DELIVERING THE NATION, RAISING THE STATE: GENDER, CHILDBIRTH AND THE "INDIAN PROBLEM" IN BOLIVIA'S OBSTETRIC MOVEMENT, 1900-1982

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For my mother, Nadine R. Bayer, and grandmother, Nadine S. Bayer

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ABSTRACT

In Bolivia, indigenous women's desires to give birth in an atmosphere of respect and cultural autonomy, as well as physicians' and politicians' attempts to mold the nation along racial lines, shaped the development of obstetric medicine. Based on oral histories of midwives, nurses and obstetricians, this study uses midwifery as a lens to examine the connections between nation-state formation and the development of obstetric medicine in Bolivia between 1900 and 1982. Putting midwives at the center of a study about nation-state formation reveals complexities that many male-centered studies miss: indigenous, mixed-race, and white Bolivian women played central roles in state projects and, through their embodiment of different forms of womanhood, influenced debates about Bolivian national identity. This study also engages groundbreaking feminist studies of the 1970s and '80s which showed that U.S. and European male physicians created obstetric medicine by pushing female midwives out of the practice. These physicians typically accused midwives of ineptitude and defined childbirth assistance as a scientific medical procedure that should not be practiced by women. While that pattern holds true in Bolivia to some extent, it does not explain the power dynamics that shaped childbirth assistance in Bolivia. Over the course of the twentieth century, Bolivian physician's desires to modernize childbirth assistance and childrearing practices intertwined with the efforts of Bolivia's elite to overcome what they considered the country's "Indian Problem."

INTRODUCTION

The Obstetric Movement in Bolivia: Gender, Race, Birth and the Nation-State

My mother was a midwife [partera] and I learned to attend births from her. We have always lived in El Alto, but she also traveled to attend women in other places, like I do now. When I was 15, my mother started forcing me to come with her when she went to attend a birth. That's how I learned. I watched how she measured the dilation with three fingers, how she used string from wheat sacks that she later soaked in alcohol to tie off the umbilical cord. Otherwise, she would use glass because the people in those days had the belief that if you cut the umbilical cord with metal, the child would be poor. Some people still have those beliefs, and we respect them. She had the women drink oregano tea with oil in it to heat the body and make the baby slippery. She showed me how to insert my hand and gently twist and pull the placenta if it didn't release on its own. She said it was important to keep the mother warm because after the birth, they say the pores are very open and if the mother gets cold, she will get sick with *sobreparto.* Another thing is knowing when the baby will be born. You have to feel the vein on the wrist and watch it. It gets really pale and moves a lot. When the baby is about to be born, it almost disappears, it almost becomes dry and hard for some women, and the heart beats very slowly.

In 1982, when I was 21 years old, a couple of men from Holland arrived at the Dutch hospital. It used to be called the 20th of October Hospital. They trained us how to attend "clean births" and complicated births. They even trained us within the hospitals in El Alto and in Miraflores [in La Paz]. They sent us to study and attend births right alongside the doctors. After that we received our certification to attend births. Since then, the other parteras and I have saved a lot of lives. We've worked as intermediaries between the señoras and the doctors. Some women are very closed off. "They're going to cut me open," they say to me. "They're going to put their hand inside me. It's cold in the hospital and I'm going to get sick from it. I'm going to be good for nothing after I go to the hospital, and I have children to take care of." Sometimes it's the family that doesn't want the woman to go to the hospital. Since the training, I always try to convince the women to go to the hospital if they have a lot of swelling or when their blood pressure rises. Sometimes the women surprise us though. They escape from the hospital after they learn that they have been scheduled for a cesarean, and they come to us. Then we don't have any choice but to attend them, even if they have placenta previa or the babies are in breech position.

These days, some doctors refuse to work with us parteras. They don't value us. Sometimes they kick us out of the hospital if we bring in a señora with complications. They say to the parturient, "How could you go to a partera? Here there are doctors!" That's why we are talking to the Ministry of Health about this, so that we are able to enter the hospital, to explain to the doctors what has been happening. We're going to the Ministry of Health to get them to work with us.

-Ana Choque de López, traditional midwife (partera) from El Alto, Bolivia, 2012

The professional experiences that Ana Choque de López shared with me in 2012 highlight the connections between race, gender, obstetric medicine, and the nation-state that I explore in this study. In many ways, her story touches on problems that have persisted throughout the twentieth century. Her complaint that physicians do not value the work of parteras reflects tensions between "traditional" and "western" medicine that would have been familiar to parteras of her great-grandmother's generation.[1] Yet, in other ways, Choque de López's story points to the ways in which the politics of childbirth have changed in Bolivia. Throughout most of the twentieth century, parteras avoided interactions both with physicians and with state health authorities. In contrast, Choque de López and other parteras turned to the Ministry of Health to mediate their professional conflicts with doctors, a decision that points both to the new position that indigenous culture holds within the Bolivian nation, and to the political power that indigenous people now wield within the state. In recent years, parteras like Choque de López, who, like many urban indigenous women, dress in *pollera* skirts and shawls with bowler hats, have enjoyed unprecedented political support from the government of Evo

[1] I use the terms "western medicine" and "biomedicine" interchangeably throughout this study, despite their imprecision. Cunningham and Andrews define western medicine as a cultural product of Western Europe. According to this definition, knowledge produced in hospitals and laboratories empowers physicians to act with absolute authority in the care of their patients. See Andrew Cunningham and Bridie Andrews, "Introduction: Western Medicine as Contested Knowledge," *Western Medicine as Contested Knowledge* (Manchester and New York: Manchester University Press, 1997), 1-23. This definition fits the Bolivian context in the early-twentieth century as much as in later decades, because Bolivian physicians used European medicine and science as the model for their own profession and for the type of medical care system they hoped to create in their country. Alternatively, in his anthropological work on medicine and healing in Bolivia during second half of the twentieth century, Joseph Bastien has employed the term "biomedicine" to refer to medicine practiced by doctors and based on microbiology. See his *Drum and Stethoscope: Integrating Ethnomedicine and Biomedicine* (Salt Lake City: University of Utah Press, 1992), xi. Both of these definitions are imperfect, particularly in a study that covers a period of time in which the type of medical care in question (obstetric care) changed dramatically. I also use the terms "traditional," "Andean," and "indigenous" medicine to talk about the type of healing methods employed by indigenous midwives. These terms are equally imprecise, both because methods differ across the Andes and into the valleys and lowlands of Bolivia, and because "traditional" healing knowledge and practices have changed over time and blended with "western medicine." On the Kallawaya and Andean healing ideologies, see Joseph Bastien, *Healers of the Andes: Kallawaya Herbalists and their Medicinal Plants* (Salt Lake City, Utah: University of Utah Press, 1987). On medical pluralism and the challenges of defining different medical systems, see Libbet Crandon-Malamud, *Social Change, Political Process, and Medical Pluralism in Bolivia* (Berkeley, CA: University of California Press, 1991), especially chapter one.

Morales and the party behind his presidency, *Movimiento al Socialismo* (MAS). Elected for the first time in 2001, MAS immediately set out to restructure Bolivian society in order to create a "plurinational" identity that both celebrates and politically empowers the country's historically subjugated indigenous population.

This dissertation explores competitions for control of childbirth assistance and childrearing in Bolivia by focusing on what I call the "obstetric movement": a transnational campaign waged by physicians in order to win professional control over childbirth and maternal-infant care. As an analytical lens, the obstetric movement emphasizes the ways in which social and political concerns—more than "objective" scientific developments—shaped the care received by women during childbirth and the advice on childrearing given to them afterwards. The four body chapters of this study move chronologically through the twentieth century and link shifts in the obstetric movement at different times to larger social and political concerns. I argue that struggles for control of childbirth and childrearing were inseparable from processes of state formation and nation-building in Bolivia during the twentieth century.

One goal of this study is to underscore Bolivian women's central position in the processes of state formation and nation-building. Many historical studies of twentieth century Bolivia have frequently focused on masculine sites of action and activism, such as political parties, insurgencies, and unionism.[2] This study provides a complementary perspective to such scholarship by drawing attention to midwives, nurses, and mothers who implemented state

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[2] James Dunkerley, *Rebellion in the Veins: Political Struggle in Bolivia, 1952-1982* (London: Verso, 1982). *We Eat the Mines and the Mines Eat Us: Dependency and Exploitation in the Bolivian Tin Mines.* New York: Columbia University Press, 1979. June Nash, *I Spent my Life in the Mines: The Story of Juan Rojas, Bolivian Tin Miner* (New York: Columbia University Press, 1992). Laura Gotkowitz, *A Revolution for Our Rights: Indigenous Struggles for Land and Justice in Bolivia, 1880-1952* (Durham and London: Duke University Press, 2007). Silvia Rivera Cusicanqui, *Oprimidos pero no vencidos: luchas del campesinado aymara y qhechwa de Bolivia, 1900-1980* (La Paz: HISBOL/ CSUTCB, 1984). Thomas Sinclair, *We Alone Will Rule: Native Andean Politics in the Age of Insurgency* (Madison, WI: University of Wisconsin Press, 2002).

policies through their work and supported and rejected state interventions through their choices about birthing and mothering. Ultimately, women shaped the state even as state programs targeted them for reform. At the same time, women's actions structured the very meaning of Bolivian womanhood in ways that male physicians and politicians did not always intend. While physicians and public health officials subjected women to scrutiny as they searched for ways to craft a new national image, women embodied competing visions of national womanhood as midwives, nurses, and mothers.

A second goal of this study is to demonstrate that in Bolivia, both race and gender shaped the growth of obstetric medicine. Whereas many scholars have examined childbirth assistance from feminist and gender perspectives, Bolivia's history of racial division and tension highlights the ways in which obstetric medicine and midwifery can both construct and reshape racial hierarchies.[3] In Bolivia, conflicting vision of the nation in racial terms played out through struggles for control of childbirth assistance and childrearing. Bolivian elites' perspectives on what the early twentieth-century white, ruling class called "the Indian Problem" changed over the course of the century, but a primary goal of all elite-led efforts to expand western medical practices of childbirth and childrearing was to transform the indigenous population to meet the economic, political, and social goals of the state. In response, indigenous mothers and their families asserted their cultural autonomy through child birthing and rearing practices.

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[3] Barbara Ehrenreich and Deirdre English, *For Her Own Good: Two Centuries of Medical Experts' Advice to Women* (New York: Random House, 2005). Ann Oakley, *Captured Womb: A History of the Medical Care of Pregnant Women* (New York: Basil Blackwell Publisher, 1984). Jean Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth* (New Barnet, England: Historical Publications, 1977). María Soledad Zárate, *Dar a luz en Chile, siglo XI*X: *De la "ciencia de hembra" a la ciencia obstétrica.* (Santiago, Chile: Colección Sociedad y Cultura, 2007). Kristen Ruggiero, "Honor, Maternity, and the Disciplining of Women: Infanticide In Late Nineteenth-Century Buenos Aires." HAHR. 72, no 3 (1992): 353-373. Maria Lucia de Barros Mott, "Madame Durocher, modista e parteira," *Estudos Feministas* 2, no. 1 (1994): 101-116. B

The oral histories I use in this study provide insights into midwives' and mothers' reactions to the obstetric movement that are difficult, if not impossible, to glean from archival sources. Several decades of debates about the authority of oral histories have drawn attention to their inherent subjectivity.[4] Memories fade and change in accordance with the memories of friends and family members, and current circumstances change subjects' feelings about the past.[5] The interviewer also alters the stories that interviewees tell, as historian Daniel James demonstrated in his book *Doña María's Story*.[6] The questions I posed when I interviewed obstetricians, nurses, university-educated midwives and indigenous midwives, like Ana Choque de López, naturally shaped their responses. As James's work suggests, even my presence transformed the way they told the stories of their lives as well as how they presented their professional experiences and methods. And yet, the very subjectivity of oral histories also makes them a rich source for analyzing what obstetric medical practices, traditional birthing techniques and state-led health programs meant to the people they touched. By putting the oral histories of Bolivian midwives, nurses and physicians in conversation with written histories of state-run health programs, Bolivian medical research, and international health initiatives, I draw attention to both the top-down flow of scientific discourses from international agencies and Bolivian physicians and the bottom-up resistance against, and interpretations of, official regulations and programs.

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[4] Alistair Thomson, "Four Paradigm Transformations in Oral History," *The Oral History Review* 34, no. 1 (2007): 49-70.

[5] Historian Carrie Hamilton uses the subjectivity of oral histories as a way to examine the way people's gender identities shaped their memories of the Cuban revolution. See her *Sexual Revolutions in Cuba* (University of North Carolina Press, 2014).

[6] Daniel James, *Doña María's Story: Life History, Memory, and Political Identity* (Durham and London: Duke University Press, 2000). See the third section of his book, "Listening in the Cold: The Practice of Oral History in an Argentine Meatpacking Community."

In examining the social relations and political interests at the base of physicians' purportedly objective, scientific claims of professional superiority, I situate this study within the body of scholarship that historian Diego Armus calls the "New History of Medicine."[7] Turning away from celebratory histories of medical advances and heroic physicians, new histories of medicine and science have sought to understand the broader social and political contexts and consequences of disease diagnoses and treatments. An important contribution of historians of medicine has been to question the objectivity of science, as Nancy Leys Stepan did in her path-breaking study of eugenics in Latin America.[8] As historians Ann Zulawski and Julia Rodríguez write, Stepan's interrogation of the connections between political and social life, medical professionalization and science have deepened our understanding of "some of the biggest themes in Latin American history: the consolidation of state power, the construction of national ideologies, the hardening and softening of racial schemes and gender expectations."[9] As an analytical lens, the obstetric movement serves as an entry point into precisely those four themes.

This dissertation begins in 1900 with the consolidation of a liberal government in La Paz and concludes in 1982 with the end of an eighteen-year period of military governance. This long view brings into focus the changing political objectives that have shaped childbirth assistance and maternal infant care in Bolivia throughout the twentieth century. Under the positivist motto of "order and progress," the liberal government supported urban beautification and modernization, including the construction of new hospitals, and promoted secular education,

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[7] Diego Armus, "Disease in the Historiography of Modern Latin America," in *Disease in the History of Modern Latin America: From Malaria to AIDS,* ed. Diego Armus (Durham and London: Duke University Press, 2003), 1-24.

[8] Nancy Stepan, *The Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca and London: Cornell University Press, 1991).

