for women, both participating in interviews and workshops, required that all participants were 18 years of age or older, had at least one child (i.e. birth experience), lived in one of the three target communities, and were willing to participate. There were no language related inclusion criteria, though the majority of participating mothers were bilingual and reported Quechua as the first language they learned.

Chain-referral and cluster sampling proved useful in the local social context, which focuses on personal interactions and requires a certain amount of rapport prior to engagement. Thus, key informants, as identified by the Center and previous personal experience in the area, served as an entryway into the local community, providing me with both social credibility and an expansive network of potential participants. I was also able to recruit biomedical practitioner participants (n=4) and local, traditional maternal healthcare providers, such as traditional midwives and curanderos (n=2), for in-depth interviews, which provided a fuller understanding of traditional beliefs and practices surrounding pregnancy and childbirth. Inclusion criteria for
providers required that all participants be currently practicing or retired within the last two years, in order to minimize recall bias. For biomedical providers, participants must have been working in a biomedical health facility, and for traditional providers and midwives, they must have self-identified as such.

During Phase One, I also began conducting participant observation and recording daily field notes, which extended through all phases of research, to gain an understanding of daily life and local conceptions of ethnic identity, gender, and class. Participant observation activities included 1) conducting informal observation in high traffic, populated areas, such as the main square or local, open-air market, 2) attending and participating in community health worker meetings and trainings, and 3) individual visits with community members who invited me to cook with them, accompany them to clinic visits, and care for their animals and crops. In addition to providing insight into the daily lives of participants, engaging in participant observation proved to be an excellent method for building rapport and establishing myself as an eager and interested learner.

I also engaged in archival research at the regional office of the national statistics bureau in Huaraz, Instituto Nacional de Estadística e Informática (INEI), to ascertain current maternal health climate as well as local rates of poverty, statistics on indigenous identity in the area, and the distribution and availability of health facilities. To complement this data and gather the appropriate background information on national and international policies affecting local maternal health efforts and outcomes, I also conducted semi-structured, in-depth interviews with social workers employed by the ministry of health (n=3) who function as links between the community and biomedical system, placing them in a unique position that straddles both spheres.
To be included in this sample, participants had to be currently working as social workers in one of the three target communities (See Appendix III for Interview Guide).

**Phase Two**

After establishing contact with households and maternal care providers and recruiting interview participants, I began Phase Two of research, which extended from month two through the final month of fieldwork and was composed of site visits with participating women recruited in Phase One, during which I conducted in-depth, semi-structured interviews. Concurrently in this phase, I also interviewed the previously recruited health care practitioners, both biomedical and traditional. Interview questions for women were aimed at collecting basic obstetric history, data concerning their perceptions and use of health services, information about their preferred prenatal care and delivery practices, and birth narratives. I asked maternal and obstetric care providers, both biomedical and traditional, similar questions about their experiences in providing care and their opinions concerning the barriers they believe prevent women from seeking maternal care (See Appendices I and II for Interview Guide). By collecting data from both the practitioner and patient perspectives, during data analysis, I was able to compare the overlapping interview results and identify disconnects in knowledge and experience existing between these two groups that may be contributing to unsafe pregnancy and delivery as well as maternal mortality.

Detailed, hand-written notes were recorded during each interview and later typed up into an electronic document to be used for coding and analysis. Observations regarding emerging themes and patterns were recorded in a separate running document to facilitate data analysis later on. All of these interviews were also audio-recorded with the permission of the participants with the exception of one biomedical provider interview during which the participant asked that our
conversation not be recorded. The length of interviews varied from 30 minutes to over two hours, with the majority of interviews lasting about an hour. As the interviews were semi-structured, the length of each one depended partially on the extent to which participants elaborated on their answers, and for the interviews with mothers, the number of children and associated birth narratives played a significant role in the length of the interview.

Additionally, with the aid of a bilingual research assistant recommended by the Center, four of the interviews with mothers were conducted in Quechua at the request of the participant. The remaining 26 interviews with mothers and all health care provider and social worker interviews (n=9) were conducted in Spanish. All participants were compensated for their time with goods from the local market totaling a value of 5 USD. Mothers were given baskets of cheese, lentils, fruits, and hair clips, and care providers and social workers were given clipboards, notebooks, writing utensils, and fruit.

The research assistant/translator also attended the PAR workshops conducted during Phase Two (n=7) in order to assist in facilitation and provide language support. A total of seven individual workshops were conducted in three different communities in the province of Carhuaz. In total, 69 women participated in the workshops, with participation varying from six participants to 22. The workshop protocol was designed to be conducted in a two-part series, but as a result of linguistic barriers, one workshop series was extended into three parts to accommodate the extra time needed for Spanish-Quechua translation. All workshops were audio-recorded with the permission of participants, and the research assistant conducted transcription immediately following the completion of the workshops.

The PAR workshops were guided by a protocol modeled off of previous maternal and reproductive health PAR-based projects in Peru and modified according to topical and
community relevance (Calisaya 2004; Hammer 2012). The workshops were composed of open-ended, interactive group activities concerning perspectives, practices, and attitudes regarding prenatal care and childbirth in the area both currently and in the past. These workshops also elicited information on routes of recourse, local resources, and areas for improvements regarding the maternal experience (See Appendix IV for Workshop Protocol). Group activities were recorded on poster paper by each group and included both textual as well as pictorial information as rates of Spanish literacy among females varied widely and Quechua is not formally a written language. After each group activity, participants presented their information and elaborated on the details, which often spurred group discussion of the topics. Hand-written field notes were recorded during the workshops and later entered into an electronic document along with all of the poster data for coding during analysis.

Phase Three

Finally, during Phase Three, which was conducted in the fourth and final month of research, preliminary analysis was conducted on the PAR workshop data in order to provide the community with initial findings. Analysis was conducted on the workshop data through an iterative coding process of the transcriptions, poster data, and workshop field notes in order to identify the most salient themes, categories, and concerns. These codes functioned to guide the construction of the community deliverable, which featured relevant quotes and illustrations that were pinpointed for inclusion to present a first-hand, illustrative perspective on the issues addressed.

The deliverable developed, *Una Conversación Sobre la Gestación y el Parto*, is a pamphlet composed of participants’ experiences and knowledge regarding prenatal care and childbirth in the target communities (See Appendix V). The pamphlet included sections on the
following topics from the workshops: daily activities in which women engage, the experiences of pregnancy and childbirth, aspects of an ideal childbirth experience, the postpartum experience, women’s messages to local health care providers, and women’s advice for other mothers and family members. In an effort to promote dialogue, messages for mothers were also requested from healthcare workers and social workers to be included in the pamphlet. However, I only received a handful of pre-printed educational and outreach materials in response, which were scanned and incorporated into the final pages of the pamphlet.

Finally, as Phase Three came to an end, the pamphlets were presented to each community during final meetings to which all interested parties were invited. Unfortunately, representatives from the health centers were unavailable to attend, so I hand-delivered the pamphlets to the two participating health centers and reviewed the information with maternal healthcare providers and other interested parties. The pamphlet was also distributed to the Center for Social Well Being and the local Women’s Emergency Center as well as Las Mujeres Líderes de Shilla, who continue to present and distribute this information to interested community members, organizational contacts, and potential collaborators and funders. The ultimate goal of the deliverable was to stimulate conversation about prenatal and delivery care between the women of the three communities and the two health posts that are providing care in order to optimize outcomes for mothers, babies, and care providers. Since leaving the field, several such meetings have taken place and there are efforts currently underway to train a local social worker for the health center that does not currently have this position filled. Moreover, I have maintained contact with several key participants and plan to continue to do so in order to understand the long-term impact of the pamphlet, as well as the overall research, on maternal health and decision-making.
Data Analysis

Data analysis took part in two phases: 1) preliminary, in-field data analysis of the workshop posters, notes, and transcriptions was conducted in order to provide the participating communities with initial findings by way of an informational pamphlet; 2) in-depth analysis of all data, including interview notes, workshop posters, interview and workshop transcriptions, and all field notes, was conducted upon return from the field site. The main method of analysis was an iterative process of open coding of all qualitative data with Atlas.ti 7. All qualitative analysis was conducted in Spanish. Descriptive statistics were conducted on demographic, quantitative data in SPSS 21. All data were contextualized within a political economic framework throughout the process of analysis and writing.

Prior to data analysis, the research assistant, who is bilingual in Quechua and Spanish, transcribed all workshop audio-recordings in-field to Spanish, translating Quechua parts of the audio-recordings as necessary. Additionally, four of the semi-structured interviews conducted with mothers took place primarily in Quechua, and thus were fully transcribed and translated into Spanish by the research assistant as well. The remaining 35 interviews were target transcribed in Spanish according to the detailed notes recorded during each interview, which were coded in Atlas.ti 7 for salient themes and patterns. First, while in the field, the hand-written notes from each interview were entered into an electronic document as soon as possible after each interview. Concurrently, a running document of researcher observations was maintained containing notations regarding recurrent themes and patterns. After returning from the field, prior to beginning coding of the interviews in Atlas.ti 7, I reread all interview notes while also listening to their corresponding audio recordings. Again, all observations were recorded in the running
document to identify relevant themes and patterns as well as potential quotes for illustration and other notable interview occurrences.

Finally, the coding process was composed of a mix of inductive and deductive coding methods in order to frame the research in relevant literature while remaining open to the emergence of novel themes and perspectives (Bernard 2012). Thus, themes from the relevant literature discussed previously were used to frame the coding process and were complemented by newly arising factors. Through the process of coding, I was able to categorize various parts of each interview into particular themes and topics, which allowed me to return to these topics for further exploration as analysis progressed.

Upon completion of coding, the most prevalent and reoccurring factors were collapsed into code families that reflected the following domains: maternal decision-making motivations, barriers to safe delivery, and ideal/preferred delivery practices. Through Atlas.ti 7, codes were analyzed for counts, and interview data were organized by codes and corresponding domains for final review and selection for inclusion in the results chapter for illustrative purposes. Selected quotes were transcribed and translated into English by the author with the exception of the interviews conducted in Quechua, which were first transcribed and translated into Spanish by the research assistant prior to the author’s translation.

**Ethical Considerations**

As is evident, this research involved work with vulnerable populations, requiring extra care on my part, as a researcher, to respect the rights of the participants and be aware of their potential vulnerabilities. Although motherhood is not stigmatized, different maternal care and delivery practices represent potentially contentious decisions within the local community and the nation. Moreover, socioeconomic status, ethnic and cultural background, and gender all play
roles in shaping the vulnerability of some of the participants, requiring special protection and consideration (Whiteford and Trotter 2008). As such, informed consent was obtained from all participants in the study, and strict confidentiality was and will be maintained for each participant. Additionally, all interviews were conducted in locations of the participant’s choosing to ensure that participants felt safe and comfortable.

The codes of ethics from the following organizations were followed during the course of this project: American Anthropological Association, Society for Applied Anthropologists, and American Public Health Association’s Public Health Leadership Society. In order to ensure local acceptability, prior to commencing research, I presented the research proposal and plans to key stakeholders in the community, in accordance with the Center for Social Well Being’s research protocol. Additionally, prior to entering the field and beginning data collection, I submitted my thesis research proposal to the Institutional Review Board at the University of South Florida for approval (IRB#: Pro00007619) (See Appendix VI).

Limitations

The retrospective nature of eliciting information about women’s pregnancy and childbirth experiences presents the possibility of recall bias. However, studies have shown that women often retain vivid and accurate memories of their birth experiences and birth narratives are largely accurate despite the passage of time (Simkin 1992).

Another limitation to this study is that many participating women were not familiar with the biomedical system prior to pregnancy and childbirth, some of whom had never been to a clinic or hospital until motherhood. As such, during their interviews, they occasionally provided vague descriptions about their biomedical birth experiences, such as the providers caring for them and medical interventions employed, and were unable to clarify when probed. For
example, many women had difficulty discerning between an obstetrician, a general practitioner, and a surgeon. Many women could also identify that medications were given to them, but were not often sure what they were, such as the insertion of an intravenous line versus being given induction medications, such as oxytocin.

As will be illustrated in the results chapter, this was often the result of a lack of communication between the provider and woman as well as a certain amount of fear that prevented a woman from asking more questions about the procedures. However, during the PAR workshops, women engaged each other in conversation about these experiences, and as some women involved were local *promotoras* (community health workers), some of these confusions were clarified and provided me with avenues for improved probing. Nonetheless, some of these details are missing from birth narratives. However, rather than seeing them as missing data, these instances are reflective of women’s actual experiences, the information that was missing to them as they moved through these life events, and reflect some of the gaps in biomedical care and areas in need of improvement.

Additionally, this study is limited regarding the sample of women because few primarily Quechua speaking women were included. However, four interviews (13.3 percent) were conducted primarily in Quechua with the assistance of a bilingual research assistant, and the majority of the sample (n=25; 83.3 percent) did report Quechua fluency in addition to Spanish, which is demonstrative of the increasingly bilingual experience that rural, Andean populations are undergoing.

A final limitation to this study is the sample of biomedical providers, which was limited to only three local, public district-level providers and one private biomedical provider. The inclusion of provincial and regional hospital employees would have further developed the
complementary perspective of biomedical providers regarding women’s birth experiences as the majority of the sample (n=21; 70 percent) had given birth at least one time in one of these institutions. Unfortunately, recruitment was difficult due to limited availability of practitioners despite repeated efforts and flexible scheduling. However, again, this limitation seems to be illustrative of the local context and the general difficult access to practitioners and their limitations as a result of high workloads and demanding schedules.

A Note on Positionality

Apart from limitations, a mention of myself and my positionality within this research is necessary. In social research, the researcher is often the primary instrument of data collection (Haraway 1988; LeCompte and Schensul 2010). Thus, my position as a highly educated Chinese-American and status as a childless woman in her mid-twenties influenced how I was perceived by others in the field, my access to participants at different levels of influence (i.e. community participants, obstetricians, and ministry of health officials), and who would listen to the research findings.

In part, these aspects of my identity were beneficial in allowing me access to health workers and establishing community-partnerships with local governmental organizations. However, these measures of privilege are often also seen as barriers or obstacles in establishing rapport in the field, particularly when working with politically and economically disenfranchised populations, in which our positionality is undoubtedly a dynamic and shifting aspect of our identity. Although I initially felt concern for how my positionality might limit my ability to engage with women in Carhuaz by creating a perception of high status, I quickly found many of these aspects were, in fact, shortcomings in my new environment. I, and others, poked fun at my lack of knowledge and experience regarding pregnancy and childbirth, and it became a common
ground through which women established relationships and built trust with me. I had no knowledge of regional medicinal herbs, so when I felt ill, women cared for me while also teaching me. Rather than an educated foreigner, I often felt simply like a defunct woman trying to figure out her place in the rural Andes, and the women around me simply wanted to enculturate me. They were the experts, and I was here to learn from them.

Moreover, although social, economic, and cultural differences existed between me and the people I worked with, there are undoubtedly shared aspects of the human condition that connect us. Although joy, heartache, and struggle may manifest differently across our lives and arise from varying situations, providing comfort, support, and a listening ear to the women confiding in me helped in attempting to bridge these divides. Although I can never claim to fully understand the realities of the women who shared their lives with me, I can confidently say that as a researcher and a human being, I engaged with them honestly and genuinely, and their truths are conveyed here similarly.
Chapter 4: Findings and Results

This chapter presents data collected over four months of field research in Carhuaz province, primarily focusing on the data derived from semi-structured, in-depth interviews with local mothers (n=30). Data collected from interviews with maternal healthcare providers (n=6) and ministry of health employed social workers (n=3) and participatory action research (PAR) workshop data, derived from seven individual workshops and 69 total participants, are also presented to complement the findings regarding women’s decision-making processes during the prenatal period and childbirth. All counts and percentages are reflective of the interview population; workshop results are presented as complementary and thematic, qualitative data. Archival data are not included in this section since they provide an aggregated perspective on regional norms that do not illustrate the nuanced, lived realities of the women of Carhuaz. Rather, these data were included in the background chapter for national and regional contextualization.

Mirroring the research objectives stated earlier and the data analysis process discussed in the preceding section, this chapter is structured to focus on the following three domains of the maternal experience: 1) factors influencing maternal decision-making, 2) perceived and experienced barriers to safe delivery, including a sense of comfort and security, and 3) preferred care and delivery practices. As much overlap exists between these topics, the results are presented in an integrated manner in which the domains flow into one another and ultimately result in the presentation of potential avenues for achieving community-relevant maternal care and childbirth practices.
To begin, I will present the sample demographics of the 30 maternal participants, including information regarding birth experiences, as well as the demographics for the maternal care providers and social workers. This information, particularly in regards to women’s birth experiences, will help to contextualize the subsequent presentation of findings, which include issues of restricted autonomy, perceived benefits of biomedical and traditional care, and physical as well as sociocultural barriers, which will be discussed in regards to women’s decision-making processes. With these factors and topics in mind, the results chapter concludes with considerations of preferred delivery practices and ideal birth scenarios as reported by participants.