[9] Julia Rodríguez and Ann Zulawski, "Science and Medicine in Latin America," *Hispanic American Historical Review* 91, no. 3 (August 2011): 387-389.

which bolstered the medical profession. Bolivia's devastating loss to Paraguay in the Chaco War (1932-1935) led the country's small cohort of professionals, intellectuals and students as well as veterans of the war to demand changes to the existing social and political order. Proposals championed by the new political leaders of the "Chaco Generation" sought to remedy the glaring race-based divisions that they felt weakened the nation. The post-war political climate directed the attention of a newly politicized medical profession to the health, birthing, and parenting practices of indigenous families. The short-lived government of Villarroel (1943-1946) and the National Revolutionary Movement (MNR, 1952-1964) carried the values of the Chaco Generation forward in number of ways: they worked to restructure the existing political order by weakening the power of the landed and mine-owning elite and incorporate indigenous people into political life while extending greater protections for rural and urban workers. But examining public maternal infant-care programs and childbirth assistance during this period both reveals the limitations of the state under Villarroel and the MNR and highlights indigenous resistance to MNR's assimilationist mission. The MNR government came to an end in 1964 with a coup that marked the beginning of eighteen years of military-headed governments. The regime of General Hugo Banzer (1971-1978) was one of the most repressive periods in Bolivian history for indigenous peasants and middle-class political dissidents alike. And yet, the Banzer dictatorship also fostered formal collaboration between traditional and western medicine that empowered indigenous mothers and midwives in new ways. In short, both directly and indirectly, major political events have shaped childbirth assistance and maternal-infant care in Bolivia over the course of the twentieth century.

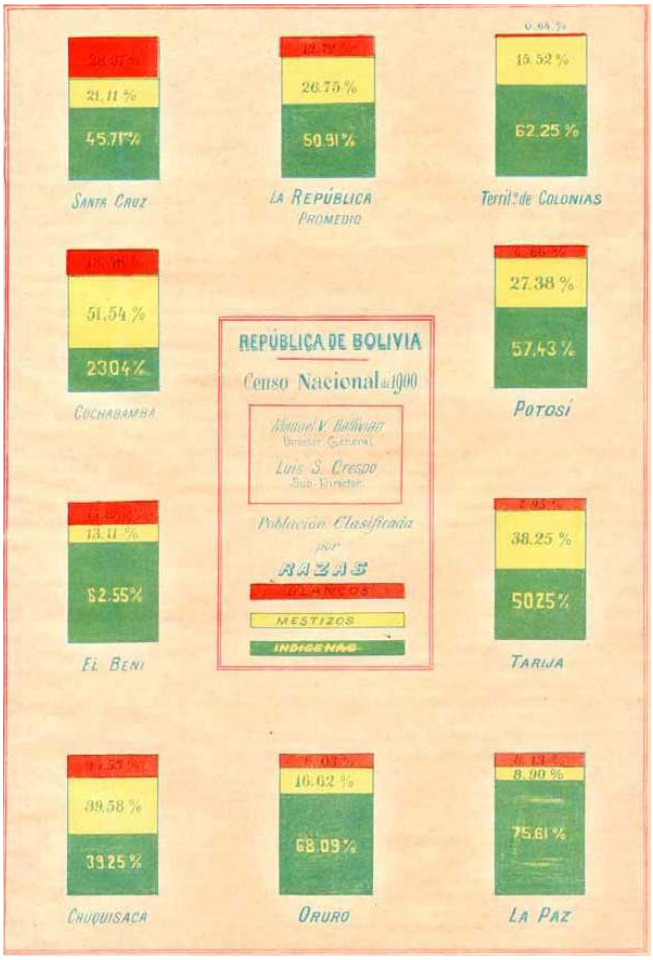

Figure 1. Bolivian Population Categorized by Race in 1900. Oficina Nacional de Inmigración, Estadística y Propaganda Geográfica, *Censo general de la población de la República de Bolivia según el empadronamiento de 1o de Septiembre de 1900* (La Paz, Bolivia, 1904), 121.

No social history of Bolivia can ignore the importance that race-based hierarchies have played in the country since conquest. Throughout the three hundred years of Spanish colonial rule and the republican period of the nineteenth and twentieth centuries, race formed the base of a social order that infused politics and the economy. According to the 1900 census, the country's white elite comprised only 19 per cent of the population. Known as "*criollos*," these descendants of Spanish colonists and later generations of European immigrants held tremendous political and economic control over indigenous and mixed-race Bolivians. In 1900, census takers used the colonial-era fiscal category "*indio"* to categorize nearly 51 per cent of the country population as indigenous.[10] Couched in the middle of the criollos and indios, both demographically and in terms of economic power, the

[10] Oficina Nacional de Inmigración, Estadística y Propaganda Geográfica, *Censo general de la población de la República de Bolivia según el empadronamiento de 1o de Septiembre de 1900* (La Paz, Bolivia, 1904), 32. Marcia Stephenson, *Gender and Modernity in Andean Bolivia,* 2; Although historically, criollo Bolivians have controlled the wealth and political power, as Lesley Gill argues, many urban Aymara women in La Paz are as wealthy as their criollo counterparts, and express their social status through their decidedly non-western style of feminine fashion.

mixed-race, or *"mestizo,"* population totaled close to 26 per cent at the start of the twentieth century. Colorful bar graphs included in the 1900 census offered a striking visual representation of the country's race-based hierarchy: a thin sliver representing the criollo population sat atop the mestizos, in the middle, and the indigenous masses at the bottom of the graph.[11] (Figure 1)

The same year that Bolivia's National Office of Immigration, Statistics and Geographic Propaganda began the 1900 census, newly-empowered liberals transferred the executive and legislative branches of the government to La Paz, leaving the judicial branch in the old capital of Sucre. Liberals had unseated a conservative government the year before in a civil war that they won, in part, because of the military assistance they received from Aymara Indians in the highlands around La Paz. In 1899, liberal leader colonel José Manuel Pando had allied himself with the caudillo-style Aymara organizer and advocate Pablo Zárate Willka in order to overthrow the Sucre-based conservatives. Aymara communities in the highlands initially supported the liberal cause because of the party's promise to restore lands to indigenous communities. Although the alliance achieved the goal of bringing liberals to power, a simmering history of abuse and domination of indigenous peasants by criollos and mestizos quickly boiled over, pushing Zárate Willka and his troops on a path toward more radical social change. Zárate Willka was himself unable to control the anger of the indigenous peasants that he had mobilized, and in early 1899, Aymara peasants carried out a mass execution of a squadron of federalist troops in a small town southeast of La Paz. The killing of the troops, and the liberal government's response to it, sparked a new battle: instead of fighting a war for political control

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Gill, "Proper Women and City Pleasures: Gender, Class, and Contested Meaning in La Paz," *American Ethnologist* 20, no. 1 (1993): 72-88.

[11] Bolivia, Oficina Nacional de Inmigración, Estadística y Propaganda Geográfica, *Censo general de la población de la República de Bolivia según el empadronamiento de 1o de Septiembre de 1900* (La Paz: Taller Tipo-Litográfico de José M. Gamarra, 1904), 33.

against criollo conservatives, Bolivian liberals now fought a race-based battle against Aymara Indians who demanded cultural and political autonomy. Like the famous Aymara rebels Tupac Katari and Bartolina Sisa, who mounted an unsuccessful campaign against the colonial government in the late eighteenth century, the criollo army ultimately defeated the indigenous rebellion and tried and executed Zárate Willka along with 288 other Indians.[12]

Once in power, the liberal government moved forward with the positivist-inspired imperative of achieving a higher level of civilization through "order and progress." The liberal leader and president Ismael Montes oversaw a number of important modernization projects during his two presidencies (1904-1909 and 1913-1917): new railroads connected tin mining centers (the financial base of liberal power) to Peruvian ports, and the new capital received an infusion of modernity with new electrical lines, expanded access to potable water, and a new general hospital.[13]

The ways that members of the criollo elite understood race and racial difference at the start of the twentieth century both reflected their anxieties about the so-called "Indian Problem" and served to bolster their social and economic power. Since the early nineteenth century, Bolivia's elite, like elites of newly independent republics, had agreed that a central problem blocking national progress was the indigenous masses.[14] Following Social Darwinist ideas, at

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[12] Brook Larson, "Bolivia: Dangerous Pacts, Insurgent Indians," *Trials of Nation Making: Liberalism, Race, and Ethnicity in the Andes, 1810-1911* (New York: Cambridge University Press, 2004), 202-245. Laura Gotkowitz, *A Revolution for Our Rights,* 34-39. On the Tupak Katari rebellion, see Thomas Sinclair, *We Alone Will Rule: Native Andean Politics in the Age of Insurgency* (Madison, WI: University of Wisconsin Press, 2002).

[13] Zulawski, *Unequal Cures,* 25; Klein, *The Evolution of a Multi-Ethnic Society,* 169.

[14] In his "Liberalism and Ethnocide in the Southern Andes," Tristan Platt argues that indigenous Andeans' efforts to hold on to communal lands positioned them as enemies the bedrock of economic liberalism: the superiority of private property. As a result, in the Andes, the consolidation of a liberal hegemony necessitated the ethnocide of indigenous cultural traditions. Gotkowitz discusses how racial concepts influenced early twentieth-century

the beginning of the century, many elite Bolivians believed that the inferior and degenerate genes of indigenous Bolivians would simply die out, leaving Bolivia with the superior heritage of white Europeans on which to build a modern nation. In their descriptions of the country's different racial groups, for example, authors of the 1900 census stressed that contemporary Indians remained in "eternal infancy, submerged in the atrophy of stagnation, without producing any tribute to civilization, but contributing every one of them to imprint the national character that has formed within the limits that today constitute the Republic of Bolivia."[15] French and Belgian scientists, who studied indigenous Bolivians using craniometry and anthropometry, offered evidence to support such contentions by concluding that Indians were naturally suited for manual labor in fields and in the mines, but should remain excluded from politics.[16]

If many members of the early twentieth-century elite saw indigenous people, in the terms used in the census, as "capable of receiving a more perfect level of civilization," but "inherently resistant to all innovation and progress," they held an even grimmer view of mestizos.[17] In contrast to their Mexican counterparts, many Bolivian intellectuals believed that mixed-race individuals inherited the negative qualities of both races. In his popular 1909 book, *Pueblo*

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presidents of the liberal and republican parties' policies toward indigenous Bolivians, see her *A Revolution for Our Rights,* 57-62.

[15] "Sea que el hombre Americano proceda de la raza mongólica, hipótesis apoyada en la analogía de los monumentos y aún costumbres asiáticas y americanas; sea que proceda de la Atlántida, continente desaparecido en el seno del oceáno atlántico; ó bien se le considere autóctono; hipotesis que no han sido todavía resueltos satisfactoriamente; el hecho es que el suelo boliviano ha sido el teatro por donde han pasado diversos pueblos cuyas huellas encuentra el aqueólogo en las ruinas de distinto género que están esparcidas en su territorio; de estos pueblos los más han influído en su progreso, y de ellos se ocupa preferentemente la historia, permaneciendo los otros en una eternal infancia, sumidos en el marasmo del estacionamiento, sin rendir ningún tributo á la civilización, pero contribuyendo todos á imprimir carácter peculiar á la nacionalidad que se ha formado dentro de los límites que actualmente constituyen la República de Bolivia." República de Bolivia, *Censo de la población nacional. 1 de Septiembre 1900* (La Paz: Oficina de Inmigración, Estadística y Propaganda Geográfica, 1904), 25.

[16] Brook Larson, *Trials of Nation Making,* 239.

[17] República de Bolivia, *Censo de la población nacional. 1 de Septiembre 1900*, 29.

enfermo, for instance, Bolivian novelist and historian Alcides Arguedas, drew on social Darwinism, psychology, and geographic determinism to argue that mestizos were inherently violent, lazy, and disloyal, among other things.[18]

Strict biological definitions of race were not only disadvantageous for the country's mestizos, many of whom were members of the upper-class, but they also condemned the future of Bolivian society as a whole, given the large size of the indigenous population. As a result, by the 1910s, many Bolivian intellectuals and scientists rejected rigid, biologically-based ideas about race in favor of more malleable understandings that linked biological and cultural difference. Intellectuals and scientists, including Alcides Arguedas, argued that the country's Indians had degenerated because of colonial exploitation, environmental factors, and poor culture. These interpretations of racial difference left open the possibility of racial improvement without the genetic extinction of the indigenous half of the population; cultural and environmental changes could redeem Indians and mestizos alike. In step with this trend, by the 1920s, many Bolivian physicians subscribed to the French brand of genetic thought called Lamarckism, which posited that education, health care, and proper "hygiene" could correct degenerative genetic traits in the population. Hygiene included social and physical practices that went beyond sanitation to include "correct" sexual and social behavior, physical fitness, and diet.[19]

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[18] Alcides Arguedas' work is widely cited by contemporary scholars as an example of early twentieth-century racial thinking. See "Identidades indias y mestizas: Una intervención al debates," *Autodeterminación* 10 (1992): 18; Zulawski, *Unequal Cures,* 30.

[19] Donna Guy demonstrated the connections public health physicians made between hygiene, health, and morality in her investigation of prostitution and public health campaigns in late nineteenth-century Buenos Aires. See her "Venereal Disease, Public Health, and Criminality," in her *Sex and Danger in Buenos Aires: Prostitution, Family and Nation in Argentina* (Lincoln, Nebraska: University of Nebraska Press, 1991), 77-104. Similarly, Katherine Bliss argues that, in 1920s' Mexico, gender biases led doctors and reformers to place the blame for the spread of

New national political concerns and international scientific trends again altered Bolivian racial ideologies by the mid-twentieth century and influenced how the planners of the 1950 census defined racial categories. Abandoning the obsolete fiscal category of "indio" used in the previous census, in 1950, the census divided the population into two groups: indigenous and non-indigenous. Without clear guidelines for determining race, census-takers appear to have equated race with an inexact combination of factors, including occupation, place of residence, language, and dress. Officials categorized people as indigenous if they worked the land, spoke a native language, or dressed in traditional garb. As a result of this expanded definition, the 1950 census classified nearly 63 per cent of the population as indigenous (See Appendix A).[20]

On the national level, political changes spurred by Bolivia's Chaco War with Paraguay (1932-1935) forced elite Bolivians to reconsider the place of indigenous people within the nation. Instigated by Bolivian Daniel President Salamanca in an attempt to divert public attention from the 1930 economic crisis as well as to gain access to the Paraguay River, the Chaco War devolved into a two-year conflict in which 50,000 Bolivian soldiers died. Almost all of the soldiers were indigenous conscripts and most perished from dehydration and disease rather than in battle. Bolivia's loss of the war sparked outrage and protest across the country. The war cost the country a piece of its territory along with two out of every ten soldiers, and it made

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syphilis on "fallen women" who prostituted themselves, rather than on their male clients. See her "Science of Redemption: Syphilis, Sexual Promiscuity, and Reformism in Revolutionary Mexico City," *The Hispanic American Historical Review* 79, no. 1 (February 1999): 1-40. A movement to create new citizens by ensuring that children were raised hygienically was also part of the Mexican revolution, as Patience Schell argues. In this case, hygiene included physical fitness and nutritious eating. The hygiene movement also became intertwined with eugenics and puericulture. See her, "Nationalizing Children through Schools and Hygiene: Porfirian and Revolutionary Mexico City," *The Americas* 60, no. 4 (April 2004): 559-587.