Sample Demographics

Mothers

The women interviewed in this sample (n=30) represent three different communities in two separate districts, each served by a district health center, in the province of Carhuaz. Ten women were drawn from each of the three communities. They ranged in age from 19 to 49 years old, with a mean age of 31. Regarding marital status, 46.7 percent of participants (n=14) were married and 46.7 percent were conviviente (living with their partner) (n=14). Of the remaining two women, one was widowed and the other single. The mean household size was five (including the participant), with a range of three to nine total household members among the sample population. Other household members included husbands, children, parents, and in-laws.

Age at first delivery ranged from 16 to 32 years of age, with a mean age of 22. Participating women had an average of two children, with a range of one to six children among the entire sample. Of the 30 women, two (6.7 percent) had reported no prenatal care whatsoever during either of their two pregnancies each. An additional five (16.7 percent) women reported
receiving some prenatal care during any of their pregnancies, and the remaining 23 women (76.7 percent) reported receiving prenatal care during all of their pregnancies.

The births ranged from 1981 to 2012, with the majority of births occurring the late 90s and throughout the 2000s. A total of 71 pregnancies were reported among participating women, with an average of 2 pregnancies per woman and a range of one to six lifetime pregnancies. Sixty-seven total deliveries were recorded, along with three miscarriages and one therapeutic abortion. Of these 67 deliveries, over three-quarters (n=51; 76.12 percent) occurred in biomedical settings, including the local health post (n=14; 20.89 percent), the provincial hospital (n=12; 17.91 percent), the regional hospital (n=15; 22.39 percent), and a local, private obstetrician who provides midwifery style care (n=4; 5.97 percent). The remaining five biomedical births (7.46 percent) occurred outside of the region, with three taking place in Lima, one in Chacas, and one in Cajamarca. Sixteen births (23.88 percent) occurred outside of biomedical institutions, including women’s own houses (n=13; 19.4 percent) and women’s mother’s houses (n=3; 4.5 percent) and were attended by midwives, mothers, and other female family members. Regarding women’s overall birth experiences, 21 women (70 percent) reported only having given birth in a biomedical setting, which includes the private obstetrician. The remaining nine women (30 percent) had mixed experiences with both homebirth and delivery in a biomedical setting.
Table 2: Delivery Demographics

<table>
<thead>
<tr>
<th>Location</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical</td>
<td>51</td>
<td>76.12</td>
</tr>
<tr>
<td>Local Health Center</td>
<td>14</td>
<td>20.89</td>
</tr>
<tr>
<td>Provincial Hospital (Carhuaz)</td>
<td>12</td>
<td>17.91</td>
</tr>
<tr>
<td>Regional Hospital (Huaraz)</td>
<td>15</td>
<td>22.39</td>
</tr>
<tr>
<td>Renata (Private OB)</td>
<td>4</td>
<td>5.91</td>
</tr>
<tr>
<td>Location Outside of the Region</td>
<td>5</td>
<td>7.46</td>
</tr>
<tr>
<td>Non-Biomedical</td>
<td>16</td>
<td>23.88</td>
</tr>
<tr>
<td>Home</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>Mother's Home</td>
<td>3</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Among the 30 women, ten (33.3 percent) had completed primary school, which is composed of six years of education, four (13.3 percent) had attended some high school, which is composed of five years of education, and seven (23.3 percent) had completed high school. An additional eight had completed further education ranging from one to five years for specializations in nursing (n=2; 6.6 percent), teaching (n=2; 6.6 percent), and cosmetology (n=1; 3.3 percent), among others. One participant (3.3 percent) reported no schooling whatsoever.

Women primarily reported their occupation as housewife (n=25; 83.3 percent), which includes household work, cooking, childcare, agricultural work, and animal care, among a variety of other chores and work. Other reported occupations included teacher (n=2; 6.6 percent), nurse (n=1; 3.3 percent), cosmetologist (n=1; 3.3 percent), and waitress (n=1; 3.3 percent), some of which were dually reported in conjunction with housewife. Additionally, two women (6.6 percent) also reported volunteering as community health promoters, promotoras, and one woman served as the president of the community chapter of Vaso de Leche, a national food program that provides low-income mothers and children with supplementary food provisions. The primary occupation of spouses was reported as agriculturally oriented (n=11; 36.6 percent). The second most common was tourism/ mountaineering guide (n=5; 16.6 percent).
percent). Other spousal occupations reported were various and included construction (n=2; 6.6 percent), teacher (n=2; 6.6 percent), driver (n=2; 6.6 percent), cook (n=1; 3.3 percent), and musician (n=1; 3.3 percent), among others. Two women reported that their spouses were unemployed (6.6 percent).

Table 3: Maternal Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women's Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>19 to 49</td>
<td>31</td>
</tr>
<tr>
<td><strong>Household Size</strong></td>
<td>3 to 9</td>
<td>5</td>
</tr>
<tr>
<td><strong>Age at 1st Delivery</strong></td>
<td>16 to 32</td>
<td>22</td>
</tr>
<tr>
<td><strong>Number of Children</strong></td>
<td>1 to 6</td>
<td>2</td>
</tr>
<tr>
<td><strong>n</strong></td>
<td>25</td>
<td>83.3</td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>14</td>
<td>46.7</td>
</tr>
<tr>
<td>Living with Spouse (conviviente)</td>
<td>14</td>
<td>46.7</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Primary Schooling (Six years)</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td>Some Secondary Schooling</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Secondary Schooling (Five years)</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Beyond Secondary School (One-Five years)</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>25</td>
<td>83.3</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
<td>6.6</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Cosmetologist</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Waitress</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Spousal Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture</td>
<td>11</td>
<td>36.6</td>
</tr>
<tr>
<td>Tourism/ Mountain Guide</td>
<td>5</td>
<td>16.6</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only Spanish</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Bilingual</td>
<td>26</td>
<td>86.7</td>
</tr>
</tbody>
</table>
Four women reported speaking only Spanish (13.3 percent) and of the remaining 26 women, all but one (n=25; 83.3 percent) reported being bilingual in Quechua and Spanish. The remaining woman had been raised on the coast and grew up speaking Spanish, but had been learning Quechua since moving to the region several years earlier. Four of the bilingual women requested that their interviews be conducted in Quechua, which was accomplished with the aid of a research assistant who facilitated translation. All four of the women who reported speaking only Spanish were from the more urbanized community, three of whom were married to guides. Two were born and raised in the province and the other two were raised in urban settings (Lima and Huaraz) and moved to the province upon marriage.

Maternal Health Care Providers

The providers interviewed in this sample (n=6) were composed of obstetricians (n=3; 50 percent), midwives (n=2; 33.3 percent), and a skilled nurse (n=1; 16.7 percent). One obstetrician, one midwife, and the skilled nurse were males, and the remaining obstetricians and midwife were female. Due to the small sample size of providers and the wide variation in their backgrounds, the remaining provider demographics will be presented separately and given pseudonyms for clarity.1

Mario, the skilled nurse, and Jorge, a licensed obstetrician, provide care at one of the district health centers. Mario is the only participating biomedical provider who is bilingual in Quechua and Spanish and was born and raised in the community he has provided care in for the last 13 years. Jorge, who works in the same community, has served as the local obstetrician for the past 12 years, but was raised in a coastal city of Peru and only speaks some Quechua. Mario

1 All names reported, including providers, social workers, mothers, and children are pseudonyms.
lives in the local community, while Jorge commutes daily from Carhuaz city, a 20 to 30-minute car ride by public transportation\textsuperscript{2}.

In the other district health center, one obstetrician, Ursala, participated in an interview. She had only worked in the district for six months, but had 16 total years of experience throughout the country, 11 of which had been served within the Ancash region. Like Jorge, she was also born on the coast and raised speaking Spanish. However, she did not report speaking any Quechua.

The remaining obstetrician, Renata, lives and works in the provincial capital, Carhuaz city. She has over 60 years of experience in the region and worked for the provincial hospital as an obstetrician for 24 years until retiring and starting her own private practice in the mid 1970s. Originally from the Loreto region of Peru, Renata had moved to Carhuaz after completing medical school in Lima. During our interview, she relayed to me her deep passion for and fascination with pregnancy and childbirth, which is reflected in the style of care she provides, which is intimate, personal, and time intensive. In addition to attending births in the hospital and her private clinic, Renata also travels to women’s homes to assist in their deliveries. She estimated that she had attended over 2000 births in her combined work at the hospital as well as her private practice, attending over three generations of women, from grandmothers to mothers to daughters throughout the province. Three participating women (10 percent) had given birth with Renata’s assistance. Although a biomedically trained obstetrician, Renata termed herself a “professional midwife” (partera profesional). However, for this investigation, she is included in the obstetrician sample due to her training and background.

\textsuperscript{2} It worth mentioning that during the course of this research, the road leading to Shilla from Carhuaz, which is 10 kilometers, was being paved for the first time and caused significant delays in transportation, as the road was only open for 30-minute periods every three hours between 6 am to 6 pm. This impacted both providers’ commutes to work at the health center as well transportation from Shilla to the provincial and regional hospitals.
Regarding the midwives who participated in this study, Alma lives within the province of Carhuaz, in one of the participating communities, and Fernando lives in Huaraz, the regional capital, though he has attended births throughout the region. Alma, who is bilingual in Quechua and Spanish, was born and raised in the area and estimated about 25 years of practice as a midwife, though her retirement was unofficial and a consequence of national mandates for the institutionalization of birth. Now, Alma serves her community as a local authority, functioning as a liaison between her community, Shumay, and district officials in Marcará. She is also the lead promotora in Shumay and works closely with the health clinic and social workers to organize community health education efforts and aid in the monitoring of pregnant women and children under-five years of age.

Fernando was also born and raised in the area and speaks fluent Quechua and Spanish. He reported over 40 years of experience as a midwife, though he also worked with the public, regional hospital and had undergone training for biomedical birth attendance, qualifying him as a skilled birth attendant, but not an obstetrician. Fernando’s maternal care is primarily composed of traditional practices and a reliance on local herbs and other natural remedies. Although he has the skills to administer injections, such as oxytocin, Fernando expressed a strong adherence to natural birth with minimal interventions. As such, he was categorized as a midwife for the purposes of this investigation.

Social Workers

Three ministry of health-employed social workers participated in this study. All three were from the health center located in the more urbanized community, though it should be noted that no social worker was employed in the other health center, and thus none were available for recruitment or participation. Social workers employed at health clinics guide community health
outreach activities and serve as a liaison between health care providers and the local population. They work closely with *promotoras* in the area on community education campaigns, such as those regarding nutrition, hygiene, and pregnancy, and also serve as a voice for community grievances regarding experiences at the clinic. In such cases, a social worker receives the complaint and discusses the challenges anonymously during staff meetings, working with the healthcare providers to identify more constructive pathways for approaching the issues presented. As with the providers, due to the small sample size of social workers and the wide variation in their backgrounds, the remaining demographic information is presented individually and given pseudonyms for clarity.

Andrea had worked in the health clinic as a licensed social worker for the longest period of time, 25 years, and retired shortly after the end of this research project, though she continues to provide support to community-based health projects in the area. Although born and raised in the south of Peru, Andrea spoke a fair amount of Quechua in addition to Spanish as a result of her extensive experience in the area. She moved to the region for her husband’s work, and lives in the regional capital, Huaraz, commuting approximate 45 minutes to and from work each day.

Milagros had worked in the region for over ten years, but had only been employed at the district health clinic for about four months at the time of our interview. She was also a licensed social worker, though her previous experience was primarily in the non-profit sector working on issues of nutrition and maternal and infant health. Milagros was also originally from the coast and had moved to the region for her husband’s work. She speaks Spanish, but did not report speaking any Quechua.

Approximately two months after our interview, Milagros left the district center. Sandra, a licensed obstetrician with some experience in social work, replaced Milagros in a support
position for Andrea. Andrea was essentially training Sandra to replace her after she retired. Sandra had begun working at the health clinic four months prior as an obstetrician, but for the last month leading up to our interview, had begun transitioning to her new position as social worker. She had four previous years of experience working as an obstetrician in a private clinic in Huaraz and two years of obstetric experience with a public clinic on the coast. Like the other social workers, she was born outside of the region, in the northern Andes, and moved to Huaraz for work. She spoke only Spanish. As part of her training, she accompanied Andrea on community visits and had begun building relationships with the local community. She also continued to work clinic hours occasionally attending prenatal check-ups.

**Where Does the Locus of Decision-Making Lie?**

The influential decision-making factors women reported during this research centered around four themes: 1) restricted maternal autonomy, 2) access to and availability of maternal care, 3) perceived health benefits, and 4) sociocultural influences, including long-standing birth customs and local social networks. Accordingly, the remainder of this chapter will present the experiences, ideas, beliefs, and overall decision-making processes and factors women shared as they relate to these four overarching themes.

As mentioned earlier, this chapter also focuses on the perceived and experienced barriers to accessing care, which are woven throughout the presentation of results in order to provide an integrated perspective on maternal decision-making. The barriers reported ranged from tangible obstacles, such as limited availability of care providers locally, to psychosocial barriers, such as concerns for personal modesty and fears of discrimination and abuse. With such a range of reported barriers, both based on personal experience as well as stories shared by sisters, mothers, friends, and other social connections, situating these obstacles within the themes of decision-
making helps to elucidate a more holistic, comprehensive understanding of the maternal experience and related decision-making processes in Carhuaz, Peru.

**Restricted Autonomy**

As discussed in the background and theoretical sections, rural, indigenous women in the Peruvian Andes are subject to significant discrimination and structural violence based on their gender, ethnicity, socioeconomic class, and educational background, placing them in a situation of limited autonomy despite significant familial and household responsibilities. Poignantly illustrating this situation is the finding that the most significant theme in maternal decision-making was women’s limited autonomy over their own health during pregnancy and childbirth, with 29 of the 30 participating women (96.6 percent) explicitly mentioning a family member, guardian, health care provider, or state level policy as influential in deciding where, when, and with whom to seek prenatal care and childbirth attendance. These constraints on personal autonomy can be categorized as proximal, occurring near or at the moment of decision-making, and/or distal, as with institutional policies, which women are constantly aware of, but whose later consequences and threats of sanction impact women’s decisions about prenatal care and childbirth. Primarily, these restrictions pressure women to seek biomedical care despite issues of cultural and ethical acceptability.

On the proximal level, 23 women (76.6 percent) reported that their decision-making was impacted by local level actors, including family members and legal guardians (n=11; 36.7 percent), and local health care providers (n=13; 43.4 percent). Women who reported that their decision was impacted by a local care provider were already at a local health center for care, either prenatal or complication-related, and were then made to stay or referred to either the provincial hospital in Carhuaz or to the regional hospital in Huaraz. The majority of these
women did not report resistance or dissatisfaction regarding the influence of their care provider in their decision to receive delivery care at a secondary health facility. For example, Kiara, a 23-year-old mother of one and chapter president of *Vaso de Leche*, explained that she felt the referral to the hospital was the safe decision for her, “The hospital is safer… I went to the local health clinic, but it [the pain] was already very serious so they transferred me to Huaraz because it was an emergency… for delivery complications… because I was in a lot of pain and not advancing.”

However, a few women expressed frustration and dissatisfaction with their provider’s decision. Luz, a 32-year-old mother of four, discussed her unexpected labor and forced health center birth with her first child, “I was throwing up and I thought, something bad has happened, so I went to the health post… I planned to just give birth at home, but in the health post, they wouldn’t let me leave. They said, it’s your time [indicating that she was in labor].” Although Luz was able to deliver her second child under the care of private obstetrician Renata, her third and fourth child were also delivered in the biomedical setting, contradicting her personal birth plan.

Remarks noted during participant observation with social workers also supported these findings, and in an informal conversation, Sandra, the training social worker, shared another story about a woman’s resistance to institutional birth and both provider and community of the district pressures around her childbirth decision-making. A woman who lived in a more remote community did not want to go to the hospital for a cesarean section. She had been told in a prenatal visit during her third trimester that her baby was breech, but she wanted to have a vaginal birth and said that when “her hour” arrived, she would give birth naturally. She resisted going and the health clinic had to issue a complaint to document their efforts to guard against
liability. The woman said she would come to the health clinic or they could come to her house, but she didn’t want to go to the hospital in Huaraz. She went to a midwife twice for sobados, prenatal massages, which are used to ease discomfort and also help shift the baby into position for birth. These encounters motivated the social worker to speak with the woman’s midwife in an effort to convince the woman. After also involving the woman’s family and neighbors, the pregnant woman relented and gave birth by cesarean in the hospital. Such a situation reveals the complex and complicated nature of maternal decision-making and the various actors that influence a woman’s choice, often swaying and obscuring her personal autonomy.

In fact, the impact of family on women’s decision-making is quite strong in many situations, and Milagros relayed to me that, “Women don’t make their own decisions. Who makes their decisions for them? If they live with their mother-in-law, their mother-in-law makes the decision. Or their husband.” Elena, a 21-year-old mother of one, shared the story of her childbirth, which had been planned as a home birth, though when labor carried on longer than expected, her father encouraged her to change her birth plan, against her in-laws wishes, and deliver at the local health center.

I was going to give birth here, just here in my house … as my husband’s grandfather is a midwife, he knows. He was sure my baby was breech, so he gave me a good massage [sobado] with pig fat, I believe. And with it, he massaged my belly and just like this, he told me I would give birth… however, my father was desperate. I was yelling and crying and my father felt sympathy for me. ‘I’m desperate,’ he said to me, ‘because now, it’s not easy to give birth at home… because you can die’… My in-laws did not want me to go, to go to the health post, but my father knew this, and he called the local nurse anyway and he took us to the post… I delivered there vaginally within 10 minutes.

As this vignette illustrates, women are not the only ones involved in decisions about their maternal experiences, nor are their voices the loudest. Elena was negotiating her father and in-law’s desires for her and their soon to be grandchild, but did not ever express her own desires for her delivery.
Although less immediate, the institutional level constraints on maternal autonomy appeared to be most influential in women’s decision-making about prenatal care and childbirth options. Ninety percent of participants (n=27) discussed this theme, which was embodied in the form of enacted punishments and a sense of obligation as a result of local health surveillance. Twenty-four women (80 percent) discussed enacted punishments, which included fines, removal (both temporary and permanent) from social support programs, and the withholding of birth documentation for the infant, which is required for enrollment in school and social support programs. Twenty-three women (76.6 percent) mentioned a looming sense of obligation, reinforced by local surveillance conducted by nurses and community health workers as influential to their decision-making.

Although only two women stated that they had had to pay a fine for homebirth and one woman struggled with the withholding of birth documentation, no one reported personal experience with removal from social support programs as a direct consequence though rumors were frequently reported. However, women reported that the threat of these penalties figured prominently into their decision-making processes, particularly in regards to the financial factors and their impacts. Moreover, during the course of this research, I observed that when families needed to purchase pharmaceutical treatments, they often did not have the immediate monetary resources to cover the costs. Instead, women often sold animals they were raising, such as guinea pigs, at the bi-weekly markets in order to acquire the necessary money to cover the costs of medicines. Thus, the financial resources of these women were limited, and monetary penalties were a difficult consequence to struggle with.

Discussing the way these mandates are enforced, Luz explained community surveillance of pregnant women. “Now they look for you if you don’t go [to your prenatal visits]. When
someone says whoever is pregnant, those from the health clinic look for you. The programs also check this, like *Vaso de Leche* and *PIN [Programa Integral de Nutrición]*. If you are receiving [benefits] from the program, you have to go to the health clinic.” Similarly, Julia, a 30-year-old mother of two, explained,

> If you don’t go, they say to you, you are not going to receive *Vaso de Leche*, the *Juntos* Program, and, uh, what’s it called, *PRONAA [Programa Nacional de Asistencia Alimentaria]*, which gives children under three and pregnant women food supplements… If you don’t go, they say that they are going to drop you from the programs, but if you yourself want to prevent problems with the prenatal check ups, you will go. It’s for yourself, so that you can prevent whatever issue… but now they put this condition on it, that they will drop you from *Vaso de Leche* or those others.

Julia’s explanation clearly demonstrates women’s restricted autonomy and the power of the threats of losing state-funded social support. She clearly states that women’s actions should be motivated by personal desires for health maintenance and complication prevention, not the conditioning of services.

Yet, many women expressed that they feel as though they do not have a choice in the matter. Carmen, a 31-year-old mother of one, whose interview was conducted in Quechua, illustrates the constrained decision-making by identifying several important factors.

> It’s obligatory. They require us [to go] so that they will give you, what is it called, papers, for you, they give them to you, I don’t know, they make a print of the baby’s hands and feet in the paper… when you don’t have this [a birth certificate] they don’t give you the items [social program benefits]. You have to. I don’t know. There is a fine also. One hundred soles, you know?

This fine played a considerable role in women’s decision-making about the location of their birth. Gabriela, a 30-year-old mother of three, had previously had two homebirths and preferred delivering with her mother and Alma, but explained that, “With Ernesto [her third child], yes, I gave birth in the health post, yeah, because they had told me that I had to pay, that I would have to pay the fine. They told me that I had to come.”
Indeed, the state-mandated obligations for institutionalized birth were changing local traditions. Cynthia, a 29-year-old mother of one, reflected,

Now, I think [birth] is more in the hospital, the health center. In the house, not anymore, very few… Before, all of it was at home. Births were common at home… Now, it’s changed because there is a health center, and there is a law that obligates also that mothers must go to the center… it changed in… the 2000s.

Adriana, a 46-year-old mother of two and local teacher and health promoter, said of her second birth experience,

No [it wasn’t for preference], it was required. It is required to give birth in the Health Center… if it hadn’t been required, I would have given birth at home, right? Because that’s the custom, you know? It has always been a custom here. It changed now because of the fine… they charge it at the health center.

Mirroring these changes, Adriana’s first birth experience occurred at home with the assistance of a midwife and her mother. Her subsequent birth, which she describes above, occurred two years later in the Carhuaz hospital, and she delivered there as a consequence of the requirement for institutional birth and the associated fine. Milagros elaborated on these punishments and explained that even state-provided comprehensive health insurance is rescinded if women opt out of the biomedical system, further limiting their bodily autonomy.

If a pregnant mother doesn’t come to her prenatal exams, through, for example, the Juntos program, they suspend the one hundred soles [an amount equivalent to approximately 36 USD] they receive… it’s like a punishment practically [laughs]… if the woman gives birth at home… all the pregnant women have comprehensive health insurance, when you have comprehensive health insurance, it covers all the costs for the birth. In the case that the mother doesn’t want to give birth here, then… uh, the obstetricians tell her that she will no longer have SIS [insurance]. She’s going to have to pay for everything.

Jorge echoed these sentiments regarding government mandates and oversight, going even further to explicitly identify government control over women’s bodies.

If you don’t go to all of your controls or if you deliver at home, they penalize you in Vaso de Leche, they don’t give you the benefits. There is also a program, Juntos, which is also involved with all those projects mandated by the state, Juntos, it is an integrated nutrition
program, it is aimed at reducing child malnutrition and has certain objectives. It practically says in their objectives that the women attend all their prenatal controls, that the women have an institutional birth so that the child is born just to be born…. not when they want, but at the time they are told.

These statements shared by a local social worker and obstetrician reflect women’s sentiments about government control, further supporting their reports of restricted decision-making autonomy.

Limited Accessibility and Availability

However, despite the national push for prenatal care and childbirth to occur in a biomedical setting, issues of limited access to and availability of these institutions were reported frequently. One avenue in which the Peruvian government has attempted to alleviate some of the barriers to accessing biomedical care, particularly for low-income, pregnant women, is through SIS, which, similar to the United States’ Medicaid program, aims to provide all pregnant women with health care coverage. Forty percent of women (n=12) reported that coverage under SIS influenced their decision to give birth in a biomedical institution. When I asked these women why they chose to give birth in a biomedical setting (i.e. the local health center, regional hospital, etc.), they responded quite simply that the care is free, demonstrating the important role of financial accessibility in women’s decision-making. Adriana explained, “When they know you are pregnant, the health center coordinates all of your prenatal visits. Now, because SIS pays for everything, we all go to the health center. All mothers are covered under SIS, so, we have to go to keep receiving coverage for ourselves and our children.”

However, although SIS provides financial support for healthcare costs to pregnant women in an effort to ensure accessibility, the data regarding the location of women’s birth demonstrate that the majority of women are not giving birth locally at the district health center. Thus, local access is still limited by other factors, such as the availability of staff and resources. Only 11
women (36.7 percent) had given birth at their local health clinic, with just 21 percent of the 67 deliveries (n=14) taking place within a woman’s home district. Thus, while some of the financial challenges are being addressed on the national level, local barriers to achieving a local, biomedical birth persist. In fact, 43.4 percent (n=13) of women reported problems with the local availability of a biomedical healthcare provider, particularly in regards to staffing and working hours, and also a lack of resources.

Maria, a 37-year-old mother of five, who had given birth at home (n=2), in the Carhuaz hospital (n=2), and with Renata (n=1), shared this about her local health center, “At night, nobody works… some women give birth here, but, uh, here, sometimes in the afternoon, there is no one. No one at night, no one on Saturday or Sunday. Because of this, the majority of women give birth in Carhuaz.” Regarding the health center in the other community, Julia explained,

Here in Marcará, it [the health center] is not equipped for birth. It doesn’t work. Now, they are improving it. Hopefully they will have a room, like, um, a room for giving birth, right? Because that time, when I arrived, there were also two other women who were in labor, one was only dilated to one centimeter and the other was in the beginning of birth, and I was at four centimeters. They just threw one outside [sent her home], and to me, they made me wait in the waiting room… it was really cold [the waiting room is open air], because it’s not well equipped.

Moreover, while maternal care is covered by SIS, women still reported having to pay for some services and supplies at the health center, emphasizing that despite this assistance, there were still gaps in adequate coverage. Daniela, a 32-year-old mother of one, explained that during her delivery, SIS covered, “half, no more, I paid with SIS, and they covered half… since I don’t have money, I am insured with SIS. They covered the other costs, the bed, the food, they cover those things…. I paid for the shots, the IVs, what else, uh, things for the baby too, they ask for gloves, yes, there are many costs!”
Further compounding the impact of financial barriers on women’s decision-making is the previously discussed fine that is associated with giving birth outside of the biomedical setting. Nineteen women (63.3 percent) specifically discussed the threat of a fine as a motivating factor in seeking biomedical care. Thus, participants made it clear that financial castigation further exacerbates their available maternal care and birth options. Gabriela explained, “Really, I went because I didn’t want to pay the fine… [laughs] It would’ve been at home if there weren’t a fine.”

Perceptions of Safety: Biomedical Care’s Health Benefits

Yet, despite the voiced resistance and hesitation to seeking biomedical care, the documented coercive impacts of SIS, and the intimidating nature of the threatened fines and social services punishments, women also voiced overwhelming perceptions of health benefits and increased safety in the biomedical setting. In fact, all mothers (n=30; 100 percent) expressed these positive sentiments about biomedical care, which fell into three main categories of motivators: 1) the availability of supplies, including technologies as well as “educated” (educado) and “trained” (capacitado) personnel (n=27; 90 percent), 2) gaining knowledge about the health status of the child and/or mother (n=25; 83.3 percent), and 3) biomedical care as the safe choice in the face of potential health risks (n=24; 80 percent). Primarily, these motivators centered on the idea that “something could happen,” and biomedical health services could help one be aware of, prepare for, and quickly respond to these risks if they were to arise.

Regarding supplies, technology, and personnel, 27 (90 percent) women reported that the availability of these resources was reassuring in light of potential complications because, as Pilar, a 28-year-old seamstress and mother of one, explained, “Giving birth, yes [it’s dangerous], because, for me, personally, various women have died. Because, first, um, they don’t seek care
at the hospital. And second is that, the second thing is that if they birth at home, sometimes, they
don’t know how to attend their birth.”

Eight women (26.7 percent) also reported that they believed that childbirth was less
painful, easier, and quicker in the biomedical setting because of the resources available. When
Lucia, a 40-year-old mother of two whose interview was conducted in Quechua, told me this, I
asked her if her health center birth was, in fact, easier than her previous homebirth and she
responded, “No, it also hurt in the health post. I suffered still, but I don’t know what thing that
the doctor cut inside with scissors, and then water came, and soon after, my baby was born.”

When I asked women about their biomedical birth experiences in local health centers and
hospitals, not one woman reported receiving pain medication. In contrast, discussion of
induction related medications was common during the workshops, and several women could
report the name of the drugs. Oxytocin was discussed most frequently, but there was evident
confusion about the purpose of injections and other medicines as many women confused them
with IV fluids or pain medication.

Knowledge about their child’s health and their own health were also perceived benefits to
biomedical care that increased women’s perceptions of safe pregnancy and childbirth. Women’s
primary concern appeared to be their child’s health, with 80 percent of women (n=24) reporting
knowing about their child’s health as a benefit of biomedical prenatal exams and birth in a
biomedical setting. Women reported wanting to know if their baby was growing and developing
properly, its positioning, and also the gender. Paula, a 34-year-old mother of four, who had
delivered at home, in the local health post, and two hospitals (Carhuaz and Cajamarca),
explained that she went to the health center,

So that my baby would be born healthy, then, so that it would be more careful, yeah, so
that they could tell me, my baby is fine, or if it were sick, if it were going to have any
kind of malformation when it was born. All of this, they see it. More now that they have the sonogram, yeah. They tell you also if it’s a boy, if it’s a girl.

During the workshops, women also frequently mentioned that during the later prenatal exams, the doctor is able to tell a woman what kind of birth she can expect, either vaginal, which women termed “natural,” or cesarean. Cesareans appeared to be a concern among the participating women, who often mentioned fears of the procedure during interviews and workshops, and the experience was even more jarring for those who were not prepared for a cesarean. One workshop participant in Marcará explained, “I felt really nervous in the hospital because it was my first child. Yeah, I felt the pain, and they had said to me, you are going to have a normal [vaginal] birth, but they had not prepared me for a Cesarean.”

Forty-six percent of women (n=14) also reported knowing about their own health status as a benefit of prenatal exams and birth in a biomedical setting, particularly in regards to proper nutrition and risks for anemia and hypertensive disorders. Julia explained, “[I went] because I wanted to know if my baby was okay, if it was growing, not growing, and how I was, if I was gaining weight, or more importantly, if I were losing weight so that I could nourish myself adequately, right? During pregnancy, and for this, I had to go to the health center. They do analyses.”

Ultimately, the availability of resources and trained personnel in biomedical settings led women to conclude that biomedical care conveyed health benefits and increased safety in the face of potential pregnancy and childbirth complications (n=24; 80 percent). Twenty-three women (76.7 percent) reported possible health risks as a motivating factor, and seventeen women (56.6 percent) reported experiencing pregnancy and/or childbirth complications that influenced their decision to seek biomedical care. Sara, a 28-year-old teacher, storeowner, and mother of one, discussed her personal experience with a breech birth, saying,
I wanted to give birth at home… but in my house, you can’t have a cesarean. Sometimes, we can, I could die, or my daughter could, and to avoid these things, and since now we are covered with the insurance, they sent me to Huaraz because of the complications [child was breech] they sent me to Huaraz… and they did a cesarean.

Similarly Lisette, a 21-year-old mother of one, experienced prenatal hemorrhaging, and she went to the hospital because she felt it was an emergency. She went straight to Huaraz because she believes it is better equipped than the local health center, and there they stopped the bleeding, and saved her life, though she lost her baby. Yet she emphasized that had she not gone to the hospital, she surely would have died as well.

*Impact of Sociocultural Factors: Culture, Comfort, and Fear*

The women in this study generally reported positive sentiments regarding biomedical care, but also shared that a lack of cultural and social respect in the delivery of these services functioned as disincentives to using these resources. However, while participants reported that they often did not feel comfortable using biomedical care as a result of this lack of cultural and social acceptability, they continued to utilize biomedical resources because they couldn’t afford alternate care and fear the financial consequences and related social repercussions of community surveillance.

Twenty-nine of the 30 mothers interviewed (96.7 percent) discussed sociocultural factors as important to their maternal experience, often linking these factors with traditional models of pregnancy and birth and midwifery style care. Frequently, women reported that the lack of considerations for these factors, such as modesty regarding the female body and the engagement of family in the birth process, functioned as impediments to seeking biomedical care. Although women stated that the threat of financial or social sanction often dominated these factors in their decision-making, the impact of these aspects is crucial to ensuring a safe, comfortable, and positive maternal experience. Moreover, as women and midwives shared, these factors are
interwoven with social ties within communities, highlighting the biosocial nature of pregnancy and childbirth and the function of these life events as perpetuating and reinforcing community relationships and social and familial ties, in addition to serving as an avenue for the preservation of cultural practices.

The sociocultural factors found to be influential in maternal decision-making in this study can be categorized into two groups, those related to customs and cultural norms and those related to social networks and community reputations. Both categories play important roles in women’s decision-making as well as in negotiating cultural identity and community ties.

Twenty-two women (73.3 percent) discussed social networks and the community reputation of maternal health care providers as motivators for where and with whom they gave birth. Interestingly, twelve of these women (54.5 percent of the 22 women) referenced biomedical care providers’ experiences and reputations as important factors in their decision-making, while the remaining women mentioned local midwives (n=10; 45.5 percent). Women’s mention of biomedical providers reflects the previously discussed notion of the increased safety and health benefits conveyed through biomedical care, with women describing biomedical providers as “educated” and “trained” specialists. When I asked Daniela about where she preferred to give birth, she responded, “Oh, in the hospital, because they help you. They are more specialized, you know? They are well trained, so I prefer birth in the hospital.”