[20] Eric Grieshaber, "la definición cambiante del indio en los censos bolivianos de 1900 y 1950," *Historia Boliviana* V, no. 1-2 (1985): 45-65. República de Bolivia, Ministerio de hacienda y estadística. Dirección general de estadística y censos, *Censo Demográfico, 1950* (La Paz: Editorial "Argote," 1955), 100.

visible the corruption of politics under the leadership of the *"rosca,"* the "small kernel" of land- and mining-owning families that maintained oligarchic control of the political system.[21] In response to nation-wide protest, a new political alliance of military officers and white middle-class professionals ushered in a series of "military-socialist" governments that advanced both individual and collective rights, as well as new social protections for the lower classes. At the base of this new political approach lay the new leadership's conviction that the racial division between white and indigenous Bolivians prevented the formation of a strong national identity and limited the country's progress in both economic and social terms.

This new political consensus refashioned the old "Indian Problem" and influenced the brief presidency of Colonel Gualberto Villarroel (1943-1946) and his allies in the *Movimiento Nacionalista Revolucionario* (MNR) party, founded in 1942. In order to promote national unity, both Villarroel and the MNR promoted racial mixing, or *mestizaje*, as the foundation of a new national identity. When the MNR captured power 1952 on the back of a national revolution, it decreed electoral reform that enfranchised both women and the illiterate adult population, giving rural indigenous people full citizenship rights for the first time. Pushed by miners and rural hacienda workers, the MNR also nationalized the major tin mines and carried out land reform.[22] Leaders of the revolutionary movement also abolished the legal usage of the term "indio" in favor of "campesino," which linked indigeneity to agricultural work.[23] As Ann Zulawski and Andrew Canessa have argued, this circumvention of racial terms revealed a new phase of racial

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[21] Ann Zulawski, "The Medical Crisis of the Chaco War," in her *Unequal Cures,* 152-85. Zulawski reports the estimated number of soldiers who fought during the war at 250,000, bringing the death toll to 20 per cent.

[22] Gotkowitz, *A Revolution for Our Rights,* 166-174.

[23] Marcia Stephenson, *Gender and Modernity* in Andean Bolivia (Austin, TX: Univerrsity of Texas Press, 1999), 2-3. Andew Canessa, *Natives making Nation: Gender, Indigeneity, and the State in the Andes* (Tucson, AZ: University of Arizona Press, 2005), 15.

thinking among elite Bolivians: rather than tying race to biology as early twentieth-century criollos had done, Bolivia's new elite understood race in cultural terms.[24] Yet even as Villarroel and the MNR worked to elevate the economic and political position of indigenous Bolivians and uphold the mestizo as a symbol of Bolivian national identity, lingering prejudices influenced the ways politicians sought to incorporate them into the nation. Although white politicians promoted the image of the mestizo Bolivian as the symbol of modernity and national progress, for example, they were often loath to identify as mestizos themselves. The process of mestizaje envisioned by the MNR, in other words, was one in which indigenous people became mestizos and incorporated themselves into the nation by abandoning the ethnic markers of indigeneity and adopting criollo culture.[25]

This national-level restructuring of racial categories paralleled a new international scientific consensus on race. By the mid-twentieth century, biological definitions of race had also fallen out of favor internationally. Mindful of the brutal extremes to which the Nazi regime had taken its racist ideology during World War II, a group of prominent biologists crafted the UNESCO Statement of Race in 1949 in order to break the connection between biological

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[24] Self-identification is equally complicated, as is particularly visible within mining communities; although many miners share indigenous cultural habits, including birthing practices, with "campesinos," they have historically rejected the term "Indian," and have instead preferred to identify with the working class. Marcia Stephenson, *Gender and Modernity,* 87-88. For an exploration of the changing politics of self-identification see, Andrew Canessa, "Who Is Indigenous? Self-Identification, Indigeneity, and Claims to Justice in Contemporary Bolivia," *Urban Anthropology and Studies of Cultural Systems and World Economic Development* 36, no. 3 (Fall 2007), 195-237.

[25] Gotkowitz, *A Revolution for Our Rights,* 166-174. On the MNR's efforts to co-opt the rural indigenous movement in the years before the revolution, see Silvia Rivera Cusicanqui, *Oprimidos pero no vencidos: luchas del campesinado aymara y qhechwa de Bolivia, 1900-1980* (La Paz: HISBOL/ CSUTCB, 1984), 73-75. On the MNR's efforts to control peasant and mining unions, see Christopher Mitchell, *The Legacy of Populism in Bolivia: From the MNR to Military Rule* (New York and London: Praeger Publishers, 1977), especially his second chapter. Laura Gotkowitz's provides an engaging discussion of the MNR's position of racial divisions between whites, mestizos, and Indians, the party's official conviction that racial unity would be achieved through cultural assimilation of indigenous people into criollo culture. See her *A Revolution for Our Rights,* 166-174.

differences and what they called the "social myth of 'race'." "[S]cientific material," they wrote "does not justify the conclusion that inherited genetic differences are a major factor in producing the differences between the cultures and cultural achievements of different peoples or groups."[26] The scientists also supported Bolivian politicians' elevation of the mestizo by debunking old assertions that racial mixing produced degenerate offspring.

Yet, even though "racial" groups had lost their imagined biological coherence by midcentury, both Bolivian criollos and officials within international bodies, such as the United Nations, held to an unspoken acceptance that some "ethnic groups" produced fewer "cultural achievements" and should therefore shed their backward ways and assimilate into a more successful culture. In 1953, a U.N. advisory commission, enlisted by the MNR to advise the newly created Agrarian Reform Commission, recommended that the new revolutionary government work toward the "social and economic integration of the campesino masses, especially the quechua and aymara habitants…"[27] Over the next twelve years, the MNR received massive financial and technical assistance from the United States government in order to solve what the U.N. commission called "the problems of the Andean indigenous populations," as well as to create political stability and bolster the economy.[28] The MNR oversaw the creation of

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[26] UNESCO, *Statement on Race*, Paris, 1951, 4. http://unesdoc.unesco.org/images/0017/001789/178908eb.pdf. Citation information for different drafts of the statement are frequently incomplete. Another version of the statement, which includes an introduction to the statement, is available here: http://unesdoc.unesco.org/images/0012/001282/128291eo.pdf. For a discussion of how the UNESCO statement influenced studies on race relations in Brazil, see Marco Chor Maio, "UNESCO and the Study of Race Relations in Brazil: Regional or National Issue?," *Latin American Research Review* 36, no. 2 (2001): 118-136.

[27] Jorge Alejandro Ovando Sanz, *Sobre el problema nacional y colonial de Bolivia* (La Paz: Librería Editorial "Juventud", 1984), 157.

[28] Following its four-month assessment, the U.N. advisory commission published its report under the name "Informe de la Misión Conjunta de problemas de las poblaciones indígenas andinas." See Ovando Sanz, 155. James Wilkie calculated US aid to Bolivia between 1942 and 1961 at USD $111.2 million, including $3.1 million for health and sanitation and $3.6 for education. See his *The Bolivian Revolution and U.S. Aid since 1952,* 10.

schools in nearly every town, many of which explicitly sought to mold indigenous children into new, mestizo Bolivians. Young men and women from rural communities, who were no longer tied to haciendas, migrated in droves to La Paz to work and, in some cases, to study at the university.[29] Health campaigns undertaken with U.S. funding also sought to expand and consolidate the revolution by bringing western medicine to rural areas, thereby creating healthy, hygienically-minded citizens.[30] The revolution opened democratic space for indigenous people at the same time that it closed off space for indigenous culture and identity within the Bolivian nation.[31]

Following a coup that ended the MNR-led revolutionary period in 1964, a series of military and non-democratic governments held power until 1982. Each government adopted different strategies for dealing with the historically problematic indigenous population, which, by 1964, included highly-organized, militant mining and peasant organizations.[32] The first military president, René Barrientos Ortuño (1964-1967), wooed rural indigenous communities by delivering speeches in Quechua, a language he spoke natively, by visiting remote areas in his helicopter, and by doling out small gifts. Barrientos' populist tactics succeeded in consolidating an agreement between rural peasants and the military, known as the *Pacto Militar-Campesino.* Under this agreement, the military was to protect and support peasant unions in exchange for peasants' loyalty and assistance in rooting out communism. Many rural workers recognized that

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[29] Andrew Canessa, "Contesting Hybridity: Evangelistas and Kataristas in Highland Bolivia," *Journal of Latin American Studies* 32, no. 1 (February 2000): 122.

[30] Nicole Pacino, "Prescription for a Nation: Public Health in Post-Revolutionary Bolivia" (Doctoral Dissertation, University of California Santa Bárbara, 2013).

[31] Andrew Canessa, "Contesting Hybridity: Evangelistas and Kataristas in Highland Bolivia," *Journal of Latin American Studies* 32, no. 1 (February 2000): 115-144.

[32] James Dunkerley, *Rebellion in the Veins: Political Struggle in Bolivia, 1952-1982* (London: Verso, 1984), 43-48.

the *pacto* was little more than a way for the military to control rural organizing, but the relationship nonetheless survived until the 1970s. At the same time, Barrientos' treatment of miners reached new levels of brutality in 1967 with the massacre of men, women and children at the Siglo XX mining complex in Posotí. In contrast, Juan José Torres (1970-71) adopted an anti-imperialist, pro-worker stance that won over the country's powerful mining union. He was quickly overthrown by Hugo Banzer Suárez. Banzer's fascist-inspired government (1971-1978) employed new levels of repression against leftists, students, indigenous peasants and miners alike, until nation-wide protests drove him from power.[33]

The 1976 census indicates that the Bolivian government had taken a definitive step away from biologically-grounded racial categories in favor of an ethnic differentiation of the population, but this shift in no way marked the end of "race"-based tensions or hierarchies in Bolivia. In 1976, officials at Bolivia's National Institute of Statistics replaced earlier racial classification schemes with linguistic categorization. The census classified all people according to their ability to speak Spanish, Aymara, Quechua, "other languages," or a combination thereof. In spite of decades of elite-led assimilation efforts, 22 per cent of the population still did not speak Spanish at all and 62 per cent spoke one or more indigenous languages (See Appendix B).[34] After generations of migration and intermarriage, Aymara remains today the dominant language in the *altiplano* region that stretches across the departments of La Paz and Oruro.[35] The

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[33] Dunkerley, *Rebellion in the Veins*, 201-248.

[34] The percentage of indigenous language speakers was undoubtedly higher in 1976 than census data specifies, because the "other"-language category includes languages such as Guaraní. See footnote 36. República de Bolivia, *Resultados del censo nacional de población y vivienda, 1976*, volume 10 (La Paz: Instituto Nacional de Estadística, 1978), 70.

[35] Bolivian departments are the largest political subdivisions in the country. Departments are further subdivided into provinces, which are they further divided into *cantones.*

central valleys that span the departments of Cochabamba and Chuquisaca as well as in the highlands of Potosí, were, in 1976, as they are today, home to Quechua speakers, the country's largest linguistic group. A small, but significant numbers of Guaraní speakers, live in small areas of the western departments of Chuquisaca, Tarija, and Santa Cruz.[36] (Figure 2).

Indeed, the shift from race-based categories in the national census came just as indigenous people across Latin America began to use indigenous identity as the basis for an international political movement. In Bolivia, the Katarista movement, named after the famed eighteenth-century Aymara leader, Tupac Katari, grew from the organizing activities of a group of university students who had migrated to La Paz from surrounding rural, indigenous communities. By the 1970s, Katarista leaders, such as Jenaro Flores, had succeeded in creating independent, nation-wide peasant organizations that could mobilize to press for political and economic change. Katarismo used indigenous identity not just as the ideological foundation for national-level political demands, but as the rallying cry for an international indigenous movement: It united Aymara communities in Southern Peru and northern Chile and formed part of what sociologist José Bengoa called the *emergencia indígena* (the indigenous awakening) of the 1980s. Indigenous rights organizations held international conferences in Andean capitals in the 1980s and then returned home to press for political change through protests, strikes, and electoral campaigns.[37]

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[36] In 2001, 77,121 people self-identified as Guaraní, making Guaraní the country's third largest indigenous group. Since people self-identified in the 2001 census, the number of Bolivians who spoke Guaraní may have been different from the number who self-identified as members of the group. Comisión Económica para América Latina y el Caribe, *Los pueblos indígenas de Bolivia: diagnóstico sociodemográfico a partir del censo demográfico de 2001* (Santiago de Chile, 2005), 38, 40.

[37] Xavier Albó, "Andean People in the Twentieth Century," in Frank Soloman and Stuart B. Schwartz, eds., *The Cambridge History of the Native Peoples of the Americas,* Vol 3.2 (Cambridge, Cambridge, University Press, 2000). José Bengoa, *Emergencia Indígena en América Latina* (Santiago, Chile: Fondo de Cultura Económica, 2000. Assies,

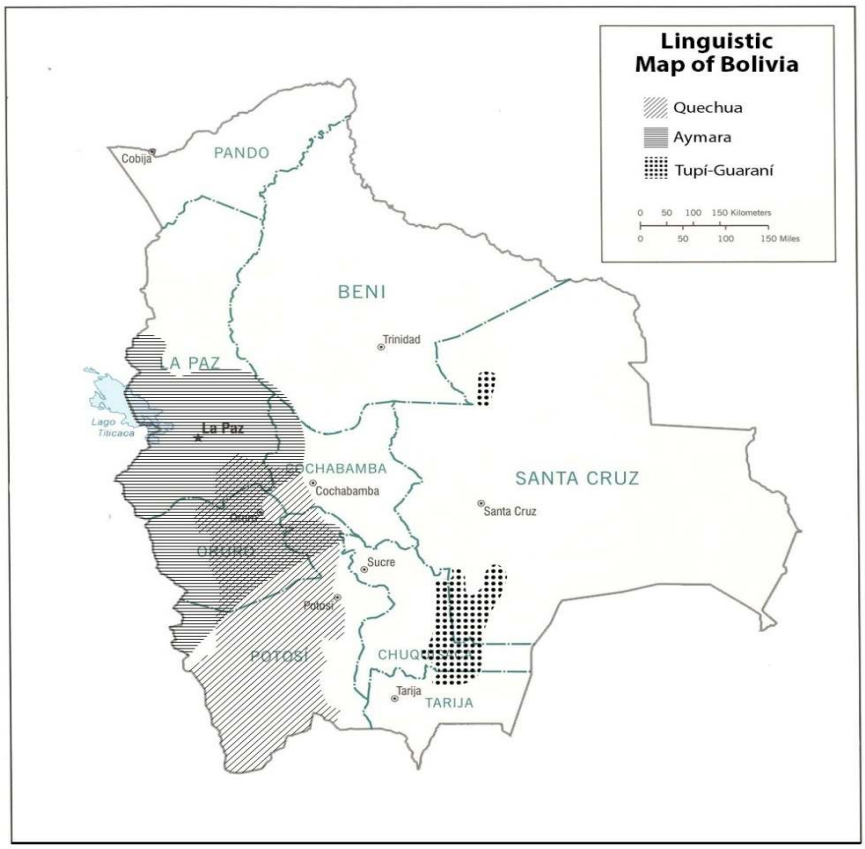

Figure 2. Linguistic Map of Bolivia. Based on Xavier Albó, 1995. Created by Jodi Ceason.