Thus, although categorized as sociocultural and within social networks and community reputations, the perceptions of biomedical care providers were primarily abstract descriptions. The names of providers were not mentioned often in the interviews, with the exception of Renata (n=2; 9 percent), and their integration into the social network was nearly non-existent for most providers, especially as very few actually lived in the community they worked in.
During the PAR workshops, there were more specific mentions of biomedical providers’ reputations and individual women’s experiences with them. These were typically descriptions of negative experiences, with some women pinpointing specific local providers to avoid for reasons of rude treatment as well as privacy. In one community, women reported that, when drinking alcohol, a particular local provider would “brag” about having “touched” women during prenatal exams and deliveries, which invades these women’s rights to their privacy. Such a situation highlights women’s fears of not only biomedical interventions, but the providers of such care as well as potential breeches of their personal privacy.

In contrast, the ten women who discussed midwife reputations and the two women who mentioned recommendations of Renata cited concrete social ties, often discussing the experiences of their mothers, aunts, sisters, and friends as how they came to choose the care of their birth attendant, or in the case of one woman, prenatal care, though she ultimately gave birth in the local health post. In fact, three of these women gave birth attended by family members who were well-known midwives in the area (grandmother, n=2 and mother-in-law, n=1). Two women gave birth with the attendance of their mothers and sought midwife care by a provider recommended by their mothers primarily for infant care. The remaining five women sought midwife care based on word of mouth from family and friends regarding community reputation, which often focused on skills and knowledge such as those about herbal remedies for birth facilitation. This quote from Lucia illustrates this point well,

She massaged my belly, and also, she arranged everything down there… She had flaxseed remedies, and later, um, flaxseed, and what else did she give me, what is it called, congona, it’s… a local herb… and later, ground eggshells… they all help with childbirth… each on its own… [I chose her] because she knew, yeah, and she knew how to prepare the remedies… and she was always around town, really well known.
Adriana simply stated that her midwife was *la persona indicada*, “She was the indicated person. She had attended many births, and it was the custom then.”

Further extending these social connections and community networks is the practice of *comadres*, in which the midwife becomes the *madrina* of the infant she helps to deliver, forming a lifelong bond with both the mother and child. Moreover, once a midwife had attended a woman’s birth, unless she later delivered in a biomedical setting, the same midwife attended all subsequent homebirths, demonstrating the built trust and established relationship produced by the shared birth experience. Adriana explained, “No, no, we don’t pay for these services. It’s something of respect, and now, she is my *comadre*. And my son is her godson.” Maria explained of her grandmother, “Before, everyone gave birth in their homes with midwives, miss. Because of this, my grandmother has many godchildren too.”

Although the majority of the sample population had no birth experience outside of the biomedical setting (n=21; 70 percent) and the majority of deliveries (n=51; 76.12 percent) took place in biomedical settings, 29 women (96.7 percent) reported preferences for the practice of cultural traditions and customs in their birth experience and voiced criticisms regarding the lack of respect for and consideration of these practices in biomedical birth environments. The traditions and customs mentioned revolved around the style of personal care and attention midwives provide, the nature of communication and dialog between mother and caregiver, the increased time investment, allowing for the involvement of family members in the birth process, the use of natural and herbal treatments, and observance of cultural norms and restrictions, such as female modesty, postpartum food taboos, and concerns for risks of *sobreparto*, a postpartum, culture-bound syndrome.

Manuela, a 48-year-old mother of six, who had had five homebirths and one hospital
birth, compared her home and biomedical birth experiences by highlighting the use of traditional medicines and physical social support, “At home, you take herbs for the pain and in the hospital, they don’t give you anything and no one held my waist and so it hurt worse.” She went on to explain of her homebirths, “My husband grabbed my waist [while I was in labor] because I felt like my waist was going to break.” This emotional and physical support through her husband’s presence and midwife’s practice of cultural tradition increased Manuela’s comfort and ease during her homebirths. When comparing it to her later hospital birth, which occurred 14 years after her fifth home delivery, she described the hospital experience as “frightening,” explaining that she was afraid of the medical interventions, primarily the risk of surgery since she was 41 at the time of this birth. She also shared that she was embarrassed during the entire hospital experience and that she felt her labor and delivery were delayed by her self-consciousness, which she felt distracted her.

Similarly, during a PAR workshop, one woman explained the desire for family and social support and the lack of such in many settings, “When you give birth in the private clinic, your husband, your mother, or another person that you want there is at your side in the moment you are giving birth, but I believe that the majority of us have been attended in the hospital, the health center, so that they couldn’t enter, none of our family.” Thus, the presence of supportive family and friends was reported to be an important and desired factor in women’s birth experiences.

Alicia, a 31-year-old mother of three shared how she was able to incorporate some traditional practices and remedies into her birth experience, though she ultimately gave birth in the hospital due to her husband’s persistence,

Now all children are born in hospitals… and I went to the hospital, but here was my mother also and she prepared herbs for me and made me drink the herbal remedies and told me, daughter, ‘it’s your time.’ And she massaged my belly so that I would not suffer
too much. But then my husband came home from work and he said to me, no. He is fanatic about doctors and education, and so I gave birth in the hospital.

Adriana explained that during her homebirth, “My mother was there and also my husband until the baby was born… They were supporting me, they were telling me, don’t give up, and they held me, here at my waist, and I was sweating from the labor. And also, they helped with the herbs… that help with the pain and dilation.” In contrast, during her hospital birth, other than the medical team present, she was alone, without the support, both emotional and physical, of her family.

Illustrating the perspective of a traditional practitioner, midwife Fernando explained, “To me, birth at home is more accurate. It’s calmer and at the woman’s side is her family. Everything is healthier. In contrast, in the hospital, first timers suffer a lot.” Fernando’s sentiments along with the many shared experiences of these women illustrate the general contrast of familiarity, comfort, support, and calm environment in homebirth with the unfamiliarity, fear, loneliness, and stress of a biomedical birth for many local women.

In addition to desires for a birth experience that incorporates these midwifery-style practices and cultural traditions, women also shared emotional reactions that went beyond simply feeling an aversion to biomedical-style care. In fact, 13 women (43.4 percent) expressed feelings of shame and embarrassment when describing their experiences in the biomedical setting. These feelings were rooted in the previously discussed cultural norms of female modesty and privacy. Claudia, a 40-year-old mother of two, explained that after her first biomedical birth, she chose to deliver her second child at home “because I was embarrassed… because they see your parts, your intimate parts, when your birth is attended [in the Center].” Julia explained that this was an issue of privacy with not only unfamiliar providers, but also other patients, “there is no privacy; they
all [providers] come in whenever they want… sometimes there are lots of patients in just one room.”

In contrast, Luz explained how her birth experience with Renata, the private obstetrician, was an improved biomedical experience, “With Renata, it’s better. She attends to you alone, she covers you with a blanket, and she takes care of you. She doesn’t expose or look at your body.” Unlike in the local health centers and hospitals, Renata, although a biomedical provider, takes into consideration women’s modesty and desires for privacy, incorporating modifications into her practice.

Even more disconcerting is the finding that 22 women (73.3 percent) specifically mentioned feeling afraid during their biomedical birth experiences. Some of these feelings of fear were associated with women’s unfamiliarity with the biomedical environment and maternal care practices. Linda, a 19-year-old mother of one explained, “I was afraid. I didn’t know how childbirth was… because it was my first child. I was embarrassed because I had never been in a hospital before.”

Other women were afraid of biomedical interventions, such as episiotomies and cesarean sections, which were often simply referred to as cortes, which means cuts. In fact, this fear appeared to be rooted in confusion and lack of communication. For example, Julia said that during her hospital birth, “They made the cut [an episiotomy]… nobody told me anything… not why, nothing… I realized [what had happened] when they told me that I would have to go to Marcará to have the stitches removed.” In situations such as these, many women reported feeling poorly informed about what was going on and wanted more information about what to expect and how things were progressing, but were afraid to ask questions or did not have the opportunity to voice these concerns. Regarding biomedical providers, Fernando explained that
from his experience working alongside them in the hospital, “They have plenty of education, but they are often rough. They don’t know how to treat someone with care. So, sometimes, women are afraid of them.”

However, the most disconcerting findings regarding fear were women’s fears of and experiences with discrimination and verbal as well as physical abuse by biomedical providers during childbirth. During workshops and interviews, some women reported personal experiences of blatant discrimination and abuse during their childbirth experiences. Cristina, a 31-year-old mother of one, shared that during her birth experience,

First, I felt afraid, pain, and other than that, sometimes, uh, fear because sometimes the doctors do not always treat you well. Then, see, they yell at you or they bother you, to me, no, they didn’t yell at me, but I saw others when they yelled [in pain], they were afraid of when the pain hurts you and you yell, but because of the pain, you want to yell. But I couldn’t because I was afraid of the doctors yelling at me.

These stories and concerns appeared across all three communities and all biomedical institutions, including local health centers and the provincial and regional hospitals. In fact, during the course of this research several women asked me to accompany them on doctor’s visits, occasionally to the local health post, but also to private clinics, explaining that they did not feel comfortable visiting the doctor alone and that their friend, daughter, or other companion was unavailable to accompany them. During some of these visits, I observed first-hand the distant patient-provider relationship, the lack of verbal communication and cultural consideration on the provider’s part, and the uncertainty women expressed after visits in which they were too nervous to ask any questions.

Moreover, fears of discrimination and violence were common themes throughout the workshops. During a workshop in Marcará, one woman shared this story,

They treat you poorly, more than anything, in the hospital, and to me too, they treated me badly, but what I saw with the other girls who were crying [with pain], they were
desperate in pain, and it was to the point where they were slapped in the face when I was watching. They said, shut up, to the point of insulting them. They said, this is what you wanted, this is why you got married, your husband, for this you opened your legs to be here, hold on, and push!

Similarly, during a workshop in Shilla, one woman relayed this story, “When I was in the hospital, a woman said, nurse, help me, and the nurse said to her, learn that this is what you spread your legs for, learn that shit, and then she turned and left.” These stories demonstrate the occurrence of poor provider care and verbal as well as physical abuse, which are serious barriers to safe and comfortable birth experiences. Women discussed their personal experiences as well as rumors about such treatment during the workshops and interviews as well as throughout the community, which appeared to intensify fears among women.

*Declines in Midwifery Practices and Providers*

As evidenced by the data, women have demonstrated strong desires and preferences for midwifery-style care and culturally-relevant birth practices and a there is a voiced need to improve provider rapport, communication, and respect for patients in order to alleviate women’s feelings of shame and fears of discrimination and abuse. Moreover, as the preceding section illustrated, the lack of these considerations in biomedical institutions has serious emotional and social consequences for women’s birth experiences. Some women in this study chose to give birth outside of the biomedical system in order to realize these desires (n=9), although most women who did so gave birth at home in the 1990s prior to the enactment of the fines and social service punishments. Of those who gave birth at home in the early 2000s (n=3), only two reported having actually been fined for the home birth. In part, this could be due to the fact that the fine appears to be an unofficial mandate enacted by local health authorities. Accordingly, there is an aura of authority and threat of sanction around the fine and other punishments that carry significant burden, outweighing the possibility of it being merely a rumor.
Additionally, as a result of the mandates on institutionalized birth and prenatal care and the threats of fines and other punishments, midwifery has declined in popularity, and few midwives continue to practice locally, further constraining women’s decision-making by limiting available options. Although midwives composed one-third (n=2) of this study’s maternal health care provider sample, it is important to note that this is not representative of the distribution of midwives versus biomedical providers in the region. Rather, this is reflective of the access I had to providers, which was limited in regards to state-employed biomedical providers despite repeated recruitment efforts in local biomedical health facilities. On the other hand, the private practice obstetrician and the two midwives I was able to identify were eager to participate in interviews. Moreover, it is also important to highlight that Alma no longer practiced childbirth care, though she did serve as a local authority and head of the promotoras. As the leader of the local promotoras, she functioned as a liaison between the local health clinic and her community. Many women continued to seek her advice and care, though she now typically referred health problems or pregnancy complications to the local health center rather than addressing them herself. She explained,

Why did I stop working as a midwife? Because the health system had begun to look for pregnant women. And midwives couldn’t attend birth anymore. It was better for the midwives to send the women to the health center. Since then, I have stopped being a midwife. I just send them all to the health center.

Fernando, having attended births all over the region, including the sample communities, discussed a marked decline in his practice as a midwife. In September of 2012, he had only attended two homebirths that year. At the height of his career in the mid-1970s when the local health authorities approached him with the idea of collaborating and training him in some biomedical methods, he was attending hundreds of births a year, which is why he felt the health authorities approached him in the first place. However, in Fernando’s case, it is important to
also be aware of his training with the regional hospital and the subsequent partnership he maintains with them. As such, women who do seek his care do not need to fear the fine or other punishments. Unfortunately, he is a private provider, and thus women face financial barriers in accessing his care.

In fact, mirroring these providers’ sentiments on the decline of traditional birth practices, 13 women (43.4 percent) mentioned that midwives are no longer locally available. When I asked Cristina whether she thought childbirth was dangerous or not, she responded that giving birth at home was not safe because it would be alone because “now, no, there are no more midwives. It’s rare.” This finding brings us back to the primary theme of women’s decision-making, their limited autonomy. Luz said, “Before, I’d prefer birth in my house, but after hearing the story of the woman who died, I prefer to go to the health post… but if there were trained midwives, I would prefer to give birth in my house [with them].”

Despite the evident desires for culturally appropriate practices and midwifery-style care as well as the negative emotional responses to biomedical birth experiences, every woman in this study had at least some biomedical birth experience. In light of this mismatch in women’s reported desires and actual actions, the question at hand then becomes, what *do* women want? Thus, the following section discusses women’s preferred care and delivery practices in an effort to elucidate avenues for future improvements to maternal care.

**Preferred Maternal Care and Delivery Practices: Integrating Biomedical Technology and Midwifery-Style Care**

As the preceding data demonstrate, difficult contradictions exist in achieving ideal maternal care and delivery practices as women have expressed desires for both midwifery and biomedical care as well as hesitations regarding both models. Thus, the presentation of data
regarding preferred care practices is approached from two angles: 1) the desires for a safe, well-equipped biomedical environment that is available in the case of a potential obstetric emergency, and 2) the need for respectful, culturally-appropriate midwifery-style care practices with only medically indicated birth interventions. Essentially, the integration of these two models of care attempts to reconcile the conflict between the physiological and sociocultural aspects of birth in an effort to provide holistic, biosocial care during pregnancy and childbirth, which as discussed in the chapter on theory and methods, are truly biosocial life events.

The data show an undeniable preference for biomedical care among the women of Carhuaz. When asked where they preferred to give birth, 26 women (86.7 percent) responded in a biomedical setting, including the local health centers, public hospitals, and private practices. Teresa, a 30-year-old mother of five who had delivered three times at home and twice in the local health center, shared, “In the health center, they attend to you better. They are trained. They’re better than midwives… they know, they have the knowledge… Midwives are caring, but they are not hygienic.”

Four women (13.3 percent) expressed preferences for homebirth and midwifery care, and one woman (3.3 percent) responded that both were equal to her. Illustrating the overall conflicts in preferences among the sample, Carmen explained, “Sometimes I want to give birth in the hospital and sometimes no because the doctors don’t treat us well, and for preference, I’d like to give birth at home.” She later told me that she was planning for her second child and wanted to give birth at home with her husband and perhaps her mother-in-law, who is a midwife. She reported that now she has previous birth experience now so she feels confident giving birth at home. Moreover, her mother would be present to support and comfort her through the delivery.

Illustrating the benefits and drawbacks to both styles of care, Paula shared,
It’s the same. For me, it’s the same. Because for me, in my house it was great, I was already in my home, resting and there were not people here to hit me, it was relaxed. Sure, but yeah, in the health post, they are looking after you and taking care of you too. Specialists. In contrast, in your house, there are no specialists. Sure, there’s also no ruckus, no, there are not those things in your house, but you don’t have specialists either.

The total number of responses regarding birth setting preferences is 31 because one woman, Paula, explicitly stated preferences for both at different times during her interview, contradicting herself. However, this finding further illustrates the constrained agency and conflicting desires and options women are faced with, and, in fact, similar, though less explicit, contradictions in maternal care preferences were recorded in nine total interviews (30 percent).

Moreover, the workshop data further complement these findings on the need for integrated approaches to maternal care. One of the group activities conducted during the workshops involved the development of an ideal birth scenario. Since the data were produced in groups by a broad range of participants (n=69), these aggregated perspectives shed further light on preferred care practices and ideal birth experiences from a community-level perspective.

Common themes that emerged during this workshop activity included provider support, respect, and privacy, an adequate and safe birthing environment, the presence of family or other personal support, and normal, vaginal birth with minimal interventions. These themes are well illustrated by the following workshop quotes,

The ideal birth should be in the hospital because you feel safe. You will be attended by a doctor or the obstetrics nurse mostly because the doctor is always gone... in the hospital, they have the necessary equipment to attend to you and you have to go with a family member or partner… The environment is not adequate [socioculturally], but you seek care there for safety. [Shumay]

[The ideal birth is] in a health center, either in a post or in a clinic, whether a doctor, nurse, obstetrician, and others, so you get good treatment that respects your privacy. Also that they treat you well, not like how we see in hospitals where they mistreat you physically and also emotionally instead of giving support. They try to insult you to make you feel bad. Besides that, [we would like that] they let you bring in a family member or someone you have you confidence in [to the birth]. [Marcará]
From these quotes, it is clear that women want to give birth in a biomedical setting because they perceive that the environment is safer because biomedical settings are staffed with skilled providers and supplied with necessary medical equipment for potential complications or obstetric emergencies. Moreover, as the second quote clarifies, local health centers are preferred over hospitals. Women explained that local providers were preferred because women typically had some rapport already built with these caregivers through prenatal exams as well as community reputations, which helped inform women’s perceptions of provider care. Additionally, from the second quote, it appears as though risks for mistreatment are higher in non-local facilities, perhaps due to the lack of rapport. Thus, local availability of adequate and appropriate biomedical care is essential to improving the maternal experience. Ultimately, while the biomedical setting is perceived as safer, the style of care provided is not acceptable, and women seemingly must choose between safety and respect in their birthing experiences.

Conclusion

This chapter presented the voices of the women of Carhuaz province regarding their pregnancy and childbirth experiences and illustrates the complex, multi-level, multi-actor decision-making processes women go through during gestation and delivery. On the national and policy levels, mandates for institutionalized births impact women’s decision-making processes in regards to fines, social service-related punishments, and the constant threat of surveillance. Yet, on the community and individual levels, family, patient-provider relationships, perceptions of safety, maternal care provider rapport and style of care, cultural traditions and beliefs, and physical availability and access of resources also influence maternal decision-making. These intricate intersections impacted the women in this study in a variety of ways and each woman’s decision-making process is in many ways unique to her own personal
situation, yet, common themes also arose regarding biomedical care experiences, barriers to accessing care, and desired maternal care practices. These include abuse and discrimination, financial and social barriers to access, especially in regards to local care, and desires for a safe environment well equipped for potential complications, a caring, respectful provider, privacy, familial support, and opportunities for the practice of cultural traditions. The following chapter will further discuss these findings and their implications for the maternal experience in Carhuaz, as well as offer recommendations for future avenues of research and community change.
Chapter 5: Discussion and Conclusion

Following the presentation of results from this ethnographic investigation, this chapter discusses the implications of these findings with regard to the maternal experience in Carhuaz province, specifically examining how the various actors and multiple levels of influence involved impact women’s decision-making processes during the prenatal period and childbirth. This discussion will also extend beyond the local experience to examine how these findings contribute to anthropology’s understanding of the political economy of health, maternal decision-making, and structural violence in a medically pluralistic environment like that of the Peruvian Andes, as the rich ethnographic data collected provide vivid illustrations of how these broad frameworks materialize in the lived realities of individuals. Finally, this chapter will culminate in the presentation of recommendations for community-based adaptations of current, local maternal health care programs and policies based on this investigation’s findings in order to optimize the maternal experience in the province of Carhuaz. Alongside these locally specific recommendations, I will present methodological proposals for similar, community-centered efforts that can be applied in alternate settings.

Implications of Findings for the Maternal Experience in Carhuaz

As suggested by relevant literature, the results of this research reveal that maternal decision-making among the women of Carhuaz province is impacted by a kaleidoscope of factors, both practical and symbolic, reflecting the biosocial nature of pregnancy and childbirth situated in a shifting political-economic context. Primarily, the results of this research identify the following thematic domains as influential in women’s maternal decision-making in Carhuaz
province: 1) restricted maternal autonomy, 2) access to and availability of maternal care services, 3) perceived health benefits of care provided, and 4) sociocultural influences in regards to both customary practices as well as social networks. Thus, this section discusses the implications of these domains in regards to the maternal experience in Carhuaz province.

**Restrictions to Maternal Autonomy: Financial, Cultural, and Emotional Factors**

Restricted autonomy as a result of explicit, state-level attempts to institutionalize birth though financial punishments and suspension of social support services, enforced by community surveillance, figured mostly prominently in women’s decision-making. As discussed previously, 96.6 percent of participating women (n=29) reported that a family member, guardian, health care provider, or state-level policy influenced their decisions regarding where and with whom they sought prenatal care and childbirth attendance. Moreover, the only participant that did not explicitly mention this influence during her interview was Linda, the youngest participant at age 19, who is a single mother of a one-year old. During her interview, she shared that she struggled with depression because of the incarceration of her partner during her unplanned pregnancy. As a result, Linda reported that she relied heavily on her mother and aunts in guiding her through the prenatal period and childbirth, willingly relinquishing her autonomy. Thus, although she voluntarily yielded to the guidance of family members, she, like other mothers who participated in this research, was not the primary decision-maker in her pregnancy and childbirth experience.

However, it is important to see that although family members, guardians, and health care providers were often reported as the immediate stimulus in many women’s decision-making (n=23; 76.6 percent), statements about the rescinding of state-provided insurance and social support programs by Milagros and Jorge, both state health employees, demonstrate the impact that these government mandates and punishments have on women’s prenatal care and birth
decision-making options. Ultimately, the individuals influencing women’s decision making are largely the embodiment of state-level efforts to situate maternal health care in a solely biomedical setting, functioning as enforcement of these policies through community surveillance. As participants frequently mentioned, if a women misses her prenatal visit, a health worker from the local health center or community *promotora* will come to look for her and inquire about her absence. Thus, for women opting out of the biomedical system, persistent surveillance makes such a decision extremely difficult and requires that they hide their pregnancies altogether in order to avoid this scrutiny. Yet, hiding pregnancy is not an easy endeavor, and several participants who had attempted to do so reported that they were eventually discovered by local health workers and given a schedule of dates for required prenatal care visits, against their desires.

Similarly, family members and guardians are subject to the same potential punishments that women face, motivating familial surveillance as well. For example, the threat of financial castigation through the fine for birth outside of a biomedical institution negatively impacts the financial stability of the entire household, motivating family members to support biomedical care options in order to avoid such punishments. Similarly, if a woman is removed from the *Juntos* program or *Vaso de Leche*, her entire family, including her husband and children, are negatively impacted, providing an incentive to family members to encourage adherence to biomedical prenatal visits and childbirth.

Although data on women’s participation in social support programs such as *Vaso de Leche* and *Juntos* were not collected as a part of this research, findings from interviews and participant observation demonstrated that it is safe to assume that these programs play an important role in participating women’s household economy for three reasons. One, the frequent
reporting of the threat of removal from social support programs reflects this as a priority among participants. Two, evidence of participation in these programs was observed in many women’s homes as program-supplied foods are labeled as such to prevent resale. And finally, through connections with the local health centers and women serving in volunteer program-related positions, such as the president of a local chapter of *Vaso de Leche*, I was able to attend and participate in some of the community education talks that are required by the programs. During these talks, I observed that many women who participated in this investigation were also recipients of these program benefits. Thus, the risk of suspension and/or permanent removal from these programs posed a serious threat to women’s household economies and food security, and therefore figures prominently into women’s decision-making.

This conditioning of services is also demonstrated with regards to access to health insurance. While the national insurance program, *SIS*, provides health care coverage to all pregnant women to facilitate access to biomedical care, it also constrains their agency in decision-making by limiting the options women have available to them. *SIS* covers maternal care within a biomedical setting, and only at particular public, state institutions that accept *SIS*. For example, while Renata is a licensed obstetrician, she now works independently from the state and is considered a private practice provider. Thus, her services are not covered under *SIS*, and if a woman chooses to seek her care, she must pay for it out of pocket. Additionally, despite comprehensive coverage for all pregnant women through *SIS*, participants reported still having to pay for supplies and other expenditures, exposing persistent financial barriers.

Moreover, when women do not give birth in a biomedical setting, their health insurance is rescinded, and they are required to pay for any future biomedical care they may seek. This punishment is particularly problematic because although a woman may choose to give birth
outside of the biomedical setting, this does not necessarily dictate that she does not find merit in biomedical care for other healthcare needs. During individual interviews and group workshop activities, women often described pregnancy and childbirth as “natural” and “normal” life events, as opposed to pathological health conditions. As such, they are not perceived as necessitating biomedical care. However, women reported that they seek biomedical care for other physiological conditions, such as high fevers and persistent diarrhea. Moreover, during the workshop activities, women reported seeking biomedical care for pregnancy and childbirth complications, such as hemorrhaging and retained placenta, demonstrating that while a non-complicated pregnancy and delivery are conceptualized as natural, these potential complications do require biomedical care. However, the conditioning of SIS coverage requires that women treat all pregnancies and deliveries as high-risk and seek biomedical care if they hope to maintain SIS coverage for any potential future health problems.

Further compounding the restrictive effects of the conditioning of both social support services as well as health insurance coverage is the presence of the fine that women face as a consequence of giving birth outside of the biomedical setting. Although reports of the exact amount of the fine varied within and between the three participating communities, ranging from 60 soles to 200 soles (approximately 21 to 72 USD), it is clear that any amount would be prohibitive to the women who participated in this study. While data on household income was not collected as a part of this research, this was due to the fact that monetary income is not a regular source of support among the participants. The majority of women reported housework and agricultural work as their primary occupations, and agricultural work was the most frequently reported occupation of spouses as well. Thus, monetary income is not easily measured nor does it appear to play a regular role in the households of participating women.
Further, as participation in state-run, social support programs like Juntos is based on district-wide levels of poverty, it is reasonable to assume that participants did not have readily available financial resources to cover the fine for childbirth outside of the biomedical setting (JUNTOS 2013; Perova and Vakis 2009). Thus, financial castigation further exacerbates women’s limited monetary resources and constrains individual agency over their maternal experience, demonstrating the disenfranchising nature of poverty in these women’s lives.

National mandates also function to reduce the availability and accessibility of alternative care options, further limiting women’s ability to fully realize their own bodily autonomy over their pregnancy and childbirth experience. As a result of the fines, social services punishments, SIS coverage of strictly biomedical care, and enforcement through community surveillance, the practice of midwifery has notably declined, as was explained by both maternal and provider participants. Despite the evidence that women maintain continued desires for midwifery-style care and the culturally relevant birth practices midwives employ, the availability and utilization of midwives in Carhuaz province has plummeted. Largely, this is due to the enforcement of biomedical birth initiatives through these financial and state support-related castigations that have led to a de facto ban on midwifery. As Alma shared, the biomedical health system began surveillance of pregnant women and so she stopped attending births because as a single, independent provider, she was vulnerable to the threat of legal sanction by the local, biomedical health center.

The consequences of this decline extend beyond the lack of available midwives and decline in midwifery practice and training, but also impact birth customs and experiences, familial relationships, and community ties. As demonstrated in the results chapter, there are notable distinctions between biomedical birth practices and midwifery style care, including the
use of poorly explained or completely unexplained biomedical birth interventions, the lack of natural and herbal remedies, the exposure of women’s bodies, distant provider-patient relationships, and the lack of familial support in biomedical birth. These differences and the unfamiliarity that most participants had with the biomedical system led to repeated reports of feelings of shame, embarrassment, and fear.

Women’s stories of feeling shame and embarrassment during prenatal care and childbirth were predominantly associated with the cultural norms of female modesty in the Peruvian highlands. Women and participating midwives reported that, customarily, women are covered during birth with blankets and the attending midwife uses her hands to check dilation and assist with delivery, but does not expose the woman’s body. Moreover, there is only one attending midwife, and other people present during birth are family members of the woman. In the biomedical setting, with the exception of Renata, women reported embarrassment and shame as a result of the exposure of their bodies to the various providers attending their delivery as well as other patients who may be present in the room as a result of a lack of resources to provide women with a private birth setting. As Manuela explained, these feelings distracted her during her delivery, and she perceived them and her self-consciousness as delaying the birth of her child, particularly in comparison to her previous experiences with midwifery care and homebirth.

This discomfort during childbirth is further compounded by women’s experiences of fear, as a result of both the unfamiliarity of biomedical birth practices as well as fears of discrimination, violence, and abuse. Although children are now required to attend regular check-ups at the local health posts in order to obtain support from social programs, thereby familiarizing them with biomedical practices from a young age, these requirements were not in place until as recently as 2005, as is the case with Juntos (Perova and Vakis 2009). Thus,
participating women were not often exposed to the practices of biomedical care in their youth nor are they accustomed to its procedures.

*The Patient-Provider Gap in Biomedical Care*

This unfamiliarity with biomedicine is further compounded by women’s reports of a lack of explanations by and communication with their provider. This lack of communication appears to stem from three different variables: 1) a lack of an established patient-provider relationship, 2) linguistic barriers, and 3) ethnic and gender discrimination. As discussed in the results chapter, prior to the influx of biomedical birth practices, local midwives attended birth. These women were well known in their communities and had established relationships with the women they cared for, allowing for a more open and comfortable discussion of the birth process and related procedures. In contrast, in the local health centers, women may have established some rapport with their provider during prenatal visits, but these providers are often from other, usually coastal, urban, areas of the country, marking a significant cultural divide between them and the rural, Andean women they care for.

Further exacerbating this divide is the linguistic barrier many women face as either monolingual Quechua speakers or Spanish-as-a-second-language speakers. As illustrated in the results chapter, only one of the biomedical providers interviewed spoke fluent Quechua, exposing a substantial gap in patient-provider communication in the health sector. Additionally, there are linguistic gaps in the translation of most biomedical services and procedures from Spanish to Quechua, often defaulting to the use of the Spanish word.

Finally, ethnic and gender discrimination may play a role in providers’ hesitation in discussing biomedical procedures and developing the patient-provider relationship. During interviews and site visits, some provider participants relayed perceptions of ignorance,
stubbornness, and backwardness regarding rural, indigenous populations, often citing their cultural beliefs and practices as barriers to adherence to biomedical practices. Rather, it appears that these misconceptions and assumptions on the part of providers function as barriers to the development of trustful and open relationships between providers and patients. Moreover, these issues of ethnic and gender discrimination were reported to have resulted in violence and abuse in some situations, instilling fear in many participating women, further deteriorating women’s trust and confidence in the biomedical system and their providers.

These negative emotional experiences within the biomedical setting are exacerbated by the absence of family members who typically provide both emotional and physical support and comfort. As women shared, in traditional birth practices, their husbands or mothers often physically supported them during labor pains and delivery by holding their waists and emotionally supported them by providing verbal encouragement and motivation. However, in local health centers and the provincial as well as regional hospitals, women frequently reported being alone during labor and birth, with the exception of their biomedical provider.

Beyond the consequences these differences have on the level of individual experience, they also impact relationships on the familial and community-levels. Participating women, particularly those who were older, and midwives themselves, shared that the practice of midwifery and birth attendance builds and develops bonds among and between family and friends and through generations within a community, functioning as an important aspect of social maintenance. After a midwife assists in the delivery of a child, she becomes the child’s madrina, which forms a lifelong bond. Moreover, bonds are established between the mother and midwife as well, with women in this study who pursued midwife care all consistently seeking the same provider for subsequent midwife-assisted births. Women also reported seeking midwives
through word of mouth, with these established relationships functioning as the basis for recommendations by mothers, aunts, friends, and other females. As the practice of midwifery declines, the persistence of these social ties, which extends throughout the community and through generations, is threatened.

Along with these declines in social ties is also the associated waning in transmission of traditional pregnancy and birth knowledge, which occurs at the level of midwifery practice as well as between laywomen. This information includes the use of regional medicinal herbs, the practice of sobados, the observance of cuarentena, and precautions against sobreparto. This knowledge is crucial to culturally-normative and relevant maternal care and childbirth practices, but is threatened by the authoritative knowledge of biomedicine, which delegitimizes and marginalizes these longstanding experienced and embodied forms of knowledge (Jordan 1997).

Desires for Biomedical Services and Challenges to Availability, Accessibility, and Delivery

Yet, despite challenges regarding the cultural and emotional acceptability of biomedical resources as well as the voiced desires for midwifery style care, all participants expressed positive sentiments regarding the physiological benefits of biomedical care. Women found the presence of educated and trained health personnel, the availability of biomedical resources, and the information provided regarding their and their child’s health beneficial, particularly in regards to potential pregnancy and birth complications. However, gaps in availability, barriers to accessibility, and persistent challenges in the delivery of biomedical maternal care services continue to hinder utilization and negatively influence women’s decision-making.

Concerning the health personnel and biomedical resources, women found comfort in their availability in the face of potential complications. In part, this may be a result of the frequent workshops and community talks women are required to attend in order to receive social program
benefits. These sessions are held by the local health centers and *promotoras* and concentrate disproportionately on pregnancy complications, warning signs, and health risks, conceptualizing pregnancy and childbirth as dangerous and requiring biomedical services.