Women at the Center of Nation Building and State Formation in Twentieth Century Bolivia

By considering the work of midwives and nurses, this dissertation provides a new perspective on the power of the Bolivian state. Many scholars have characterized the Bolivian state as "weak" for reasons that include a lack of legitimacy in the eyes of indigenous Bolivians; internal geographic barriers created by the country's lack of infrastructure in combination with its rugged terrain; and a reliance on economic aid from the United States. [38] Examining state-led

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Willem. "Indigenous peoples and reform of the State in Latin America," in Willem Assies, Gemma van de Haar, André J. Hoekema, eds., *The Challenge of Diversity: Indigenous peoples and reform of the State in Latin America* (Amsterdam, The Netherlands: Thela Thesis, 1998).

[38] Tristan Platt, *Estado boliviano y ayllu andino: tierra y tributo en el norte de Potosí* (Lima: Instituto de Estudios Peruanos, 1982).; Gotkowitz, chapters two and three in her *A Revolution for Our Rights*. On the lack of medical

health programs and regulations reveals times when the Bolivian state failed to achieve the cultural authority and medical outcomes that policymakers and health officials desired, as well as moments in which the Bolivian state succeeded in creating intimate relationships with Bolivian mothers and families.

Focusing on midwives, mothers and public health nurses within Bolivia's obstetric movement also furthers our understanding of state formation by drawing our attention to a variety of institutions and individuals through which the Bolivian state operated during the twentieth century. From the perspective of childbirth assistance, we see the state not as a monolith that is separate from society but as a fluctuating constellation of institutions, agencies, and individual members within the society itself. Many midwives and nurses acted as formal representatives of the state when they worked for public hospitals or health programs, but they were also mothers, community members, and, after 1952, citizens with full political rights. The participation of Bolivian midwives, nurses and mothers in state programs, therefore, fits the model of state formation presented by A. Kim Clark in her study of female medical professionals in Ecuador. She contends that state formation is more than the creation of laws and policies, but rather operates through a variety of institutions and individuals and includes, in her words, the "prosaic, everyday activities that entangle different social groups in a variety of ways."[39]

While midwives and nurses acted as agents of the state, their ability to do so depended heavily on the relationships between physicians and lawmakers. Midwives' and nurses' work, therefore, sheds light on the connections between medical professionalization and state

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services and the state's inability to deal effectively with epidemics, see Ann Zulawski, "The Medical Crisis of the Chaco War" in her *Unequal Cures.* In his *The Bolivian Revolution and U.S. Aid since 1952,* James W. Wilkie reported that the Bolivian government relied heavily US aid during the revolution.

[39] A. Kim Clark, *Gender, State, and Medicine in Highland Ecuador: Modernizing Women, Modernizing the State, 1895-1950* (Durham and London: Duke University Press, 2012), 11.

formation. In his study on the professionalization of medicine in nineteenth-century Argentina, historian Ricardo González-Leandri shows that the establishment of a medical "profession" implied, by definition, that its members held considerable social and political prestige that positioned them within the same circles as the political elite. Becoming a full-fledged physician required years of study and self-governance according to the profession's own ethical standards, but the consolidation of doctors' authority in matters of health also required that the state assist in policing the boundaries of the profession. When it came to practitioners like dentists and midwives, who possessed unique and valuable expertise, the medical profession relied on the state to enforce regulations that placed those specialists under the supervision and command of doctors.[40]

This dissertation shows that physicians' relationships with auxiliaries, such as nurses, were just as important to the establishment of the obstetric profession and the expansion of state programs as their connections to political leaders. Along with regulations of midwifery practices in the 1920s, physicians pushed for the expansion of nursing with the goal of creating a team of medical auxiliaries who could work independently to expand western medical services but would not infringe on the authority of the doctors. Even at midcentury, however, the high demand for midwives of all kinds, in combination with a limited number of state resources for regulating medical practice, meant that licensed and unlicensed midwives alike continued to practice as

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[40] Ricardo González Leandri, "La profesión médica en Buenos Aires: 1852-1870," in *Política, médicos y enfermedades: Lecturas de historica de la salud en la Argentina,* ed. Mirta Zaida Lobato (Editorial Biblios, 1996), 19-53. Other studies—like those by Carl Murdock and Ann Zulawski—have shown that the power of medical doctors has, historically, increased as doctors aligned with the state to solve medical problems with economic and political consequences for the nation. In Chile, a series of epidemics in the nineteenth century motivated presidents Santa María and Balmaceda to increase the authority of Chilean physicians, who, in turn, used their authority to call for the expansion of the executive branch in order to protect public health. This relationship also held true in Bolivia, where, as Ann Zulawski has argued, following the Chaco War, physicians capitalized on the dire health of the indigenous troops, and the spread of disease (both real and imagine) to the health of urban populations, to cement the position of the medical profession within the state apparatus. Carl J. Murdock, "Physicians, the State and Public Health in Chile," *Journal of Latin American Studies.* 27, no. 3 (October 1995): 551-567.

they pleased. In short, Bolivian physicians' ability to strengthen their professional authority over maternal-infant care and childbirth depended on their ability to train midwives and nurses who would defer to their authority and enhance the image of the medical profession as a whole.

By assisting in childbirth, advising mothers, and choosing their assistants before and after birth, therefore, Bolivian women both embodied and molded the state. They did so not only by implementing state policy, but also by bending and side-stepping the rules. Midwives and nurses participated in state health programs through their work in maternity clinics and their advocacy of education and health service reform. At times, midwives disregarded regulations on midwifery practice and pushed the official boundaries of their professions. Most of the mothers in this study appear as targets of state-led maternal-infant care programs, but they also influenced the direction of state projects, either actively, by participating in health campaigns, or passively, by avoiding hospitals and clinics and continuing to demand the services of independent midwives.

Midwives and nurses also participated, consciously and not, in debates about Bolivia's national identity and how best to shape and maintain it. Indeed, their work illustrates, as James Dunkerley writes, that "material institutions and 'stateness' cannot be divorced from literary or other 'imagining' and inventing' of a collectivity."[41] During the 1940s and '50s, as I discuss in the second chapter, public health nurses acted as agents and forces of national unification and cultural transformation. Trained by the *Servicio Cooperative Interamericano de Salud Pública* (SCISP), an institution created jointly by the United States and Bolivian governments, public health nurses worked to expand the country's new public health system and promote cultural assimilation of indigenous families. While a central mission of their job was to provide prenatal

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[41] James Dunkerley, "Preface," in *Studies in the Formation of the Nation-State in Latin America,* James Dunkerley, ed. (London: Institute of Latin American Studies, University of London, 2002), 3. For a historiographic reflection on scholarship on the nation-state in Peru, Mexico and Chile, see Florencia Mallon's essay, "Decoding the Parchments of the Latin American Nation-State: Peru, Mexico and Chile in Comparative Perspective," in the same volume.

check-ups and convince expectant mothers to seek care from a state-licensed physician or midwife during delivery, this chapter shows that most indigenous mothers remained both physically and culturally beyond the reach of western medicine professionals.

I assign a central place in this study to indigenous, mestizo and criolla women, who often linger outside of view in histories of indigenous resistance to elite nation-building interventions. Studies on the movement toward the country's 1952 revolution, for instance, have focused on the role indigenous miners, rural laborers on estates and indigenous community members.[42] However, middle and upper-class women were among the cross-class base that supported the MNR. As Gloria Ardaya has shown, middle- and upper-class women who supported the MNR also demonstrated the festering class- and race-based divisions that persisted after the revolution, when they violently confronted miners' wives who protested the dismal living conditions of mining families.[43]

Bolivian mothers of all class and racial backgrounds received special scrutiny within physician's debates obstetric care and infant health over the course of the twentieth century, and examining those debates reveals changes and continuities in the ways that physicians linked questions of reproduction to concerns about the nation's racial identity and level of cultural development. As Jadwiga E. Pieper Mooney argues in her study of twentieth-century Chile, "analyzing the changing social construction of motherhood allows us to draw conclusions about

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[42] On the role of miners in the revolution and the nationalization of the mines, see James Dunkerley, *Rebellion in the Veins: Political Struggle in Bolivia, 1952-1982* (London: Verso, 1982), 58. On the "rural roots of the revolution" and the rather un-revolutionary results of the 1953 agrarian reform, see Gotkowitz, "Conclusion and Epilogue: Rethinking the Rural Roots of the 1952 Revolution," in her *A Revolution for Our Rights,* 268-290."

[43] Gloria Ardaya, "La mujer en la lucha del pueblo boliviano: Las Barzolas y el Comité de amas de casa," *Nueva Sociedad* 65 (Marzo-Abril 1983): 112-126. On conflict between the House Wives Committee and the Barzolas, see Domitila Barrios de Chungara with Moema Viezzer, *Let Me Speak!* (New York: Monthly Review Press, 1978).

the changing state of women's rights over time—and in different environments."[44] In Bolivia, Ann Zulawski drew similar conclusions about physicians' debates about women's health during the first half of the twentieth century; inevitably, physicians could not separate their opinions about women's health issues from their conviction that women's "proper" social function was birthing and raising children. Importantly, she also shows that Bolivian physicians' concern over the mothering habits of women differed according to the mother's race.[45] By examining physicians' debates about motherhood over a span of eighty years, I show that physicians' attention to reproduction has remained steadfastly focused on the problems of indigenous reproduction. From the SCISP-led public nursing initiatives of the 1940s to the mothers' centers and "clean birth" programs of the 1970s and '80s, reproductive health programs in Bolivia have targeted indigenous mothers almost exclusively.

Race and Gender in the Professionalization of Obstetric Medicine in Bolivia

The experiences of Bolivian midwives substantiate feminist critiques of medical science and professionalization. In the 1970s and '80s, feminist scholars argued that medical professionalization strengthened patriarchy by empowering men to act as healers while preventing women from doing the same work.[46] Feminist historians also identified state-enforced regulation of medical practice and negative propaganda against midwives as two common

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[44] Jadwiga E. Pieper Mooney, *The Politics of Motherhood: Maternity and Women's Right in Twentieth-Century Chile* (Pittsburgh, PA: University of Pittsburgh Press, 2009), 3.

[45] Ann Zulawski, "Women and Public Health, 1920s-1940s," in her *Unequal Cures,* 118-156.

[46] Barbara Ehrenreich and Deirdre English, *Complaints and Disorders: The Sexual Politics of Sickness.* Old Westbury, NY: The Feminist Press, 1973). Barbara Ehrenreich and Deirdre English, *For Her Own Good: Two Centuries of Medical Experts' Advice to Women* (New York: Random House, 2005). Ann Oakley, *Captured Womb: A History of the Medical Care of Pregnant Women* (New York: Basil Blackwell Publisher, 1984)

techniques physicians employed in their campaign against midwives.[47] The same pattern of professionalization held true in Bolivia; neither midwives nor nurses could avoid the gender-based barriers to professional independence established by male physicians. Starting in the 1920s, Bolivian physicians intensified their efforts to create a gendered division of labor within the medical care system. They did so by placing new legal restrictions on childbirth assistance and by funneling young women into nursing, a career that ensured their continued subordination to the authority of male physicians. Yet, just as Bolivian doctors helped to create new gendered, legal parameters for medical practice, they also sought to maintain professional boundaries and hierarchies by portraying midwives as less-skilled, less educated, and less sanitary. In these ways, Bolivia's history of obstetric medicine paralleled what historian Jean Donnison dubbed the shift from "midwives to medical men."[48]

However, focusing on the obstetric movement reveals that the transition from "midwives to medical men" was far more than a patriarchal, professional shift led by men at the expense of women. Although I focus on the efforts of physicians, who were almost exclusively male, to train medical auxiliaries, who were almost exclusively female, I show that their professional jostling cannot be reduced to a battle of men against women, as early feminist works suggested. The masculine power of western medicine was not harnessed only by male physicians at the expense of female midwives; rather, university-educated midwives' and nurses' knowledge and

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[47] Londa Schiebinger, "Skeletons in the Closet: The First Illustration of the Female Skeleton in Eighteenth-Century Anatomy"

[48] Jean Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth* (New Barnet, England: Historical Publications, 1977). Other feminist scholars have convincingly argued that male scientists used science to define women as biologically different from men and therefore as unsuited for work in scientific professions (including childbirth assistance) and participation in politics. See, for example, Londa Schiebinger, "Skeletons in the Closet: The First Illustration of the Female Skeleton in Eighteenth-Century Anatomy" in *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century,* eds. Catherine Gallagher and Thomas Lacquer (Berkeley: University of California Press, 1986), 42-82.

practice of western medicine afforded them greater state-sanctioned professional power and legitimacy in comparison to their informally-trained counterparts. In this way, this study employs a gender analysis of medicine, a perspective that proved fruitful in more recent works on childbirth assistance in Latin America. Historian María Soledad Zárate, for example, showed that, in Chile in the late-nineteenth century, physicians succeeded in bringing childbirth assistance into the masculine domain of science, transforming it into an appropriate occupation for men, and outcompeting empirically-trained midwives (*parteras*). This professional transformation was possible, she argues, because the new cohort of midwives (*matronas*), whom doctors began training to act as their assistants, actively reinforced the authority of doctors in order to distinguish themselves from their empirically-trained counterparts.[49] In Bolivia, midwives and nurses, who completed education in medical science, benefited professionally, socially, and economically from the masculine authority their professions conferred on them.

Yet, in Bolivia, race structured power hierarchies within the medical profession as well. Examining the racial connotations of the different types of birthing assistants in Bolivia reveals changes and continuities in the meaning and social significance of those racial categories in the twentieth century. As Rossana Barragán argued, terms like "indio" and "mestizo" are not easily defined because legal-political and popular understandings of racial categorizations in Bolivia have shifted, and because too few studies have connected the lived economic and political

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[49] María Soledad Zárate, *Dar a luz en Chile, siglo XIX*: *De la "ciencia de hembra" a la ciencia obstétrica.* (Santiago, Chile: Colección Sociedad y Cultura, 2007). Kristen Ruggiero has similarly shown that the rise of obstetricians in Argentine did not signal the end of careers for professional midwives. Instead Argentine matronas were allowed to continue practicing under the condition that they cooperate with state medical authorities in infanticide cases. In this way, Argentine midwives became part of a state system that monitored women's sexual conduct and penalized them for deviating from a highly restrictive concept of honor. Kristen Ruggiero, "Honor, Maternity, and the Disciplining of Women: Infanticide In Late Nineteenth-Century Buenos Aires." HAHR. 72, no 3 (1992): 353-373.

realities of individuals with their experiences as racialized subjects.[50] In the decade since Barragán's publication, a number of insightful works by historians have investigated the intersection between the production of political discourses of race and the agency of racialized subjects.[51] In her study on public health and political change in Bolivia, *Unequal Cures,* for example, Ann Zulawski showed that medical practice in Bolivia during the first half of the twentieth century was deeply influenced by social debates about the proper roles of Indians and women in society. Like Zulawski, I start at the intersection of politics and health, but I move the inquiry beyond debates to examine state policies and programs. The racial and gender assumptions of Bolivian physicians infused state policies and programs such that they affected different women differently.

This racial complexity makes Bolivia a unique case study through which to examine the ways that both race and gender shaped professionalization of obstetric medicine. In doing so, it contributes to a relatively small body of studies on midwifery and obstetric professionalization in which race served as an equally important subtext to gender.[52] The contrast between Bolivian

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[50] Rossana Barragán, "Identidades indias y mestizas: Una intervención al debates," *Autodeterminación* 10 (1992): 31.

[51] Marcia Stephenson, *Gender and Modernity in Andean Bolivia;* Laura Gotkowitz, *A Revolution for Our Rights: Indigenous Struggles for Land and Justice in Bolivia, 1880-1952* (Durham and London: Duke University Press, 2007). Ann Zulawski, *Unequal Cures: Public Health and Political Change in Bolivia, 1900-1950* (Durham and London: Duke University Press, 2007). In the U.S., Susan Lynn Smith has studied the experiences of Japanese-American midwives (*sanba*). She argues that race shaped the ways that state officials viewed and responded to sanba. Furthermore, racialized treatment of sanba was different on the island of Hawai'i and the mainland and distinct from the racism African-American midwives experienced in the U.S. South. Smith, *Japanese American Midwives: Culture, Community, and Health Politics, 1880-1950* (Urbana: University of Illinois Press, 2005).

[52] The historian María Lúcia Mott's analysis of the professionalization of obstetric physicians in Brazil is an important exception and offers an important comparison to the Bolivian case. She contends that, in spite of the fact that Brazil had highly-skilled and formally-trained midwives of European decent, doctors worked to portray all midwives as uneducated, slovenly and dark-skinned at the same that they created new regulations for the practice of midwifery. In Bolivia, physicians employed racist attacks as they struggled to win control of childbirth assistance and maternal-infant care; they frequently criticized the midwives who assisted rural and urban indigenous women not just on their lack of scientific knowledge, but on their lack of hygiene and their ignorance—characteristics that were frequently used as derisive descriptions of the indigenous population as a whole. María Lúcia Mott, "Midwifery and the Construction of an Image in Nineteenth-Century Brazil," *Nursing History Review* 27 (2003):

midwives and the Chilean midwives in Zárate's study illustrates this point. Zárate categorized Chilean midwives as either matronas or parteras, depending on whether they had received formal, obstetric training from physicians. Matronas' access (however limited) to the masculine power of obstetric medicine gave them professional authority that parteras did not have. The relationships between physicians and midwives were more complicated in Bolivia, because Bolivian midwives differed in terms of their cultural identity and racial subjectivity as well as in their access to formal education. Consequently, I expand Zárate's categorization and refer to "matronas", "parteras", and "empíricas" in this study. This triumvirate classification highlights the fact that professional distinctions in Bolivia were based not just on access to masculine (in other words, gendered) medical-based education, but on racial difference as well.

In this study, "matrona" implies both that the midwife received medical education in childbirth assistance and that she is either criolla or mestiza. The medical training matronas received changed over the course of the study but generally included courses in bacteriology and anatomy in addition to courses on both normal and "pathological" childbirth. The racial, social class, and age composition of matronas likewise changed over the course of the twentieth century as western medicine gained more authority in Bolivia. Importantly, as Andrew Cunningham and Bridie Andrews argue, "science and scientific medicine are the products of western Europe and North America…and…. they embody its values, both political and social."[53]

31-49. Also see, Maria Lucia de Barros Mott, "Madame Durocher, modista e parteira," *Estudos Feministas* 2, no. 1 (1994): 101-116.

[53] Andrew Cunningham and Bridie Andrews, *Western Medicine as Contested Knowledge* (Manchester and New York: Manchester University Press, 1997), 5. The rise of obstetric medicine also went hand-in-hand with a new understanding of childbirth and prenatal care. Feminist historian, Ann Oakley traced the understanding of childbirth as a fundamentally unsafe and pathological process to the rise of obstetricians in Britain in the late-nineteenth century. For her, prenatal care amounts to little more than a form of social control over women. Oakley, *Captured Womb: A History of the Medical Care of Pregnant Women* (New York: Basil Blackwell Publisher, 1984). In the

At the beginning of the twentieth century, Bolivian matronas were commonly white married women with European surnames, and their own racial identification reflected the small (but growing) number of patients who sought western medical care. In contrast, by the 1960s, as I discuss in chapter three, many more matronas were young mestiza women. In their professional appearance and practice, young matronas of the 1960s advanced the political and cultural process of mestizaje. Because of their knowledge of obstetrics, graduates of the midwifery schools of the 1960s and '70s received the title of *obstetriz*. In this work, I also refer to them as university-educated midwives.

Parteras also figure centrally in this history. Physicians have used a variety of other terms to refer to parteras throughout the twentieth century, including *comadrona* and *empírica* (the latter a term which refers simply to the fact that they learned through experience, rather than from formal education). Here I use the terms partera and "indigenous midwife" interchangeably to refer to Aymara- and Quechua-speaking midwives whose knowledge is based primarily on Andean medical principals and knowledge imparted to them by other parteras.[54] The Aymara-speaking midwives whom I interviewed for this study identified themselves as parteras in Spanish, but a greater diversity of terms exists in Aymara to indicate the type of services the women (or male *parteros*) provide.[55] In an effort to highlight their distance from criollo culture

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Chilean case, in contrast, María Soledad Zárate linked the "medicalization" of childbirth to the creation of professional matronas, who worked under the supervision of obstetricians at the Casa de Maternidad in Santiago.

[54] See for example, Joseph Bastien and Nancy Eden's interpretation of Bolivian "traditional birth attendants" "Midwives and Infant Health Care," in *Drum and Stethoscope: Integrating Ethnomedicine and Biomedicine in Bolivia,* ed. Joseph Bastien (Salt Lake City, UT: University of Utah Press, 1992), 137-172.

[55] For example, the term "*partira*" has been incorporated into Aymara from the Spanish version, but Aymara speakers also distinguish between *partiras* and *qaquris,* who massage the parturient mother and assist her in delivery but do not read coca leaves. Denise Arnold and Juan de Dios Yapita with Margarita Tito, *Vocabulario aymara del parto y la vida reproductiva de la mujer* (La Paz, Bolivia: ILCA, 1999), 167, 273. Two of the parteras whom I interviewed (María Raguido Coca and Cleta Calle Calle) called themselves *yatiris* (or wise women) because they performed divinations using coca leaves.

and western medical culture and their proximity to the Andean healing tradition, I refer to these women as "indigenous," regardless whether the parteras resided in rural or urban areas. Furthermore, as Ana Choque de López's story illustrates, and as I discuss in the fourth chapter, in the 1970s and '80s, many parteras acquired biomedical training through state-run "clean birth" programs. I also discuss a third type of midwife whose knowledge is neither based on Andean medicine, nor derived from formal biomedical study. I adopt the term commonly used by physicians in referring to these midwives simply as empiricists, or by the Spanish version, "*empíricas.*"

I begin this study by locating the dawn of Bolivia's obstetric movement in the early-twentieth century liberal period. Inspired by the liberal (and positivist) catchwords of order, progress, and civilization, Bolivian physicians campaigned to modernize the country's medical profession and infrastructure. With the foundation of the medical profession in place, physicians set out to control childbirth assistance and become expert advisers on infant care. What prevented physicians from consolidating professional authority over childbirth? The thriving careers of criolla matronas and the indispensable work of parteras.

CHAPTER ONE

The Dawn of Bolivia's Obstetric Movement: Midwives, Mothers, Nurses, and Nation, 1900-1930s

In 1883, Señora Modesta Sanjinés U. approached the Municipal Council of La Paz with a sizable donation to fund a public maternity ward for the poor. As a midwife, she must have witnessed the living conditions of poor mothers firsthand, and her own professional experiences most likely inspired her wish to help less fortunate women receive the kind of care she provided her wealthy clients. Whether from her personal earnings, family money, or her husband's wealth, Sanjinés had the means to donate enough money for the construction of what one council member referred to as "elegant and comfortable" maternity room within the city's public women's hospital. The Municipal Council praised their benefactor in their annual report, calling her a "distinguished *matrona*" and a great "humanitarian."[56]

Although Mrs. Sanjinés stands out for her charity, she was only one of many female professionals in a trade that was a respected occupation for nineteenth-century women. But while few gender barriers prevented women's engagement in medical trades like midwifery, class and ethnic differences divided both the clients Sanjinés had considered in her donation and midwives themselves. During the late-nineteenth and early-twentieth centuries, the variety and social position of midwives in La Paz mirrored the ethnic and class diversity of the city. *Matronas*, who received formal biomedical education, worked independently in the homes of upper- and middle-class families and in public maternity wards, such as the one Sanjinés created.

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[56]*Memoria de los actos del Concejo Departamental de La Paz en el Año 1883* (La Paz: El Siglo Industrial, 1884), *Memoria de los Actos del Concejo Departamental de La Paz, 1884*. (La Paz, 1885) Biblioteca y Archivo Archivo de la Torre (BACT).

Empíricas, like matronas, attended women throughout the city but learned their skills informally and relied on a blend of home remedies and personal experience. A third type of midwife, *parteras*, served indigenous women in rural and urban areas with practices based in Andean medical traditions. On many levels, the tasks of these different professionals overlapped, and midwives of all types practiced autonomously, but only matronas regularly worked alongside doctors in and outside of public maternities.

By the 1930s, however, the Municipal Council's annual reports and medical theses from national universities revealed that physicians had taken a more prominent role in state matters and that the relationships between physicians and midwives of all types had changed. In his 1938 medical thesis, doctor Julio Manual Aramayo reflected the growing tension between doctors and midwives. Accusing improperly trained midwives of endangering the lives of parturient women and "threaten[ing] the collectivity," he called for laws that would sentence violators with "jail or the scaffolds."[57] Some of Dr. Aramayo's like-minded colleagues had already begun to advocate new restrictions on the practice of midwifery in the 1930s, so his position was not unique. Yet, while his outlook reflected that of others in the medical establishment, Aramayo's opinion ultimately held more political weight; from 1952 to 1959 and again from 1961 to 1964, Dr. Aramayo acted as Minister of Health, a position of authority from which he had the power to promote his views.[58]

What brought about medical doctors' new perspective on the work of midwives, and what were the implications of that perspective for Bolivian midwives and the mothers they served? In his medical thesis, Aramayo declared that doctors' birthing assistance techniques

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[57] Julio Manuel Aramayo. "Infección puerperal y su tratamiento" (Universidad Mayor de San Andrés, Medical Thesis, 1937), 2.

[58] Rolando Costa Ardúz, *Historia del Ministerio de Salud y Previsión Social.* La Paz, Bolivia: Organization Mundial de Salud, 2000), 334-337.

were far superior to midwives' techniques because doctors' knowledge and practices were based on the latest scientific discoveries. While scientific studies did improve doctors' ability to diagnose and treat post-partum infections, I argue that the pursuit of "objective" science was only one of several motivations for Aramayo's insistence that doctors should control childbirth assistance. Instead, larger political and social objectives explain doctors' quest for professional control over both childbirth assistance and maternal-infant care. Bolivian physicians' campaign to expand their professional domain sought to reify an idealized social position for both women and the country's large indigenous population within a new, "modern" Bolivian nation: Doctors' commitment to expanding the power of their profession depended on women's adherence to a form of femininity that was rooted not just in professional and corporeal submission to male authority, but in the ethnic markers of whiteness and the class-based consumption patterns of the well-to-do.

Nuns, Midwives, and Western Medical Care in at the Turn of the Century

Mrs. Sanjinés made her donation at a time when "western medicine" held little social authority, professional prestige, or political power in Bolivia. Western medicine, according to Andrew Cunningham and Bridie Andrews, is a cultural product of Europe that rests on the absolute authority of physicians whose knowledge is produced through two key institutions: the hospital and the laboratory.[59] Following this definition, western medicine barely existed in Bolivia at the end of the nineteenth century. Nor did Bolivian physicians enjoy professional coherence or prestige at the time. As historian Ricardo González Leandri shows in his study of medical professionalization in Argentina, physicians' alliances with political elites made possible

[59] Andrew Cunningham and Bridie Andrews, "Introduction: Western Medicine as Contested Knowledge," in *Western Medicine as Contested Knowledge* (Manchester and New York: Manchester University Press, 1997), 1-23.

the construction of hospitals and laboratories and provided the nascent profession with legal supremacy over the folk healers, herbalists, dentists, and midwives with whom they competed.[60] In contrast, at the turn of the century, Bolivian physicians held little political influence and were far from establishing authority over the array of Andean healers, empirics, nuns, and midwives who worked in both public and private sectors.

The dilapidated condition of public hospitals at the end of the nineteenth century exemplified both the weak state of the medical profession and the class divisions that structured demand for medical care. La Paz, for example, had three public hospitals in two adjacent lots in the city center. Landaetta, the men's hospital, sat on the same lot as the Lazaretto, which was used to house patients with highly contagious or incurable diseases. The women's hospital, Loayza, also stood in the city center.[61] In 1884, in a city with a population of around 50,000, the men's hospital served just over 1,268 patients, while the women's admitted only 972.[62] At absolute maximum, in other words, only around 5% of the population was admitted to the hospital during the course of the year. The fact that one in ten patients died in the hospitals certainly did not instill confidence among patients. Patients also underused hospitals because they were dirty and understaffed. Landaeta consisted of four rooms with colored curtains and straw mattresses tucked in niches throughout the room, each accompanied by bedsides tables

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[60] Ricardo González Leandri, "La profesión médica en Buenos Aires: 1852-1870," in *Política, médicos y enfermedades: Lecturas de historia de la salud en la Argentina,* Mirta Zaida Lobato, ed. (Buenos Aires: Editorial Biblios, 1996), 19-53.