Although longitudinal data on changing perceptions of pregnancy and childbirth were not formally collected as a part of this investigation, women frequently reported during both individual interviews as well as workshops that pregnancy and childbirth are more difficult now and that women’s bodies are not as strong or prepared as they were in the past, such as in the case of their mothers and grandmothers. When I asked women what they meant by this, they referenced their perceptions of increased incidences of pregnancy and birth complications, such as spontaneous abortion and postpartum hemorrhaging, maternal mortality, decreased nutritional health, and the decline in the quality and variety of foods available (especially in regards to naturally grown organic foods versus the use of chemical fertilizers and pesticides) and often cited learning about this information during the social program required workshops and community talks. These explanations seem to reflect gradual shifts in how women’s bodies, pregnancy, and childbirth are conceptualized as a result of these required sessions, with an increasing emphasis on malfunction and the need for biomedical intervention to support the apparently weakening female body. This has led many women to struggle with the fears related to their socialization into the rationale that biomedical birth is necessary “in case something bad happens” (Cheyney 2008).

Moreover, as a result of the required health education sessions, women now commonly report wanting to know about their child’s positioning, its health and growth, as well as gender, and often expect this information as a part of standard maternal care. Biomedical maternal care
can provide these answers and visuals that midwifery care and other traditional practices cannot, and women find benefit and comfort in this knowledge.

Thus, the results of this investigation demonstrate that women in Carhuaz province do maintain a positive perspective on the physiological benefits of biomedical care and believe that it provides increased safety and improved health outcomes. Accordingly, the local availability of these institutions and providers and adequate provision of resources and technology need to be improved in order to facilitate the achievement of state level mandates for birth in biomedical institutions. By doing so, the difficult decisions many women may face in seeking biomedical care can be mitigated, to some extent, in regards to local access and availability.

As the data regarding the location of women’s deliveries show, the majority of births are taking place outside of district health centers, demonstrating a disconnect in the implementation of national, biomedical birth initiatives in local settings. Thus, even when attempting to adhere to these national mandates, women face continued barriers to local access and availability of services. As participants shared, local barriers to achieving biomedical birth within their district persist, with many women reporting a lack of availability of providers and necessary resources.

In Shilla, the health center is only fully staffed until lunchtime, about 1 pm. After the health personnel leave for the day, there are normally one or two providers on-call, though births are rarely attended after hours. As Maria explained, most women in her community give birth in the hospital in Carhuaz because often, there is not a trained birth attendant available at the district health center. In Marcará and Shumay, the district health center is supposedly staffed for birth attendance 24-hours a day, but through frequent visits and participant observation, it became clear that this was not often the case. During the course of this research, I visited this health center during the day, afternoon, and evening to assist with a variety of health promotion
efforts, recruit participants for provider interviews, and follow-up with scheduled interviews, but frequently found that obstetricians were regularly not present at the center. Again, this demonstrates physical barriers to accessing biomedical care despite national mandates for its use.

Furthermore, the local health centers are not equipped for complicated births that may require cesarean section, which forces women to travel to Huaraz, 27 and 45 kilometers away from the Marcará and Shilla health centers, respectively, in order to receive emergency obstetric care. Although both health centers have an ambulance, there are often challenges of a lack of a licensed driver, an inadequate supply of gas, or the ambulance is already out on another emergency. In such cases, women must find alternate transportation, which they must pay for out-of-pocket. Additionally, while public transportation is available between these communities, the buses make frequent stops and do not run later in the evenings, posing additional challenges.

Moreover, beyond the barrier of physical distance, women also face the challenge of unfamiliar providers in Huaraz as their prenatal care has been provided locally. For women who frequently have little to no experience in a biomedical setting and value personal modesty, particularly in the physical sense, having their birth attended by a stranger in an unfamiliar hospital setting in a large, urban city adds additional stress to the situation. Consequently, in addition to having to undergo major surgery, women must also struggle with the social and emotional consequences of a cesarean in Huaraz.

Thus, it is clear that many factors exist in women’s decision-making processes regarding prenatal care and childbirth in Carhuaz province. Although these factors have been categorized into the thematic domains of restricted maternal autonomy, issues of access to and availability, perceived health benefits and sociocultural influences in the discussion of their impact on the maternal experience, the results of this investigation also contribute to broader-level frameworks,
including the political economy of health and structural violence in a medically pluralistic environment. The following section explores this research’s contributions to anthropology’s understanding of these frameworks.

Contributions to the Literature

Ultimately, the factors that operate on the local level of participating women’s lives are shaped by broader political-economic factors that function to enact structural violence based on gender, ethnicity, and socioeconomic status, resulting in disproportionate maternal risk among rural, indigenous women in the Peruvian Andes. This research identifies a range of influences on maternal decision-making, including structural issues of access and availability, financial barriers, and cultural norms, mirroring many of the issues described in relevant literature regarding the maternal experience in Peru (Bristol 2009; Campbell and Graham 2006; Fraser 2002; Gabrysch, et al. 2009; Vega 2006; Yamin 2007; Yamin 2008). These findings contribute to an expansion of the current understanding of maternal decision-making, its influences and impacts, by broadening the scope of current literature to include the voices of the women of the north-central Andes. Moreover, this research has further elucidated some less focused on factors, such as fears of discrimination and violence in biomedical settings and the impacts of conditioning state-provided social support and other services, as well as providing the often difficult to find voices of maternal healthcare providers, both biomedical and traditional, that illustrate the impact of global and national policies on multiple levels of influence.

The results of this research demonstrate that broad-level political-economic and sociocultural forces have coalesced in the lives of rural, Andean women to transform the physical, social, and emotional experiences of pregnancy and childbirth into political, dehumanized spaces of policy fulfillment, focused on objectives and outcomes determined by
global, and arguably Western, ideologies. Despite the national efforts to increase access to healthcare coverage, institutionalize birth, and improve maternal health outcomes, participating women’s experiences demonstrate that gaps in actually achieving these goals persist, and that these efforts, have, in fact, exacerbated women’s disenfranchisement and further reduced their bodily autonomy. Healthcare budgeting remains low, health facilities in rural areas are still understaffed and difficult to access, women continue to endure discriminatory care, and the decentralized, national health system is complex, fragmented, and contradictory as a result of disorganization, lack of resources, and poor regulation (Francke 2013).

The broader level, development-oriented emphasis on modernizing and institutionalizing pregnancy and birth to combat maternal mortality and morbidity has led to the excessive medicalization and depersonalization of traditionally intimate life events, further silencing women’s voices and experiences in the on-going debate on reproductive and maternal health policies. These outcomes reflect comparable unintended consequences of similar reproductive and maternal health development efforts in other parts of Latin America, including fertility and population policies in Cité Soleil, Haiti (Maternowska 2006), reproductive health and population policies among indigenous populations in Mexico (Castro 2004) as well as conditional cash transfer programs in rural Veracruz (Smith-Oka 2009), and cervical cancer screenings and female gender roles in Recife, Brazil (Gregg 2003), contributing to the increasing need for ethnographic data and holistic understanding of local environments in designing and implementing women’s health policies and programs.

As participating women’s stories illustrate, their decision-making regarding their bodies and their babies is shaped by their socioeconomic status, gender, and ethnicity. As a result of their economic disenfranchisement, these women depend on conditional cash transfers (Juntos),
supplementary food supplies (PVL), and state insurance (SIS) to ensure the stability of their households. Yet, in exchange for accepting these services, they must sacrifice their bodily autonomy and submit to the institutional control of (poor) women’s bodies, a seemingly terrifying trade-off given the Peruvian government’s largely unpleasant history with women’s rights, including the forced sterilization campaigns of the 1990s and the only recent repeal (in 1997) of Article 178, that allowed a rapist to avoid prosecution through marriage of his victim (Merino 1997). Yes, the data demonstrate that women find safety in biomedical care. However, the vast majority of women explained that their decision to seek this care was primarily motivated by external factors, including local health authority surveillance, financial castigation, and the dependence on social support.

Moreover, women are making these trade-offs and still facing physical and financial barriers to access to and availability of the necessary health infrastructure and personnel needed to meet these conditions as well as the emotional consequences of culturally and ethically unacceptable care. As the literature demonstrate, these continuing inadequacies can be linked with the violence of institutionalized discrimination that disproportionately concentrate the country’s health resources in wealthier, urban, and largely Hispanic areas of the country (Yamin 2007). These structural factors are further compounded by the delegitimization of rural, Andean women’s cultural birth practices as well as the unethical treatment they reported experiencing.

Consequently, as this research demonstrates, a declining number of women in Carhuaz province have reclaimed their autonomy and chosen alternative birth attendants and models. In a traditionally indigenous region such as Ancash, and given the significant socioeconomic inequality of the country, alternative models of health do persist, and individuals seek these options for a variety of reasons beyond simply financial factors, including the expression of
social identity, the observance of cultural norms, and the maintenance of community bonds (Crandon 1986). Pregnancy and childbirth in Carhuaz province are more than biological events. They are also social mediums, and relationships and longstanding birth practices play important roles in women’s maternal experiences and their decision-making processes (Jordan 1983). Women participating in this research often discussed traditional, culturally rooted pregnancy-related health issues, including sobreparto and cuarentena, and how these concerns were not observed in biomedical setting. As Crandon-Malamud has noted, the continued observance of these practices demonstrates the ways in which individuals can continue to express resistance and identity in the face of dominant forms of knowledge (1991).

Thus, in the face of global and national forces shaping local realities, women continue to maintain avenues for subversion and resistance, which were further facilitated by the PAR workshops of this research. These functioned as forums for women to voice their concerns and desires, opening up a bottom-up dialogue in which local forces aim to impact the macro-level. Without a cyclical dialogue such as this, international efforts at improving local health outcomes will continue to face challenges in community implementation, lead to exacerbation of inequalities, and fail to meet overall goals.

**Recommendations for Community Adaptations of Maternal Health Care in Carhuaz Province and Related Methodological Proposals**

*What Women Want: Integrating Biomedical Services with Midwifery-style Delivery*

The results of this research validate the need for the consideration of the sociocultural aspects of pregnancy and childbirth in addition to the biomedical and physiological concerns. Thus, in addition to the expansion of the availability of local, biomedical maternal health services, there is a clear demand for community-based, culturally relevant adaptation of these
services in order to facilitate the uptake of and adherence to biomedical institutions by improving their local acceptability. Although the national mandate regarding birth aims to increase the number of women birthing in biomedical institutions in order to reduce maternal mortality and morbidity, this goal cannot be realistically achieved without accompanying improvements to the availability and delivery of biomedical maternal health services to make them more physically accessible and socially and culturally relevant and acceptable. This is particularly important in regards to the trust and respect that is necessary in order for women to feel safe, informed, and supported during their pregnancy and birth experience (VandeVusse 1999).

Overall, the women participating in this investigation appear to desire biomedical birth services delivered with a midwifery-style twist that integrates the perceived security of biomedical technology with the comfort and social as well as cultural relevance and respect of midwifery care. Specific recommendations arising from the women participating in this research include: 1) the increase in availability of local services and staffing so that women can rely on 24-hour local availability of maternal care service, 2) the improvement of the patient-provider relationship in order to facilitate open communication, in an appropriate language, a sense of confidence and trust, and respect for women’s desires for bodily modesty and privacy, 3) the presence of family members during labor for emotional and physical support, and 4) the incorporation of beneficial and benign traditional birth practices, such as the covering of women’s bodies and the observance of postpartum food taboos.

In accordance with previously identified barriers in the literature, these recommendations focus on the issues of accessibility, availability, and acceptability of services and address identified barriers operating in women’s decision-making that impact the delays in seeking, arriving at, and receiving appropriate care (Amnesty International 2009; Yamin 2007).
However, the implementation of these recommendations and further efforts at improving maternal health services in Carhuaz province must be rooted in community-grounded inquiry that incorporates impacted populations into the entire research to implementation process. Such an approach ensures local relevance and applicability as well as facilitating the generation of community investment and ownership of such efforts in order to increase the likelihood of uptake and long-term sustainability. Accordingly, the remaining portion of this section will discuss methodological proposals for community-centered research and benefits as well as lessons learned through the PAR methods employed in this research.

Engaging with the Community: Optimizing Local Relevance and Ownership

The findings of this research were elucidated through long-term, ethnographic field methods and a reliance on participatory action research methods that incorporate participants as co-researchers, allowing them to help guide the direction of inquiry in order to focus on the local relevance of both the investigation as well as its findings and recommendations. The participatory nature of this research, and the PAR workshops specifically, cultivated a supportive and open environment for critical group discussion of and reflection on local pregnancy and childbirth understandings, practices, experiences, and forms of knowledge and learning, aspects that are often overlooked by external-researcher guided investigations as well as by biomedical providers and national-level health initiatives (Calisaya 2004). Moreover, the safe space of the PAR workshops allowed for the presentation of aggregated as well as competing perspective and experiences, as well as sensitive and potentially controversial subjects, including violence, abuse, and discrimination, and the role of researcher as co-collaborator minimized the potential power differentials inherent in bottom-up research.
After the completion of the PAR workshops, I reviewed and coded the transcripts and other data sources to identify the most frequently appearing issues and themes, which were then incorporated into a community deliverable, *Una Conversación Sobre La Gestación y El Parto* (A Conversation about Pregnancy and Childbirth) (See Appendix V). The deliverable presented the most common and relevant issues arising from the workshop data, including pregnancy discomforts, desires for emotional and social support, concerns regarding unknown and unfamiliar biomedical technologies, ideal birth scenarios, and postpartum care, in a brief list. Following this information are direct quotes from the workshops that illustrate the points listed in order to allow the participating women’s voices to come through. The pamphlet closes with three sections of messages regarding pregnancy and childbirth: 1) from the women for healthcare workers, 2) from the women to other women and families, and 3) from healthcare workers for women. This format presents the participating women’s voices, experiences, and knowledge with minimal intervention and interpretation on my part, maintaining the fidelity of the results. Moreover, the printing of these pamphlets and their distribution back to participants as well as local health centers and other organizations helped facilitate a sense of accomplishment and validation among participating women, which was further cultivated by their aiding in the development of the community deliverable, the valuation of their knowledge by a foreign researcher as well as local community organizations, and the sharing of their own practices and experiences. These sentiments are empowering, particularly for women in a traditionally patriarchal environment, and have the potential to inspire critical consciousness and motivate community activism (Freire 1993).

Yet, such an approach is not without its own set of challenges. Researchers are typically accustomed to leading data collection and utilizing structured instruments. However, the use of
participatory methods is often difficult to organize and manage because, by nature, data collection and routes of inquiry will flow into other avenues the researcher may not have planned for. However, this potential for surprise is also the potential for even richer data, open to inquiry beyond the researcher’s perspective.

An additional challenge to participatory methods, specifically the PAR workshops, is the potential for certain individuals to dominate the discussion, while the voices of quiet and shy participants may go unheard. In this research, this challenge was mitigated by the use of small groups within each workshop to further develop smaller, more personal spaces of discussion and examination that allowed more timid participants to express themselves within more intimate groups. After small group activities were completed, the workshop participants regrouped and one member from each group shared their findings with other groups, allowing all participating voices to be heard.

Yet, ultimately, this approach had positive results within this investigation. As a result of this research, a women’s group, Las Mujeres Líderes de Shilla-Virgen María (Women Leaders of Shilla) formed in one of the participating communities, demonstrating the ability for participatory, collaborative research to be locally empowering as well as transformative. Primarily, it was through the PAR workshops that this women’s group formed, and it was through continued workshops in the same format that the women came together to discuss other local concerns and initiatives they hope to work on, including adolescent sexual and reproductive health education and domestic violence prevention and awareness. Although the women’s group operated informally for a couple of months as this research progressed, they formally organized and were officially inaugurated by the local mayor on November 23rd, 2012. Like any new organization, Las Mujeres Líderes de Shilla is continuing to find its footing, establishing a broad
network of participants, and struggling with funding for their efforts. However, they have
established relationships with other local organizations, including the Center for Social Well
Being and the provincial Women’s Emergency Center, and continue to hold regular meetings to
discuss local concerns, funding opportunities, and project planning.

Within this investigation, the use of PAR methods resulted in a holistic, community-
guided illustration of the complex nature of the maternal experience in Carhuaz through the
production of the informational pamphlet. The use of PAR methods allowed for meaningful
community collaboration and the eventual generation of community ownership of and
engagement with the research, as demonstrated by the formation of a local women’s group.
Ultimately, this approach led to the sustained pursuance of the research issues after my
departure. Thus, rather than coercive tactics, like the conditioning of social services, using
supportive and empowering strategies aids not only in the improvement and adaptation of local
services, but also facilitates community engagement and investment, supporting the development
of shared interests and goals.