[61] Juan Manuel Balcazar, *La historia de medicina en Bolivia* (La Paz, Bolivia: Ediciones "Juventud", 1956).

[62] The population of La Paz grew from roughly 43,000 to 55,000 between 1846 and 1900, according to Bolivian censuses from those years. Klein, *A Concise History of Bolivia,* 160. At a constant rate of increase, La Paz's population would have been 51,436 in 1884. Death statistics for the city of La Paz and patient statistics from the men's and women's hospitals in La Paz are found in "Movimiento de Población" and "Rejistro estadístico de la ciudad de La Paz—Mortalidad en los Doce Meses del Año de 1884" in the appendix of the "Memoria de los Actos del Concejo Departamental de La Paz-1884 (La Paz, El Siglo Industrial, 1885). BACT.

cluttered with dishes and bedpans. Filth coated the floors. Two showers with cold water provided the only bathing facilities for the unfortunate patients, who sometimes simply died in bed and went unnoticed for hours because the medical students and "servants" visited so infrequently. The hospitals' poor conditions caused considerable unease in the population and those with any means for alternative care avoided them.[63]

Throughout the republican period of the nineteenth-century, municipal governments and national leaders made intermittent efforts to impose order on the irregular, charity-based system of public health care, but with little funding and no clear direction from national or departmental ministries, state responsibility for public health remained undefined and inconsistent. In 1868, for example, the liberal caudillo and dictator Mariano Melgarejo proposed new hospital regulations that were adopted throughout the country. The new regulations sought to solve the hospitals' chronic understaffing problems by requiring medical student interns to work in hospitals, making regular rounds, feeding, cleaning, and caring for the patients, in addition to giving treatments.[64] New regulations were, of course, harder to implement than to write. As a result, hospitals continued to depend on charitable organizations for funding and remained hopelessly understaffed.

One initiative taken by the state in the nineteenth century was to contract an order of nuns to run the hospitals. In 1878, the Municipal Government of La Paz contracted the Franciscan friar Vicente Rocchi to travel to Europe in search of nuns to run the city's hospitals. Rocchi

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[63] Juan Manuel Balcazar, *La historia de medicina en Bolivia* (La Paz, Bolivia: Ediciones "Juventud", 1956).

[64] Gregorio Mendizábal Lozano, *Historia de salud pública en Bolivia* (La Paz, Bolivia, OMS/OPS, 2002), 92. Melgarejo proposed a new hospital regulation that included, designating one day per week for surgeries, since no separate room existed for the purpose. Student interns' other duties included preventing people from taking cadavers without permission. Students were to perform autopsies when necessary. Otherwise, cadavers were to be used for instruction. Nineteenth-century doctors themselves relied on bloodletting, leeches, enemas, other purgative remedies, and occasionally performed crude operations. Balcazar, *La historia de medicina en Bolivia,* 244.

eventually settled on the *Hijas de Santa Ana*, an order of Franciscan nuns from the northern Italian city of Piacenza. The order had already sent a number of their sisters to Bolivia at the behest of the conservative president, Aniceto Arce Ruíz. The friar and the Municipal Council believed that Franciscans, because of their customary austerity and self-sufficiency, would be particularly suited for the work. The founder and head mother of the order, Sister Ana Rosa Gattorno, apparently concurred, and signed an agreement to send sixteen nuns to take up their positions as "assistants, administrators, and directors" of La Paz's hospitals. In subsequent years, groups of Santa Ana nuns also took over management of hospitals in the country's other major cities, Sucre, Potosí, Cochabamba, Tarija, and Santa Cruz.[65]

During the thirty years that the nuns managed the hospital in La Paz, professional physicians exerted almost no power whatsoever within the hospital system; the nuns administrated the hospital autonomously, managing finances, petitioning the municipal government for more funds, managing staff and caring for patients. In the first contract between the nuns and the Municipal Council, the government agreed to a budget of 28,831 bolivianos and 60 cents for the first year of administration, with which the nuns were to cover the wages and salaries of one doctor, two medical students, a number of servants, a cook, a launderer, and a guard for each hospital, in addition to feeding patients and providing and maintaining bedding.[66] Although the Municipal Council had hoped that the nuns' self-sufficiency would allow the city

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[65] Gregorio Mendizábal Lozano, *Historia de Salud Pública en Bolivia.* (La Paz, Bolivia: OPS/OMS, 2002), 93. In Sucre, a different order of nuns, the Siervas de María, replaced the Hijas de Santa Ana and continued provided care in the hospitals. Balcazar, *Historia de la medicina en Bolivia,* 246. According to midwife, Juana Gómez, some Siervas de María were working in the Santa Bárbara hospital even in the 1970s.

[66] The expense report from December 1886 indicates that for 76 bolivianos and 70 cents, the nuns paid for laundry detergent for both hospitals, repair for cushions in both hospitals, thread for hats (amount unspecified), paper and cotton (amount unspecified), 21 yards of carpet for the consultation room. "Resumen de los gastos estraordinarios hechos en ambos hospitales segun [sic] recibos. Mes de Diciembre," *Proyecto de Contrato entre los Hijas de Santa Ana y el Honorable Concejo de La Paz/Cuentas de los Hospitales* BACT.

to reduce the budget for the second year of the contract, a desperate request for funds written by the Mother Superior, Sister Ana Josefa Troni, only five months after their arrival, showed that the budget had been wholly insufficient. Worn down by disease, constant work, and hunger, the nuns lost three of their sisters in the first five months. In response, during subsequent years, the municipal government increased hospital budgets to meet the demands of a growing population and the basic needs of the nuns. By 1892, the annual budget for the two hospitals reached 42,000 bolivianos.[67]

In their third contract, signed in 1900, the same year that liberals replaced Sucre-based conservatives, the Municipal Council of La Paz again recognized the value of the nuns to the city's public health. The nuns successfully negotiated a number of terms that improved their working and living conditions; the Council agreed to pay for the nuns' medical care, and if necessary, for transfer to a more temperate climate, if a nun became ill because of her work in the hospitals. When nuns died in La Paz, the municipal government consented to pay for the repatriation of their remains back to Italy and provide 2,000 francs toward the replacement of the deceased nun. Since the Hijas de Santa Ana worked at hospitals and schools around the country, replacements could sometimes be found in Bolivia, rather than sending for another nun from Italy.[68] The Council also agreed to pay each nun 30 bolivianos (or 12 U.S. dollars) per month and to cover the cost of their work attire (pinafores and clothes) and bedding.[69] As a result, the nuns'

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[67] *Proyecto de Contrato entre las Hijas de Santa Ana y el Honorable Concejo de La Paz,* 1878. BACT. For annual budget for hospitals between 1877 and 1892, see the *Memoria del Honorable Concejo Municipal de La Paz, 1895,* 50. BACT.

[68]"Hermanas de Caridad. Renovación de contrato," *Anexos, Memoria Municipal de 1898 de La Paz*. (La Paz, Bolivia, 1899), 82-84. BACT.

[69] This dollar value is based on the 1904 rate reported by the International Bureau of American Republics. At that time, the average exchange rate for one Boliviano was USD $.40. International Bureau of the American Republics, *Bolivia. Geographic Sketch, Natural Resources, Laws, Economic Conditions, Actual Development, Prospects of Future Growth* (Washington, D.C.: Government Printing Office, 1904), 161.

remuneration far exceeded that of the servants at the two hospitals. In addition to these marked improvements in the terms of their employment, the 1900 contract again formalized the authority of the nuns within the hospitals. On article stipulated that the Hijas de Santa Ana would "exercise administrative functions with specified freedom." "In regards to the subordinate employees," the contract specified, "they will be subject to the orders of the Mother Superior, who will be able to remove them at will, if discipline and the good service of the hospitals so requires." [70]

During the time that nuns controlled the hospitals, midwives controlled childbirth. Although the scarcity of written records about the activities of indigenous midwives (parteras) indicates that they attended their clientele beyond the reach of the emerging medical authorities, various written sources show that matronas collaborated with physicians and the nascent state medical authorities, both in and outside of the public hospitals. Indeed, municipal government documentation of Señora Sanjinés's donation reveals the social, economic, and professional power of matronas at the end of the century.

The professional and social authority matronas held at the turn of the century is evident in the intimate connections they had with the city's elite families. Wealthy women received personal care in the privacy of their homes from matronas during delivery. Funeral announcements published in newspapers between January and May of 1884 show that the upper-class citizens of La Paz held matronas in high regard for their services. On January 15, 1884, *El Comercio* announced that the remains of one of the city's most respected matronas, "doña Isabel Bacarreza, viuda de Pacheco," had been taken to the General Cemetery of La Paz, accompanied

[70] Original quote: "Las hijas de Santa Ana ejercerán sus funciones administrativas… con libertad precisa. En cuanto á los empleados subalternos, se sujetarán á las órdenes de la Superiora, pudiendo ésta renovarlos á su voluntad, si así lo exigiese la disciplina y el bueno servicio de los Hospitales." "Hermanas de Caridad. Renovación de contrato," *Anexos, Memoria Municipal de 1898 de La Paz*. (La Paz, Bolivia, 1899), 82-84. BACT.

by numerous distinguished mourners.[71] Only five months later, La Paz lost another respected matrona; her funeral procession similarly included "abundant and magnificent accompaniment" (*mucho y lucido acompañamiento).* [72] Although matronas like Bacarreza, who had "distinguished" clients, most likely had no need to promote themselves, as late as 1915 many matronas publicized their services in local newspapers. Celia N. de Murillo, for example, paid for a small ad in *El Diario,* which ran daily during the months of February and March of 1907. Such advertisements show that midwives worked independently and openly and that they earned enough money to invest in marketing.[73] Matronas' use of print promotion also suggests that they sought to attract clientele from the country's tiny literate population. Even decades after Celia N. de Murillo's death, census data from 1950 indicates that a mere 25% percent of women of childbearing age (between sixteen and forty-four years) would have been able to read her advertisement. Literacy rates among men were slightly higher, at 47% percent for men of the same ages.[74] (See Appendix C) As a result, some upper-class wives undoubtedly learned of midwives from their husbands who read *El Diario.*

Matronas also held positions of authority in public maternities. Because of their professional expertise, the Municipal Council in La Paz turned to matronas when they sought to improve and expand care for the cities' lower-class women during childbirth. The Municipal

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[71] *El Comercio. La Paz de Ayacucho*, (martes 15 de Enero de 1884, No. 1,173), 3.

[72] *El Comercio. La Paz de Ayacucho*, (sábado 3 de mayo de 1884, N. 1,239), 3.

[73] Advertisements ran on page 3 or 4 of *El Diario* during the month of March, 1907. In another case, a midwife with the surname Smalders published a notice that she had moved to a new location in the city center on "El Prado" and General Campero Street. Her ad indicated that her new location was directly across from the Facultad de Medicina, a detail that suggests she had a working relationship with physicians. Her notice appeared in *El Diario* on January 12, 1915 on page 5 and on different pages over the next month.

[74] República de Bolivia, Ministerio de hacienda y estadística. Dirección general de estadística y censos. *Censo Demográfico, 1950* (La Paz: Editorial "Argote," 1955), 112-113.

Council credited Señora Sanjinés for providing the funds necessary to create an "elegant and comfortable" maternity room, containing twenty-four beds within the Loayza women's hospital. Since public hospitals continued to serve the poor who could not afford treatment at home or in private clinics, the Council also proposed the creation of a position for a matrona at the Loayza hospital, for a monthly salary of 120 bolivianos, roughly 82 U.S. dollars.[75] Although a matrona was hired to work at Loayza, the proposed salary seems to have been a little optimistic. By 1906, not even the three doctors working at Landaeta and Loayza earned a salary of 120 bolivianos per month. When the matrona's salary was settled at 50 bolivianos per month (around 20 U.S. dollars), her pay still exceeded the salaries of the nuns, servants, and medical students by nearly 20 bolivianos per month.[76] The comparatively high salary paid by the municipal government, and the even higher one proposed by council members, reflected the value of matronas' unique skills at the start of the twentieth century.

The municipal government of La Paz also subsidized the practice of at least one traveling "midwife of the poor" (*matrona de pobres*) during the late-nineteenth century. Adelaida Zubieta submitted an itemized list to the Municipal Council that included the thirty-four babies she delivered to families who were unable to pay for her services between July and December of 1885. The street names of houses to which she was called indicate that families in historically indigenous neighborhoods relied on her services. Over a period of six months, Zubieta delivered

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[75] *Memoria de los Actos del Concejo Departamental de La Paz, 1884* (La Paz, 1885) BACT. In 1893, the Bureau of American Republics reported that the value of one Boliviano at USD $.69. Bureau of the American Republics, *Hand Book of the American Republics, 1893.* Bulletin No. 50 (Washington, D.C., 1893), 61.

[76] *Memoria de los Actos Administrativos del H. Concejo Municipal, 1908* (La Paz, Bolivia, 1908). BACT. According to a 1904 report by the International Bureau of American Republics, the average exchange rate for one Boliviano was USD $.40. International Bureau of the American Republics, *Bolivia. Geographic Sketch, Natural Resources, Laws, Economic Conditions, Actual Development, Prospects of Future Growth* (Washington, D.C.: Government Printing Office, 1904), 161.

five babies on Calle Sucre, and another six on the streets of Illimani and Sagárnaga, suggesting that the women she attended referred other friends and relatives to her. [77]

Other evidence shows that the poor state of medical research, or, more specifically, doctors' inability to adequately treat infections in parturient women, limited physicians' professional authority. Without clear superiority in care or treatment, women had little reason to seek the care of male physicians, nor did doctors have much ground to claim professional authority over childbirth. When Juan de D. Martínez wrote his medical thesis on puerperal, or post-partum, fever in 1913, doctors had identified two main types of bacteria responsible for post-partum infections, but their methods of treating infections were often no different than a midwife could have provided. When their methods did differ, they were often either ineffective or so invasive that they put the patient at risk for greater infection or other complications. Dr. Martínez contended that the best treatment for puerperal infections was to ensure that the patient was comfortable, hydrated, and well-fed so that she could fight the infection naturally. Common remedies for helping patients fight fever included alcohol, caffeine (which was sometimes injected), strychnine, and "all of the heart tonics."[78] In three of the five case studies from his residence at the public maternity in Sucre that the doctor included in his thesis, doctors prescribed "tonics" and alcoholic beverages as part of the patient's treatment. Other common treatments included uterine douches and injections of various antiseptic solutions, including "lisol" (Lysol), phenol, thymol, and mercury. Dr. Martínez cautioned against the use of mercury

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[77] *Memoria de los Actos del Concejo Departamental de La Paz, 1885* (La Paz, 1886). BACT. Laura Gotkowitz has written about the historic importance of the "Indian Quarter" around Sagárnaga Street as a center of meeting of the nation-wide indigenous rights movement. During the early-twentieth century, indigenous community leaders convened in the Sagárnaga-area neighborhood to meet with lawyers and discuss strategies for maintaining ownership of ayllu lands and pushing for greater citizenship rights. See her *A Revolution for Our Rights: Indigenous Struggles for Land and Justice in Bolivia, 1880-1952* (Durham and London: Duke University Press, 2007).