Closing Remarks

As both the literature and this research document, a kaleidoscope of social, political, and
economic factors are impacting rural, indigenous women’s risks during pregnancy and
childbirth. The results of this research illustrate the mismatch in women’s desires and actual
actions as impacted by their limited autonomy as well as the serious gaps in the provision of
appropriate, acceptable, and accessible maternal care despite targeted national policies and
programs in place. These contradictions must be addressed in order to effectively decrease
maternal risks across the country, regardless of socioeconomic background, ethnicity, or location
of residence.
Moreover, in considering routes for the expansion of services, it is also necessary to consider how these services are delivered, both in regards to cultural adaptation as well as social respect, ethical treatment, and informed decision-making. Participatory research methods and local collaboration can help to elucidate the details of what these reforms should address, particularly in a decentralized healthcare system like Peru’s. Doing so can help to ensure the acceptability of services offered by alleviating hesitations and fear, thereby increasing the likelihood of actual utilization and sustainability. However, the remaining challenges are that of insufficient funding for and organized regulation of the national healthcare system. If the national government is truly dedicated to the improvement of health across the country, a larger portion of the national budget must be dedicated to health expenditures aimed at expanding infrastructure, increasing the number of skilled personnel, and the availability of necessary supplies and equipment. This is certainly a monumental charge, but in consideration of the country’s rapid economic growth, it seems only appropriate to redistribute these national successes across the country in order to benefit the entire population.
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Appendix I: Women’s Interview Guide

Demografía
Fecha de Nacimiento _________  Idiomas Que Habla _________
Residencia Actual _________  Lugar donde Nació _________
Estado Civil _________  Ocupación _________  Ocupación de Marido _________
Años de Escuela Completados _________  Personas en el Hogar _________
¿Qué hace cuando alguien se enferma en su familia?

Historia Reproductiva
¿Está usted embarazada? _________  En caso afirmativo, ¿cuántas semanas o meses?
_________
¿Ha recibido atención prenatal? _________
Número total de embarazos _________  Número de Hijos _________
Edad al Primero Parto _________
Hijos:

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¿Alguna vez ha tenido usted algún problema con alguno de sus embarazos?
En caso afirmativo, qué tipo de problemas? ¿Y qué hizo usted?

Para partos en el hogar:
¿Por qué dio a luz en casa/la casa de la partera (preferencia, problema de acceso, percepción de la atención, tiempo, etc.)?
¿Quién estaba con usted durante el parto? ¿Qué hizo esta persona?

¿Quién le ayudó cuando estaba dando a luz (TBA, partera, familiar, amigo, otro)?
¿Por qué eligió la ayuda de __________ (tipo de asistente)?

¿Cómo __________ (tipo de asistente) le ayudó durante el parto?

¿Cómo pagó por los servicios de la partera? ¿Tuvo apoyo financiero?

¿Puede usted contarme sobre esta experiencia? ¿Cómo te sentiste? ¿Algo puede ha mejorado?

Para partos en el hospital:
¿Por qué dio a luz en el hospital (preferencia, percepción de la atención, tiempo, etc.)?

¿Alguien le acompañó al hospital? Si es así, ¿quién? ¿Qué hizo esta persona?

¿Cómo pagó por los servicios hospitalarios? ¿Tuvo apoyo financiero?

¿Quién le ayudó con el parto en el hospital? ¿Cómo? ¿Qué hicieron?

¿Quién estaba presente durante el nacimiento?

¿Puede usted contarme sobre esta experiencia? ¿Cómo te sentiste? ¿Algo puede ha mejorado?

Si el participante ha experimentado las dos configuraciones de nacimientos:
¿Usted siente que hay alguna diferencia entre las dos experiencias de parto? ¿Cómo?

¿Cuál le gusta más? ¿Por qué?

**Preguntas para Mujeres Embarazadas sobre Próximo Parto**
¿A dónde va a dar a luz? ¿Por qué?
¿A quién le va a pedir ayuda durante el parto? ¿Por qué?

**Preguntas Sobre Prácticas de Embarazo, Preferencias, y Utilización de Servicios de Salud**

¿Cómo describiría un embarazo saludable/sano (atención prenatal, la dieta, actividades, etc.) (Quechua: Buena salud: Alliku kekanki)?

¿Cómo describiría un embarazo no saludable/sano (atención prenatal, la dieta, actividades, etc.) (Quechua: Buena salud: Mana alliku kekanki/qeshyapa kunkiku)?

¿Qué se puede hacer si se está teniendo un embarazo no saludable?

¿Las mujeres son tratadas de manera diferente cuando están embarazadas (en la casa, la posta, la comunidad, etc.)?

En caso afirmativo, ¿cómo así y por qué?

¿Es peligroso estar embarazada? Sí o no ¿por qué?

¿Es peligroso dar la luz? Sí o no ¿por qué?

¿Es importante el cuidado/atención prenatal? Sí o no ¿por qué?

¿La mujer cuando debe buscar cuidado/atención prenatal?

¿Con qué frecuencia debe hacer visitas prenatales durante el embarazo? ¿Cuándo?

¿Es común que las mujeres en esta área reciban cuidado/atención prenatal? ¿Por qué?

¿Quién ofrece la atención prenatal (médicos, enfermeras, parteras, etc.)? ¿Qué hace?

¿Dónde se da la atención prenatal (hospitales, clínicas, en casa, etc.)?

¿Ha recibido usted atención prenatal?
En caso afirmativo, ¿por qué buscó cuidado prenatal?

En caso afirmativo, ¿qué hace el ________ (medico, enfermera, etc.)? ¿Cuántas veces ha ido?

Si no, ¿por qué no busco cuidado prenatal?

¿Es importante que después del parto te cuides? ¿Es importante el cuidado después de dar a luz? Sí o no ¿por qué?

¿Ha recibido cuidado después del parto (incluyendo con familiares)?
   En caso afirmativo, ¿con quien, dónde, y por qué?

En caso afirmativo, ¿Qué paso durante este chequeo o el cuidado?

¿Cuáles son los problemas o las complicaciones más comunes durante el embarazo?

¿Cuáles son los problemas o las complicaciones más comunes durante el parto?

¿Generalmente, las mujeres dónde dan a luz y con quién? ¿Por qué?

¿Dónde prefiere usted dar a luz? ¿Por qué?

¿Cuando es necesario ir al hospital para dar la luz?

¿Tiene usted experiencias o algún caso particular, o ocurrencia sobre salud maternal que le gustaría compartir conmigo? No es necesario incluir ninguna información personal, como nombres.
Appendix II: Provider’s Interview Guide

**Demografía**

Género __________  Idiomas Que Habla __________
Residencia Actual __________  Lugar donde Nació __________  Años de practica __________

Si es de otro lugar, ¿por qué decidió trabajar en Carhuaz (familia, las necesidades locales, etc.)?

**Preguntas Sobre Prácticas de Embarazo, Preferencias y Utilización de Servicios de Salud**

En esta región, ¿cual es los problemas más comunes asociados con la salud maternal?

¿Cómo describiría un embarazo saludable/sano (atención prenatal, la dieta, actividades, etc.)?

¿Cómo describiría un embarazo no saludable/sano (atención prenatal, la dieta, actividades, etc.)?

¿Ofrece usted atención prenatal?
   En caso afirmativo, ¿puede describir lo que hace durante las visitas prenatales y con qué frecuencia las tiene?

¿Es común que las mujeres en _____ reciban atención prenatal?

¿Cómo le compensan o le pagan por sus servicios?

¿Es peligroso estar embarazada? ¿Por qué o por qué no?

¿Es peligroso dar la luz? ¿Por qué o por qué no?

¿Cuáles son los problemas o las complicaciones más comunes durante el embarazo?

¿Cuáles son los problemas o las complicaciones más comunes durante el parto?

¿Generalmente, dónde mujeres dan a luz? ¿Por qué?

¿Dónde prefiere usted las mujeres dan a luz? ¿Por qué?
¿Cree usted que las mujeres a las que ofrece cuidado siguen sus consejos? ¿Por qué o por qué no?

¿Cree usted que las mujeres confían en usted y los servicios que ofrece? ¿Por qué o por qué no?

Si es proveedor biomédico:
   ¿Puede contarme sobre las practicas del parto en el hospital? (Incluye cuidado después del parto)

   ¿Por qué cree que algunas mujeres dan a luz fuera del hospital?

   ¿Qué piensa usted de las parteras? Parteras capacitadas?

   ¿Alguna vez ha trabajado con este tipo de proveedores? ¿Cómo son diferentes los servicios que usted ofrece y los que ofrecen las parteras?

Si es proveedor tradicional:
   ¿Puede contarme sobre las practicas del parto con ud.? (Incluye cuidad después del parto)

   ¿Por qué crees que algunas mujeres dan a luz en el hospital?

   ¿Qué piensa usted de los obstetricias / ginecólogos?

   ¿Alguna vez ha trabajado con este tipo de proveedores? ¿Cómo son diferentes los servicios que usted ofrece y los que ofrecen los obstetras?

¿Qué cree usted que está contribuyendo a los riesgos de mortalidad maternal en esta área?

¿Tiene usted experiencias o casos particulares u ocurrencias sobre salud maternal que le gustaría compartir conmigo?
Appendix III: Social Worker’s Interview Guide

Demografía
Género ___________ Idiomas Que Habla ___________ Años en Trabajo ___________
Residencia Actual ___________ Lugar donde Nació ___________
Si es de otro lugar, ¿por qué decidió trabajar en Carhuaz (familia, las necesidades locales, etc.)?

¿Qué se dedica? ¿Qué son sus responsabilidades?

Preguntas Sobre Prácticas de Embarazo
En esta región, ¿cuáles son los problemas más comunes asociados con la salud maternal?

¿Es peligroso estar embarazada? ¿Por qué o por qué no?

¿Cuáles son los problemas o las complicaciones más comunes durante el embarazo?

¿Cuáles son los problemas o las complicaciones más comunes durante el parto?

¿Generalmente, dónde mujeres dan a luz? ¿Por qué?

¿Dónde prefiere usted las mujeres dan a luz? ¿Por qué?

¿Qué cree usted que está contribuyendo a los riesgos de mortalidad maternal en esta área?

¿Cuáles son las políticas locales sobre la atención prenatal y la asistencia durante el parto?
Appendix IV: Participatory Action Research Workshop Protocol

Sesión 1 (~1 ½ horas)
1) Introducción: (~15 min.)
   • ¡Bienvenidos! Introducción del equipo, el proyecto, y el taller
   • Consentimiento informado- Voluntario y confidencial
   • Actividad para Rompehielos con Hilo

2) Actividad: Cuentas Saliente: ¿Cómo es la vida de en esta comunidad? (~40 min.)
   • Pregunta al taller, ¿Cómo es la vida de una mujer típica en esta comunidad?
     Apuntado para entender la vida de mujeres, sus experiencias (cosas que disfrutan, las preocupaciones, los problemas, etc.) (~5-10 min.)
     ○ Escribir las respuestas del taller en papel grande y discutimos
   • Forma Tres Grupos: ¿Cómo es la vida de una mujer ________ (embarazo, durante el trabajo del parto (incluye el parto), y después del parto) en esta comunidad? (15 min.)
     ○ Cada grupo trabajar en juntos para discutir su tema e identificar actividades, preocupaciones, experiencias, problemas, y otros asuntos físico, emocional, mental, y social, pertinentes a su tema. Pueden dibujar un ejemplo de un cuerpo o escribir una lista de sus ideas.
   • Una persona de cada grupo presenta la información del grupo para discutir (5-7 min. c/ grupo; total ~20 min)
     ○ Después de cada presentación, las otras mujeres discutirán los resultados del grupo para añadir otros asuntos que piensan están importante

3) Actividad: Mapas del Cuerpo (~40 min)
   • Forma Tres Grupos: ¿Cómo es un parto ________ (actualmente, en el pasado, y ideal/perfecto)? (15 min.)
     ○ Cada grupo trabajar en juntos para discutir su tema e identificar actividades, preocupaciones, y problemas física, emocional, mental, y social.
       ▪ ¿Cómo es la experiencia? ¿Dónde, quien atender, quien participar, con cuales practicas (posición, hierbas, ampollas, sobados, etc.), como prepara, que pasa después?
   • Una persona de cada grupo presenta la información del grupo para discutir (5-7 min. c/ grupo; total ~20 min)
     ○ Después de cada presentación, las otras mujeres discutirán los resultados del grupo para añadir otros asuntos que piensan están importante

4) Tarea: Piensa sobre Rutas de Recursos/Mapas de Acciones (5-10 min.)
• Preguntar a los participantes para pensar en un caso de alguien que ella conoce quién ha experimentado una complicación o un problema durante gestación o el parto. Piensa en cada paso que la mujer ha tomado para buscar una solución, quién estaba involucrado, y cuales factores estaban importante en el proceso de decisiones. Usa su cuaderno para escribir o dibujar el proceso de decisiones para compartir en la siguiente sesión. (Distribuir los cuadernos y las frutas)
• Coordinar el dato, tiempo, y ubicación de la segunda sesión. Pasar una hoja de inscripción por entrevistas.
• Pide a las mujeres para pensar en y revisar los folletos para hacer una corta evaluación en el fin de la siguiente sesión.

Sesión 2: (aprox. 1 ½ horas)
1) Introducción (10 min.)
   • ¡Bienvenidos y gracias! Hoy hablamos sobre como las mujeres pueden tomar sus propias decisiones durante gestación y el parto. Quiero decir que mi meta de estos talleres es para producir algo para uds., para mejorar sus experiencias durante gestación y el parto, y quiero aprender de uds. y sus experiencias y opiniones.
   • Revisión de los temas de la sesión anterior (10 min.)
      ○ Revisar los posters de ¿Cómo es un parto…?  ¿Qué son los problemas con o desafíos durante el parto actual?  ¿Qué cosas se pueden mejorar en la experiencia del parto?
   • Cada paso del proceso de decisiones, las personas que están involucrado, los factores que influyen, como factores económicos o sociales, y otras cosas importantes.
2) Actividad: Rutas de Recursos/Mapas de Acciones (45 min)
   • ¿Quién hizo la tarea?
   • Forma Tres/Cuatro Grupos y preguntar a las mujeres para discutir los cuentos y escoger uno para elaborar y para dibujar y exponer los pasos en un papelote. Preguntar a las mujeres a enfoque en los momentos de decisiones, cada paso, y quién y cual cosas estuvieron importante y porqué (15 min)
      ○ Cada paso del proceso de decisiones, las personas que están involucrado, los factores que influyen, como factores económicos o sociales, y otras cosas importantes.
   • Cada grupo presenta su mapa de acciones y discutir el caso y los resultados (5-7 min cada grupo)
      ○ Después de cada presentación, la investigadora va a preguntar,
         ▪ ¿Cómo podría mejorar esta situación?  ¿Quién o que cosa podría ayudar o mejorar esta situación?  Si la situación salió mal, ¿Cómo puede evitar estar resultado en el futuro?
3) Actividad: Mensajes para Mejoramiento (Distribuir la fruta) (25 min)
   • Revisar los temas de los dos sesiones y preguntar a las mujeres a pensar en esos durante la próxima actividad (5 min)
      ○ Problemas durante gestación y el parto y rutas de recursos que las mujeres tiene
   • Forma Tres Grupos y preguntar a los participantes a discutir (10 min)
      ○ ¿Qué recomendaciones da al puesto de salud y los médicos para mejorar la experiencia de embarazo y parto?
- ¿Qué recomendaciones quieren decir a otras mujeres, madres, y primerizas para tener una buena experiencia durante gestación y el parto?
  - Preguntar a cada grupo a presentar nuestro mensajes y discutimos en juntos (5 min cada grupo)

4) ¡Gracias! (10 min)
- Distribuir la compensación y diles gracias por su participación
- Voy a hacer un folleto para distribuir y voy a avisarles cuando sé la fecha por un reunión por distribución
- Inscripción por entrevistas
  - Falta 6 en Shumay
- Si recibió un folleto de nutrición, ¿puede quedar por un ratito para hacer una evaluación para mejorar los folletos?
Appendix V: Una Conversación Sobre la Gestación y el Parto

UNA CONVERSACIÓN SOBRE LA GESTACIÓN Y EL PARTO

Las Experiencias y los Conocimientos de las Mujeres y de los Trabajadores del Centro de Salud de Marcará, Shilla, y Shumay Carhuaz –Ancash - Perú
Introducción, Métodos, y Agradecimientos

La información que contiene este folleto son los conocimientos de las mujeres de Marcará, Shilla y Shumay, a través de talleres participativos, las mujeres conversaron sobre sus experiencias durante la gestación, el parto y el postparto en un ambiente de confianza para compartir y reflexionar sobre sus experiencias, perspectivas y conocimientos. En conclusión la información que contiene este folleto son las palabras de las mujeres de estas comunidades: sus pensamientos, sus preocupaciones y sus deseos.

Los 7 talleres de donde viene esta información del folleto se han realizado durante el mes de Octubre 2012. En total, 69 mujeres han participado en los talleres y cada taller tenía un mínimo de 6 participantes y un máximo de 22 participantes. Los talleres se han realizado en castellano y quechua, depende del idioma de las participantes.

Mi objetivo es, que este folleto ayude la facilitación de una conversación abierta entre las mujeres y los trabajadores de los Centros de Salud sobre los temas reproductivos en un esfuerzo de entender la mezcla de perspectivas y experiencias, y al final, crear una experiencia de gestación, parto, y postparto sano, cómodo, seguro, y bello.

Estoy muy agradecida por la ayuda de Inés Yanac León, la orientación de Dra. Patricia Hammer y la participación activa y entusiasta de las mujeres de Marcará, Shilla y Shumay.

Usurpakí Llapallaykikunata
Isabella Chan
Universidad de Florida del Sur-Estados Unidos
Correo Electrónico: Isabella1Chan@gmail.com
¿Cómo es la vida de una mujer?

Se sienten felices por tener una familia
Están preocupadas por la salud de la familia
Están preocupadas por falta de trabajo y recursos económicos
Están preocupadas por la alimentación de la familia y la producción de la chacra
Están preocupadas por la contaminación en el medio ambiente
Ellas se dedican a los que haceres de la casa: cocinan, lavan, y limpian todo los días
Ellas trabajan en la chacra y pastean a los animales
Ellas cuidan los hijos, los llevan a la escuela y a los controles, y ayudan con las tareas
Trabajan en negocios y en las tiendas
Hacen compras para la familia

“Estamos en la casa con el cuidado de los hijos, con la preparación de los alimentos, y si tenemos animales, nos dedicamos a cuidar los animales, a la crianza de animales, en los biohuertas también.” Marcará
¿Cómo es la vida de una mujer en Shilla?

- Cocinan
- Lavan
- Limpieza de la casa
- Pastura los animales
- Van a la chacra
- Desiervan el maíz
- Llevan almuerzo a los trabajadores
- Traen papa para cuy
- Van regar la chacra
- Dan comida a los chanchos
- Cuidan a sus hijos
- Llevan sus niños al centro
- Van a la Carhuaz para hacer compras (frutas, verduras)

Preocupaciones
- Para cocina
- Su educación de sus hijos
- Se enferman sus hijos, sus esposos
- Agua potable
- Cuando (a chacra) producen menos
- Agua para regar
- Una vez más hasta años

A veces venden cuy, maíz, 
Papa (que tenemos) en la Carhuaz (feria) 
y con esto dinero compra frutas, verduras 
y lo que falta

Arriba: Una imagen del papelógrafo de un taller en Shilla.
¿Cómo es la experiencia de gestación?

Las mujeres se sienten, emocionadas, sensibles, cansadas, pesadas y gorditas, y renegonas.
Las mujeres tienen algunos problemas de vómitos, náuseas, sueño, hinchazones, infecciones urinarias, presión alta.
Las mujeres se preocupan sobre el desarrollo del niño
Se alimentan bien, saludable, y adecuadamente
Sienten las pataditas y escuchan los latidos del bebé
Algunas mujeres tienen vergüenza de tener hijos seguidos
Las mujeres quieren amistad y apoyo, especialmente por los cambios físicos y psicológicos.

“Durante el embarazo como que estamos sufriendo esos cambios tanto físicos, psicológicos, entonces, el mismo hecho hace que de repente no podemos hacer las cosas como antes hacíamos normalmente. Las personas que nos ayudaban en mi caso era mi esposo, mi mamá.” Marcará

“Tiene que alimentarse adecuadamente desde el primer mes hasta los 9 meses” Shumay

“Creo que a la mayoría de todas lo que nos ha pasado es que nos da mucho sueño, el otro es las náuseas y los vómitos” Marcará
“Todo los embarazos no son iguales.” Marcará

“Cuando estaba embarazada, le hablaba a mi hijito y hacia esto, me hacía así y era una emoción.” Shumay

“Eso [infección urinaria] nos curan en el centro de salud.” Shilla

“Mis pies y mi cara estaban hinchados... y una señora me dijo, tómate haciendo hervir el maíz negro, chicha morada, eso me tomé y me bajó el hinchazón.” Shilla

Arriba: Una imagen del papelógrafo de un taller en Marcará
¿Cómo es la experiencia del parto?
Las mujeres sienten muchos dolores
Están nerviosas, asustadas, y preocupadas por el bebe
Tienen vergüenza al momento del parto
A veces falta privacidad en los instituciones
Algunas se ubica en una posición incómodo
Tienen miedo de la cesárea y corte vaginal
Se sienten felices al tener sus bebes sanos
Hay muchas cosas nuevas y desconocidas- sueros, ampollas, cortas
Algunas han experimentado casos que le gritaban y pegaban
Se sienten solas sin alguien de confianza en su lado
Quieren más información y orientación

“Sientes muchos nervios y vergüenza porque en ese momento te quitan toda la ropa, te ponen en una posición que no quisiera recordar.” Marcará

“Sentí muchos nervios, porque era mi primera hija, claro que sentí los dolores, me habían dicho que iba a tener un parto normal, no habían preparado para una cesárea.” Marcará

“Cuando estuve en el hospital, una mujer le dijo, ‘enfermera, ayúdame,’ y la enfermera le dijo, ‘aprende para eso has abierto las piernas, aprende carajo, así se fue volteándose.’” Shilla
“A mí me trató bien una enfermera, hasta sobó mis pies, mis manos.” Shilla

“Un mal trato te dan, más que todo en el hospital, a mí también me han tratado mal, pero de lo que yo veía cuando las demás chicas gritaban, se desesperaban por el dolor, hasta han llegado dar sus cachetadones cuando he estado viendo, dicen cállense, hasta te insultan, dicen para eso has querido, para eso has tenido tu marido, tu esposo, para eso has abierto las piernas para que estés así, ¡aguanta! Y puja y casi te pegan.” Marcará

“Cuando das a luz en una clínica están sus esposos, sus mamás, o personas que uno quiere que esté a su lado al momento de dar a luz, pero creo que la gran mayoría de nosotras nos hemos atendido en el hospital, en el centro de salud, entonces no pueden ingresar ninguno de nuestros familiares.” Shumay

“Ahora, nosotras estamos obligadas a ir al centro de salud porque hay una multa.” Shumay

“Ahora quieren que paguemos 200 soles por dar la luz en casa. A una señora que ha dado la luz en su casa le han cortado el programa Juntos.” Shilla
“Después nos damos cuenta, te cortan al momento cuando no puedes dar a luz.” Marcará

“Las enfermeras no respetan la intimidad de una mujer... por eso yo decía me da vergüenza y nunca más regresaría.” Marcará

“En el hospital estas tirado, abierto tus piernas, por eso tenemos vergüenza. Con vergüenza no puedes dar a luz.” Shilla

“La causa de la pérdida de su hijito fue por el quiste, cosa que a los tres meses no le diagnosticaron, no le dijeron que tenía un quiste.” Marcará

“En la posta dicen si nosotras queremos, podemos llevar nuestra partera.” Shilla
Arriba: un mapa de acción sobre el problema de presión alta y su cuidado en la posta y en su casa
¿Cómo es un parto ideal?

Con apoyo, respeto, privacidad y cariño de las personas que atienden
Un ambiente adecuado y seguro
Contacto inmediato con el bebé
La presencia y apoyo del esposo, la mamá, u otra persona de confianza
Parto normal, sin cortes

“Lo ideal del parto debe ser en el hospital, porque te sientes segura que te va a atender el médico o el obstetra enfermera mayormente, porque el médico va siempre en cuando lo comunican van, no está presente. En el hospital tienen el equipo necesario para que te atiendan, tienes que ir al hospital junto con un familiar o pareja... El ambiente no es adecuado, pero se acude por seguridad.” Shumay

“En un centro de salud, ya sea en una posta o en una clínica, ya sea un médico, una enfermera, una obstetra, y los demás que te den un buen trato, que respeten tu intimidad. También que te traten bien, no como vemos que en los hospitales que te maltratan físicamente y también emocionalmente en vez de darte un apoyo, ellos tratan de insultarte para hacerte sentir mal y a parte de eso que te dejen hacer entrar a un familiar o alguien que tú tengas de tu confianza.” Marcará
“Para mí, sería mejor en casa, más tranquilo, sin vergüenza. En el hospital hay muchas personas.” Shilla

“En el hospital, cuando dices, ‘ay,’ nadie te agarra, en cambio, en la casa, tu mamá o tu esposo te agarran.” Shilla

Arriba: Una imagen del papelógrafo de un taller en Shumay
¿Cómo es la experiencia después del parto?

Las mujeres se sienten contentas, aliviadas, y débiles
Las mujeres tienen sueño, sed, y hambre
Ellas sienten la gran responsabilidad de tener hijos
Están alegras al lactar a sus bebes
Tienen que recuperar y descansar por 15-30 días, sino les puede agarrar el sobreparto.
Evitan agua fría, el aire, demasiado sol, y comidas pesadas
Van al control postparto y los controles del hijo
Cuidarse tener relaciones sexuales

“Después del parto, después del dolor que todo ha pasado, después que haya nacido tu hijito, te sientes contenta, sientes que quieres verlo a tu bebe, quieres que lo traigan, porque no sabes todavía cómo es su rostro.” Marcará

“Una mujer que tiene un hijo piensa que es una gran responsabilidad, también se ve el cambio físico... vas a lactar por primera vez al bebé, todo el pecho se cuelga, durante un mes es cuidado por su pareja o familia o algunas que buscan su empleada porque es necesario.” Shumay

“Tiene que cuidarse, no tener relaciones sexuales por dos meses, cuarenta días.” Shumay
“Te sientes débil, después del parto sientes esa sensación de estar débil, te da sueño, sed, no sé, tantas cosas. Entonces, para recuperar esto tienes que alimentarte bien. La mayoría después del parto, a todas también nuestras mamas o nuestras suegras siempre nos ayudan, porque nosotras mismas no estamos en la capacidad de hacer o preparar nuestros alimentos. Entonces, hay alguien que siempre nos prepara un buen caldo, como dicen el levantamuertos. Te tomas un caldo y te sientes un poco más reconfortada. Después, tienes que descansar, pero acá la costumbre de descansar es durante 15 o 30 días no tenemos que tocar agua fría, nos cuidan de esto, solamente lavarnos la mano con agua caliente o tibia y para bañarse, se usa hierbas... así no te pase sobreparto.” Marcará

“Nos sentimos felices, alegres lactamos a nuestro bebés, nuestras comidas es dieta, no más.” Shilla

“Cuando nace el bebe ellas se sienten aliviadas porque ya no hay nada en el vientre, todas las mujeres se quedan débiles y deben alimentarse para recuperarse. No hay ni una mujer que pueda quedar bien, porque traer un hijo en este mundo no es fácil. No realiza actividades mínimo un mes, tiene que cuidarse todavía.” Shumay
“El sobreparto es una enfermedad que te da escalofríos, te sientes mal, para eso, para el baño es especialmente esto, pero bañarse, lavarse con agua tibia, nada más.” Marcará

“Así no más es, nos cuidamos un mes, no tocamos agua fría, no cocinamos, no salimos de casa.” Shilla

“Incluso en el hospital tienes que bañarte. Ellos no ven el sobreparto. Ellos no creen en eso.” Shumay

“Todo nos dan en el hospital, pero en nuestra casa no comemos así. Comemos todo suave.” Shilla

“Después de dar luz a los 7 días vamos a nuestros controles, para que vean si ya bajó toda la sangre acumulada, si estamos bien o no, nos revisan.” Marcará
Mapas de Acción

El EMORAFÍA Después del Parto

Después de haber nacido el bebé, me sobornaron el estómago y hubo una fuerte emorafía. La obstetra y con eso salió el quiste al médico me ayudaron a controlar la emorafía y luego me pusieron suero y una unidad de sangre y fui en Centro de Salud.

Arriba: un mapa de acción sobre hemorragia después del parto. Ella va al Centro de Salud.
Arriba: Mapa de Acciones
Arriba: Mapa de Acciones
Mensajes de las Mujeres para los Trabajadores de Salud y MINSA

“No hacer esperar mucho, atender con rapidez. Si es gestante o un niño, tratar con mucho cuidado”
Marcara

“Que nos atiendan con paciencia y voluntad.”
Shumay

“Nos preparen para el parto... Si nos dicen tú vas a tener un parto por cesárea, que nos expliquen cómo va a ser. A veces al momento nos llevan y nosotras no sabemos, cómo va a ser si llevamos dinero o cómo vamos estar que nos preparen.” Marcará

“En el hospital de Carhuaz, de noche no hay doctor, sólo nos dejan con la enfermera. Aquí en Shilla no hay ni doctor, también de noche en Shilla no hay ni técnicos.” Shilla

“No estar chismoseando con los practicantes.”
Shumay

“Quisiera una obstetra amable, que nos atienda de una buena manera.” Shumay
“Quisiera una atención mejor, porque no nos atienden rápido en nuestro control.” Shumay

“A las mujeres embarazadas nos deben atender más rápido, mucho nos hacen esperar.” Shilla

Arriba: un mapa de acción que trata problemas comunes durante embarazo
Mensajes de las Mujeres para las Primerizas, Madres, y Para Sus Familias

“Cuando sufren de presión alta, no consumir azúcar, sal en exceso, nada de golosinas ni café. Siempre cuando les duele algo o se sienten mal, acudir a la posta en sus controles puntuales.” Marcará

“Siempre irnos a nuestro control puntualmente, porque en nuestros controles sabemos si el bebé se está desarrollando bien.” Marcará

“A veces por vergüenza las mamás o nosotras no avisamos a la obstetra, al doctor que es lo que estamos sintiendo. Decirle todo lo que sentimos, nuestros síntomas, cualquier cosita o detalle decirle.” Marcará

“Siempre en algunos de nuestros controles que nos acompañen nuestros esposos, porque a veces cuando tenemos alguna molestia o algún problema, a nuestro esposos no les importa a veces. Es necesario que nuestros esposos también sepan cómo es lo que nos vamos a cuidar.” Marcará
“Mamitas, alimentarse bien para tener hijitos y hijitas sanos y fuertes. Durante el embarazo debemos de alimentarnos bien y también después, más todavía porque vamos a lactar a nuestros hijos.” Marcará

“Después de dar luz, depende mucho ya de nosotras, cuidarnos bastante para que no nos dé el sobreparto.” Marcará

“Una mujer debe caminar y hacer ejercicios cuando está gestando.” Shumay

“Durante el parto, no desesperarse ni gritar mucho para no perder energía.” Shumay

“Después del parto cuidarse. No tocar agua fría y bañarse con diversas hierbas medicinales para evitar el sobreparto.” Shumay

“Una mujer embarazada debe alimentarse bien, balanceado para que crezca el bebé y para tener fuerza. Debe comer más frutas y verduras.” Shilla

“Aconsejaríamos a las mujeres embarazadas para que no se dejen maltratar por sus esposos.” Shilla
Mensajes de los Trabajadores de Salud

SEÑALES DE ALARMA DURANTE EL EMBARAZO

Hinchazón  Vómitos Exagerados

El Bebé no se mueve  Hemorragia

¡¡CUIDADO!!
PUEDE SER PELIGROSO
ACUDE RÁPIDO AL ESTABLECIMIENTO DE SALUD MAS CERCANO
RECUERDA

1. El embarazo es un proceso que debes compartir con tu pareja y tu familia.

2. Acude al Establecimiento de Salud desde el Primer mes del embarazo y solicita la prueba de Sífilis y VIH.

3. Si tienes VIH o sífilis debes recibir tratamiento de inmediato para evitar transmitirlo a tu bebé.

4. Reconoce las complicaciones que se pueden presentar durante el embarazo y solicita ayuda de inmediato.

5. Planea la atención de tu parto en un Establecimiento de Salud. Tu bienestar y el de tu bebé es importante.

"Por una Maternidad Saludable y Segura: Planifica tu Embarazo"
Las Experiencias y los Conocimientos de las Mujeres y de los Trabajadores del Centro de Salud de Marcará, Shilla Carhuaz – Ancash – Perú
Appendix VI: Institutional Review Board Approval Letter

June 5, 2012

Isabella Chan, B.A.
Anthropology
14607 N 43rd St. Apt. 22
Tampa, FL 33612

RE: Expedited Approval for Initial Review
IRB#: Pro00007619
Title: The Political Economy of Maternal Mortality in a Medically Pluralistic Community: A Case Study in the Callejón de Huaylas, Peru

Dear Ms. Chan:

On 6/5/2012 the Institutional Review Board (IRB) reviewed and APPROVED the above referenced protocol, Please note that your approval for this study will expire on 6/5/2013.

Approved Items:
 Protocol Document:
 Chan-eIRB Protocol-MMR in Peru

Consent Documents:
ICF-BioMedPractitioner-English.doc.pdf
ICF-BioMedPractitioner-Spanish_2.docx.pdf
ICF-BioMedWomen-Spanish_2.docx.pdf
ICF-MoHOfficial-English.doc.pdf
ICF-MoHOfficial-Spanish_2.docx.pdf
ICF-TradMedPractitioner-English.doc.pdf
ICF-TradMedPractitioner-Spanish_2.docx.pdf
ICF-TradMedWomen-English.doc.pdf
ICF-TradMedWomen-Spanish_2.docx.pdf

Please use only the official, IRB- stamped consent/assent document(s) found under the "Attachment Tab" in the recruitment of participants. Please note that these documents (the consent/assent documents to be signed by participants) are only valid during the approval period.
indicated on the stamped document. If you have been granted a Waiver of Informed Consent Documentation you do not need your document IRB-stamped.

Your study qualifies for a waiver of the requirements for the documentation of informed consent (for illiterate and Quechua speaking subjects) as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) that the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) that the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

[Signature]

John A. Schinka, Ph.D., Chairperson
USF Institutional Review Board