[78] Juan de D. Martínez, "Fiebre Puerperal" (Medical Thesis, Universidad Mayor de San Francisco Xavier, 1913), 65.

because of the risk of poisoning the patient and noted that the most common solutions used in the maternity in Sucre were those made with lisol and thymol (an antimicrobial substance that occurs naturally in essentials oils of thyme, oregano, and rosemary).[79] In cases of more serious infections, Dr. Martínez employed the uterine curettage, a procedure in which the doctor used a special spoon-like instrument to scrape infected tissue from the uterine walls. Although Dr. Martínez noted that the procedure had been abandoned by many doctors in France because of the risk of creating new infections, he had resorted to the procedure in at least one case, after which his patient died.[80]

Modernizing Hospitals, Maternities, Midwives and Nuns

The rise of Bolivia's obstetric movement—Bolivian physicians' campaign to control childbirth—coincides with the consolidation of a liberal government in La Paz. Bolivian liberals consolidated their political power in 1900 and moved forward with a number of projects intended to expand free market capitalism and give Bolivia a veneer of "modernity" and "civilization" modeled on European cities. They built a network of railroads across the country to connect mining centers to international railways and to ports, and they invested in urban infrastructure and beautification projects, including sanitation systems and electrification.[81] Like their counterparts throughout Latin America, in theory, turn-of-the-century Bolivian liberals also

[79] María Rajkiewicz, Wiktor Tyszkiewicz, and Zbigniew Wertejuk, eds., *Chemistry and Physics of Complex Materials: Concepts and Applications* (Toronto and New Jersey: Apple Academic Press, 2014), 16. A common practice among parteras is to have their patients bathe in rosemary water—possibly because of the benefits of the essential oil.

[80] Juan de D. Martínez, "Fiebre Puerperal" (Medical Thesis, Universidad Mayor de San Francisco Xavier, 1913).

[81] Herbert Klein, "The Ages of Silver and Tin, 1880-1932," in his *A Concise History of Bolivia* (New York: Cambridge University Press, 2011), 144-177. Ann Zulawski, *Unequal Cures,* 23-25.

upheld the political principal of equal citizenship. In practice, however, they worked diligently to maintain the traditional social order based on patriarchy and racial hierarchy. [82]

These infrastructural changes laid the groundwork from which physicians launched their campaign to control childbirth assistance and childrearing. Liberalism influenced a generation of physicians and scholars, who viewed hospitals and western medical services as a measure of a modern society. [83] As a result, in early twentieth-century, liberal politicians and physicians united to reform hospital administration and regulation, construct a new general hospital and public maternity, and launch nursing education programs.

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[82] On Bolivia, for an overview of economic and political battles of liberals and their similarities with the rival conservative party, see Herbert Klein, "The Ages of Silver and Tin, 1880-1932," in his *A Concise History of Bolivia* (New York: Cambridge University Press, 2011), 144-177, On the effects of liberal-led land privatization on indigenous collective land rights see, Laura Gotkowitz, "The Peculiar Paths of the Liberal Project" in her *A Revolution for Our Rights*: *Indigenous Struggles for Land and Justice in Bolivia, 1880-1952* (Durham and London: Duke University Press, 2007), 17-42. As Gotkowitz notes, liberals proposed separate education curricula for Indians in the hopes that such programs would pacify and incorporate indigenous Bolivians into the nation, while keeping them clearly separate from and subordinate to the white population. Brook Larson argues that Bolivian liberals were even more convinced than ever, following the Pablo Zárate Willka rebellions, that Indians should not be allowed to participate equally in the nation. An increase in anthropological studies by European anthropologists supported their conviction; in the early years of the twentieth century, studies used "scientific" techniques like craniometry to show that Indians were different and unequal to whites, and therefore unequipped for citizenship. See, Larson, "Bolivia: Dangerous Pacts, Insurgent Indians" in her *Trials of Nation Making: Liberalism, Race, and Ethnicity in the Andes, 1810-1910* (Cambridge: Cambridge University Press, 2004), 202-243. Liberal governments throughout Latin America proved equally unwilling to extend equal citizenship rights to women, and they looked to science to uphold traditional gender roles. Argentina has been the subject of insightful studies on that subject. See, for example, Julia Rodríguez, "Women Confined to Save the Future Nation: Home and Houses of Deposit," in her *Civilizing Argentina: Science, Medicine, and the Modern State* (Chapel Hill, NC: The University of North Carolina Press, 2006), 95-130. Kristin Ruggiero, "Liberalism in the Ego," in her *Modernity in the Flesh: Medicine, Law, and Society in Turn-of-the-Century Argentina* (Stanford, CA: Stanford University Press, 2004), 23-52. On the connections between liberal projects, science, and the medical normalization and moralization of women's roles in society in Argentina, see Julia Rodríguez, *Civilizing Argentina: Science, Medicine, and the Modern State,* 95-130 and Kristin Ruggiero, *Modernity in the Flesh,* 23-52. For a discussion on the patterns of liberal governments' treatment of women's rights throughout Latin America, see Elizabeth Dore, "One Step Forward, Two Steps Back: Gender and het State in the Long Nineteenth Century" and Maxine Molyneux, "Twentieth-Century State Formations in Latin America, in *Hidden Histories of Gender and the State in Latin America,* ed. Elizabeth Dore and Maxine Molyneux. (Durham and London: Duke University Press, 2000), 3-81.

[83] Physician-historian Gregorio Mendizábal Lozano writes that liberal governments were "expressly passive" when it came to questions of public health. *Historia de salud pública en Bolivia,* 58. Nonetheless, physicians of the early twentieth century used liberal catch-phrases of "modernization" and "progress" when the improvements to the medical system.

Bolivian physicians' first step toward consolidating their professional authority and creating a modern medical system was to take charge of La Paz's hospitals. In 1906, the Municipal Council created the position of Chief Surgeon of Hospital and Public Assistance, and assigned the first Chief Surgeon, Claudio Sanjinés T., the job of submitting annual reports on hospital operations to the Council, a task the Mother Superior performed previously. In his first report, Dr. Sanjinés praised the continued work of the "virtuous" Hijas de Santa Ana, who consoled the sick and dying with the word of God and "suffer[ed] patiently and with saintly abnegation" the behavior of patients. From that report onward, however, the nuns received very little mention.[84] By 1919, the municipal government had restructured hospital administration completely. The General Hospital Regulations specified duties for a Municipal Inspector, the Chief Surgeon, the doctors and surgeons, the medical student interns, and the guards, in addition to laying out the rights and restrictions of patients and the purpose of each hospital. The Municipal Inspector and the Chief Surgeon took over all the administrative tasks that the Hijas de Santa Ana had exercised previously, including "intervening in the administration, direction, order, morality, and economic efficiency of the hospitals" and ensuring that "all doctors, surgeons, interns, matronas, maternity ward assistants, nurses, and pharmacists comply with their obligations."[85]

For La Paz's small professional medical community, the construction of a new hospital was another victory in their battle for medical modernity. In 1907, in addition to restructuring

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[84] "Informe del Cirujano Jefe de los Hospitales" *Memoria del H Concejo Municipal de La Paz 1919* (La Paz, Bolivia, 1920), 116. I was unable to locate *Memorias* between 1911 and 1918, so the details of their continued presence in the hospital after the end of their second contract, in 1910, is not clear. They had no role in hospital operation in the 1918 "Reglamento General de Hospitales" but were still caring for patients in the new *Hospital General de Miraflores* as late as 1931.

[85] "Reglamento General de Hospitales," *Memoria del H Concejo Municipal de La Paz 1919.* (La Paz, Bolivia, 1920), 21-22.

hospital administration, a committee of doctors, architects and urban planners settled on a construction site in La Paz's Miraflores neighborhood for a new general hospital. They chose the new site for the hospital because of its distance from the city center and its proximity to the canalized San Rafael ravine, which would allow hospital waste to flush away from the city. Construction of the Miraflores General Hospital stalled in 1913, and once the buildings themselves were completed, the Chief Surgeon reported that movement of equipment and patients was often impossible because the rains washed away the road from the city center to Miraflores. Finally, in 1919, the men's and children's section of the hospital, as well as a separate section for paying patients, were fully functioning.[86]

Maternity care held a special place in the midst of hospital modernization, and efforts to improve conditions for women in labor illustrated the government's intention to expand care to more women. By 1910, either due to lack of demand or simply higher demand in other areas, the maternity ward at Loayza hospital had been reduced to only twelve beds in a facility with 130 beds.[87] The new two-building maternity offered more beds in a clean, modern atmosphere to better attend women as they performed "the woman's most noble and painful function."[88]

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[86] Concejo Municipal de La Paz, "Memorias de los Actos Administrativos del H. Concejo Munipio de La Paz, presidido por Sr. Carlos Flores W. durante el año 1907," *Memoria. Concejo Municipal de La Paz* (La Paz, Bolivia, 1919). Concejo Municipal de La Paz, "Informe del Cirujano Jefe de los Hospitales." *Memoria del Honorable Concejo Municipal de La Paz 1919* (La Paz, Bolivia, 1920). BACT.

[87] Concejo Municipal de La Paz, "Informe del señor Carlos Villegas, Munícipe Inspector de Hospitales," *Memoria. Concejo Municipal de La Paz* (La Paz, Bolivia, 1910), 31. BACT.

[88] Carlos Nieto Navarro, "Informe de la inspección de hospitales y casas de Beneficencia a cargo del doctor Carlos Nieto Navarro," *Memoria del Presidente S Señor Adolfo González año de 1923* (La Paz, Bolivia: Imp. "Artística", 1924), 513. BACT.

Photographs taken of the new maternity in 1923—still under construction—showcased the new maternities' bright façades and massive windows (see **Figure 3** and **Figure 4**).[89]

Figure 3. Miraflores General Hospital. Maternity Buildings: one nearly finished and the foundation of another– in the background, the administration building. Source: Concejo Municipal de La Paz, "Memoria del Presidente Señor Adolfo González año de 1923" (La Paz, Bolivia: Imp. "Artística", 1924). BACT.

Figure 4. The "Maternity Post" building under construction. Source: Concejo Municipal de La Paz, "Memoria del Presidente Señor Adolfo González año de 1923" (La Paz, Bolivia: Imp. "Artística", 1924). BACT.

The construction of the new maternities did not simply represent the gentrification of public health; it was part of an expansion of the public health system that sought to make modern obstetric care accessible to all women. The Municipal Council also funded the construction of a maternity post (*posta de maternidad*) on the "main avenue" in the city's center in order to serve women who could not make the trip to the new maternity in Miraflores. The proposed central location for an additional maternity post was more accessible for women who lived in the "Indian Quarter" around Sagárnaga Street and other higher-altitude, working-class

[89] Concejo Municipal de La Paz, *Memoria del Presidente Señor Adolfo González año de 1923* (La Paz, Bolivia: Imp. "Artística", 1924). BACT.

neighborhoods west of the city center. Like the main maternity in Miraflores, the maternity post was a model of modern architecture.[90]

At times, appearances projected a more optimistic vision of modernity than the reality behind the facades, a contradiction that revealed that the performance of modernity was just as important as the real improvements that the municipal government could afford. The country's limited economic resources posed continual challenges. The new hospital buildings were constructed in a domed cathedral-style of stone and lime and lacked any type of heating system, making them uncomfortably cold during the winter months. Reports to the Municipal Council also recount a litany of difficulties in acquiring and maintaining mechanical equipment in the hospitals. Although proposals for the purchase of electric ovens began in 1923, ovens remained prohibitively expensive until 1931. In another example of Bolivia's arduous crawl toward technological modernity, a steam-powered disinfection oven (*Estufa de desinfección*), languished on a back patio of the new hospital in 1923, its mechanical pieces slowly disappearing until the municipal government contracted a local company to complete its restoration.[91]

In spite of those challenges, the new hospitals improved patient care and, thereby, the image of hospitals in general. Improvements to the hospital included the purchase of new dishware to serve meals, uniforms for care-givers and doctors, and hygienic metal tables to

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[90] Concejo Municipal de La Paz, "Memoria del Presidente Señor Adolfo González año de 1923" (La Paz, Bolivia: Imp. "Artística", 1924). BACT. The long-term service of those facilities is unclear from available documents. In 1946, the Miraflores Hospital Maternity had 26 beds, while the gynecology division had an additional 20 bed. Furthermore, the only maternity post in the city in 1946, which had 24 beds, was listed as a private institution. It is possible that the maternity post had passed to the administration of a charitable organization or to the administration of SCISP (see Chapter 2). Ministerio de Trabajo, Salubridad y Previsión Social, *Guía de profesionales en medicina y ramas anexas* (La Paz, Bolivia: Departamento de Bioestadística, Personal y Escalafón Sanitario de la Dirección General de Sanidad, 1946). Biblioteca del Ministerio de Salud y Deportes.

[91] Concejo Municipal de La Paz, "Informe de la Inspección de Hospitales y Casa de Beneficencia a Cargo del Doctor Carlos Nieto Navarro," *Memoria del Presidente Señor Adolfo González de 1923.* (La Paz, Bolivia, 1932), 539. BACT.

replace the wooden tables of the old hospital. In 1931, the hospital in Miraflores finally acquired an electric washing machine; until then, laundry for the hospital's 400 patients had been washed by hand, "with great loss of time… and little guarantee of sterilization."[92]

National-level initiatives in the 1920s also enhanced the prestige and professional rigor of Bolivian medicine. In 1922, President Bautista Saavedra pronounced a Supreme Decree that standardized the duties of medical school administration and set minimum subject requirements for courses of study in general medicine, pharmacy, odontology, and obstetrics.[93] Five years later, medical education also received a boost from the national government with a grant of 850,000 bolivianos for the acquisition of land on which to construct new buildings for the medical school in La Paz and a mandate for an open, international competition for all professorships in the medical school in order to revitalize the faculty.[94] Given that the San Francisco Xavier de Chuquisaca University in Sucre had historically served as the country's oldest and most prestigious medical school, the expansion of medical education in La Paz points to the growing importance of the profession on the national level.[95]

The foundation of the nursing profession during the same period strengthened the medical profession and created the kind of professional opportunity for women that liberal politicians endorsed. While liberals upheld the ideal of 'equal citizenship' and promoted education for women, they simultaneously believed that motherhood and domesticity were

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[92] Memoria y Anexos del H Concejo Municipal de La Paz*, Presidente, Sr. Ezequiel Jauregui, 1931.* (La Paz, Bolivia, 1931), 51. *Presidente Señor Adolfo González de 1923* (La Paz, Bolivia, 1932), 539. BACT.

[93] Decreto Supremo de 10 de noviembre. Facultad de Medicina. "Nuevo Plan de Estudios." *Anuario de 1922.* BACT.

[94] Dr. Alfonso Gamarra Durana, "Hernando Siles, su gobierno y la medicina," *Archivos bolivianos de historia de la medicina* 4, no. 1, (January-June 1998): 23-30.

[95] Mendizábal, *Historia de Salud Pública en Bolivia,* 44.

women's natural roles.[96] Because it was a profession based on the provision of care and nurturing, liberal politicians and physicians upheld nursing as a socially-respectable substitute for motherhood, matrimony, or the convent. Additionally, because nursing was a scientific practice, it also satisfied liberals' belief in positivism, and the rational, scientific management of society.[97] Nursing also reinforced hierarchal separations between male and female medical professionals and put a new face on traditional notions of proper femininity based on Christian morality and self-abnegation. Indeed, just as Katrin Schultheiss found that French doctors envisioned the ideal nurse as "a nun without a habit," so too, Bolivian physicians hoped to train nurses to be not only professional and capable of scientific study, but also to be obedient and self-abnegating enough to maintain the authority of doctors while carrying out the physically exhausting task of nursing.[98] In the Bolivian case, the Hijas de Santa Ana provided the model for nurses' demeanor within the hospitals.

Nursing programs ran only intermittently between the creation of the first school in 1917 and the late 1930s, but they nonetheless set the mold for the nursing profession and created a

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[96] On the elevation of scientific motherhood and the restructuring of patriarchy under Argentina's liberal state, see Julia Rodríguez, "Women Confined to Save the Future Nation: Home and Houses of Deposit," *Civilizing Argentina: Science, Medicine, and the Modern State* (Chapel Hill, NC: The University of North Carolina Press), 95-120.

[97] In Argentina, for example, politicians and jurists cited the latest scientific studies from Europe to justify the legal subordination of women to their husbands or fathers. When they supported education for women, they did so because they believed that scientific education would better prepare women to fulfill their nature, and patriotic, duty of motherhood. Ruggiero, see her chapter "Liberalizing the Ego" in her *Modernizing the Flesh*. In Ecuador, as A. Kim Clark demonstrates, liberal governments that had expanded education for women, also sought to create respectable career opportunities for women. Midwifery fit the bill; midwives who were trained at universities in Ecuador in the early twentieth century showcased the advancements of modern science and progress without breaking from traditional gender roles.

[98] Katrin Schultheiss, *Bodies and Souls: Politics and the Professionalization of Nurses in France, 1880-1922* (Cambridge, MA: Harvard University Press, 2001), 3. Schultheiss' study of French nursing suggests that doctors' push to find self-abnegated, dedicated assistants who answered to their authority was based on problems they faced in working with autonomous religious order. In Lyons, the nuns, who worked for hospitals but answered only to secular, municipal authorities rather than to a mother superior, became the national model for the nursing profession.

new vision of "proper" womanhood.[99] In the first nursing school proposal in 1917, La Paz's Hospital Inspector wrote that nurses were "women, who possessing basic notions of medicine, and above all, the delicate art of carrying out the doctor's orders, dedicate themselves to attending to the sick…"[100] The Municipal Council concurred that a new profession of medical assistants would more effectively administer care and proposed a two-year nursing program for students of at least eighteen-years of age. In order to apply for the program, young women also had to prove their good health, and produce a "certificate of morality."

The 1923 Nursing Regulation (*Reglamento de Enfermeras*), written by Dr. Claros Nieto Navarro and the Municipal Council president, again stressed that morality should be a key attribute of professional nurses. In addition to laying out a new three-year training program and detailing the rights, responsibilities and duties of the nurses, the new regulations required that prospective students submit the standard "certificate of morality" along with written permission from her parents or another guardian, in addition to providing a certificate of good health and proof of basic reading, writing and mathematical skills. As students, the young women would

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[99] Doctors began planning for nursing programs as early as 1917 and the first Nursing School (*Colegio de Enfermeras*) was created in La Paz two years later. *Memoria Municipal presentada por el Presidente del H. Concejo Doctor Jose Salinas el 1º de enero 1918* (La Paz, Bolivia, 1918). BACT. The first two-year program ran from 1919 to 1921, after which it closed. The lack of hospital staff to care for patients persisted such that, in 1923, the Chief Surgeon, Dr. Claros Nieto Navarro once again informed the Municipal Council of the urgent need to train nurses. "Reglamento de Enfermeras," *Memoria del Presidente Señor Adolfo González de 1923* (La Paz, Bolivia, 1924). In their article on the development of nursing education in Bolivia published by nursing faculty at the Universidad Mayor de San Andrés in La Paz, Betty T. de Oliden and Margarita de Millan contend that Bolivia's first nursing school was "created" in 1938, but the authors do not discuss the initial schools operations or even its location. They are likely referring to the *Escuela Nacional de Enfermería* in La Paz. See de Oliden and de Millan, "Desarrollo de la educación de enfermería en Bolivia," *Educación médica y salud* 13, no. 4 (1979): 380-388. In contrast, in his 2002 book on the history of public health in Bolivia, Dr. Gregorio Mendizábal notes only the "creation", by decree, of the *Escuela Nacional de Enfermería y Vistadores Sociales* in 1945. See Gregorio Mendizábal Lozano, *Historia de Salud Pública en Bolivia* (La Paz: OPS/OMS, 2002).

[100] "Entre los servicios particulares cuya necesidad se siente impeRíosamente, puede considerarse el de *Enfermeras,* o sean mujeres que, teniendo ligeras nociones de medicina, y sobre todo, del arte delicado de ejecutar las prescripciones médicas, se consagre, como profesionales, a atender enfermos…" "Curso de enfermeras" *Memoria Municipal presentada por el Presidente del H. Concejo Doctor Jose Salinas el 1º de enero 1918* (La Paz, Bolivia, 1918), 7.

complete their practical training in the hospitals and would receive an annual raise, as their experience increased. The 1923 regulations emphasized that schools would enforce proper moral behavior, stipulating that, any "insubordination or immorality" would result in the immediate repossession of funds from the student-nurse's compulsory savings account. In the end, nurses wouldhave more medical knowledge than the nuns, but nurses' professional activities would also be more strictly circumscribed than nuns'. The regulations stressed that nurses would be "absolutely prohibited from abandoning the hospital during their scheduled shifts or from implementing, of their own accord, medical, surgical or dietary treatment of patients."[101]

It was in the context of elite concerns about morality, modernity, medical professionalization and the relationship between physicians and the state that doctors first moved to restrict midwives' activities. In 1923, an abortion case brought against a midwife sparked an outcry among physicians that reflected the key concerns of the day. Staff at the women's section of the Lazareto, where prostitutes received treatment for venereal diseases, reported that a woman had arrived at the hospital with a "general infection of the blood" caused by an abortion that had been performed by a midwife named Lola de Brandt. The Chief Surgeon, A. Ibáñez Benavente, reported the incident to the Municipal Council of La Paz and called on the Council to make an example of Lola de Brandt in order to put an end to the supposed impunity with which the midwives of the city performed abortions. Although abortions were illegal under the penal code, the illegality of the act was only part of the doctor's concern:

> The Municipality must facilitate the expansion of the population as well as the health of the inhabitants, and as a base for this mission, it must safeguard the correct exercise of the medical profession and its related branches (odontology, obstetrics, and pharmacy). Matronas are only authorized, by the laws of all countries, to attend and assist simply in

[101] "Reglamento de Enfermeras," *Memoria del Presidente Señor Adolfo González de 1923* (La Paz, Bolivia, 1924), 242. BACT.

> the development of normal births, and are prohibited from attending difficult or pathological births, much less installing clinics for internal treatments, because those enter the field of gynecology that belongs *exclusively* to the profession of the medical surgeon (*médico cirujano*).[102]

Dr. Ibáñez Benavente's letter illustrates that, when doctors demanded the legal restriction of midwives' activities, they were reacting as much to Bolivian physicians' failure to enforce the internationally-accepted medical chain of command as they were to Lola de Brandt's infraction. According to French obstetricians, midwives were to act purely as assistants to medical doctors, and their practices and knowledge were to be limited to procedures of assistance during "normal" births. Although Bolivian physicians had long been aware of French midwifery regulations, Ibáñez Benavente's statement indicates that, before the De Brandt case, they had not enforced the same standards.[103]

Lawmakers responded at both municipal and national levels to doctors' demands to regulate midwifery, and in doing so, they stressed that midwives' abortion practices were not only illegal but immoral. In response to Dr. Ibáñez Benavente's letter, the Municipal Council of La Paz passed a resolution that called illegal abortions by matronas "a grave question that intensely affects social morality."[104] The following year, a supreme decree issued by President

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[102]"La Municipalidad debe velar por el aumento de la población así como por la salud de los habitantes y como base para esta misión, debe vigilar el correcto ejercicio de la profesión médica y de sus ramas anexas (Odontología, Obstetricia y Farmacia). Las matronas solo están autorizadas por las leyes de todos los países por las leyes de todos los países, para atender o ayudar simplemente, el desenvolvimiento de los partos normales, siéndoles prohibido el atender partos difíciles o patológicos y mucho menos el instalar clínicas de curaciones internas porque éstas entra en el campo de la ginecología que pertenece *exclusivamente* a la profesión del médico cirujano…" *Memoria del Presidente Señor Adolfo González de 1923* (La Paz, Bolivia: Imp. "Artística", 1924), 196. BACT.

[103] Pablo Petit, "Cuestiones Jenerales del Modo de Partear y Cuidar a las mujeres que están Embarazadas" (La Paz, Bolivia: La Opinion, 1856). Bolivian doctors had been in possession of an instructional medical pamphlet on pregnancy and delivery written by a French surgeon, "Pablo" Petit for nearly seventy-five years. Petit's manual, *Cuestiones generales del modo de partear* clearly defined the midwife in relation to the medical doctor.

[104]*Memoria del Presidente Señor Adolfo González de 1923* (La Paz, Bolivia: Imp. "Artística", 1924), 197. BACT.

Bautista Saavedra called abortion by midwives "a criminal act that, in addition to threatening the health of the mother and diminishing birth rates, [is] a moral felony."[105] The new law prohibited matronas from "holding private practices, writing prescriptions, or treating illnesses not based strictly on their competency and knowledge" and made noncompliance punishable. Midwives, who provided illicit services, would receive three- and six-month suspensions of their licenses for the first two offenses, and a permanent revocation following a third offense.[106]

Eugenics, Puericulture, and Medically-Supervised Motherhood for the Good of the Nation

Physicians' efforts to unite with the state to create a modern nation were not limited to the construction of new hospitals and the creation of a modern professional hierarchy; doctors also sought to improve the nation's genetic stock by intervening in childrearing. Scientific medical ideas emerging from Europe held great sway over Bolivian physicians not only because they sought to harness, in historian Nancy Stepan's words, the "immense social authority" of science, but also because they held Europe as the model of modernity and civilization.[107] After identifying the childrearing practices of indigenous mothers as a root cause of racial degeneration and national stagnation, doctors began to dispense advice to mothers based on

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[105] "Que son frecuentes los casos de aborto provocados expresamente, cuyo act criminal, a más de perjudicar la salud de la madre, disminuye la natalidad y [illegible—entra?n] un acto delituoso moral, penado por nuestras disposiciones vigentes." Decreto Supremo in Anuario, 1924, 217. BACT.

[106] Decreto Supremo in Anuario, 1924. BACT. Matronas prohibited from establishing consultorios, "expedir recetas, efectuar curaciones y atender consultas que sean estrictamente de su competencia y conocimiento."

[107] Nancy Stepan, *The Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca and London: Cornell University Press, 1991), 11. Works by María Lúcia Mott and Erica Windler also show Brazilian physicians sought to strengthen their own professional domain not only by claiming that midwives were scientifically ineffective. Rather, Brazilian doctors sought to eliminate their competition by using race- and gender-based slander that reflected both creoles' anxiety about the possibility of abolition and the continued power of Portuguese-born Brazilians. Erica M. Windler, "Madame Durocher's Performance: Cross-Dressing, Midwifery, and Authority in Nineteenth-Century Rio de Janeiro, Brazil," in *Gender, Sexuality, and Power in Latin America since Independence* (New York: Rowan and Littlefield, 2007), 52-71. María Lúcia Mott, "Midwifery and the Construction of an Image in Nineteenth-Century Brazil," *Nursing History Review* 27 (2003): 31-49.

principles of Lamarckian eugenics and the French infant-care science, puericulture. Their advice held up the self-abnegating, middle-class, white mother as the model for Bolivian womanhood. In contrast, they cast indigenous mothers as ignorant, backwards, and unwelcome in the new Bolivian nation.

Throughout Europe and the Americas, elites who were concerned with protecting the genetic stock of the population and ensuring strong, healthy nations, debated the biological laws of genetic inheritance and advocated different forms of eugenics philosophy in response. Whereas British, American, and most notoriously, German doctors adhered to Mendelian eugenics, Latin American doctors overwhelmingly adopted the ideas of French naturalist, Jean-Baptiste Lamarck. Based on an understanding of genetic inheritance that asserted that genetic characteristics could not be influenced by external factors, Mendelian eugenists believed that the population could only be improved by 'better breeding'. As such, Mendelianists advocated reproductive restrictions and prohibitions for certain undesirable populations. Lamarckian eugenists, by contrast, believed that characteristics acquired by parents through habits and environmental influences could be passed on to their children. From a Lamarckian perspective, therefore, states could improve their national stock by providing medical treatments (like premarital disease screening and treatment) and by educating eugenically weak sectors of the population in a range of socially "hygienic" behaviors. Importantly, the Lamarckian belief in eugenic education linked race to culture. Whereas the styles of eugenic thought that gained popularity in Britain, for example, advocated sterilization for people with physical or moral defects (including criminality, promiscuity, and others who could be lumped into the category of "moral imbeciles"), Lamarckian eugenists, held that moral deficiencies could be corrected

through instruction in healthful behaviors.[108] These fundamentally different understandings of race held by Mendelian and Lamarckian eugenists also shaped the ways that members of the two camps saw themselves in relation to the populations they defined as eugenically weak.[109]

Eugenics ideas gained popularity in Bolivia and across Latin America at the same time that elites began looking for solutions to what they perceived as "the Indian Problem." While the Bolivian elite agreed that Indian men were of value to the nation because of their labor, they worried about how to incorporate Indians more fully into the nation's social milieu without contaminating the urban, white and mestizo sections of society with disease and other traits they believed were typical of Indianness. Although Bolivian physicians held slightly different opinions on the causes of Indian degeneracy, they collectively agreed on two issues: that the disease and 'backwardness' common among indigenous populations were primarily a result of poor culture, rather than an indicator of genetic inferiority, and that doctors were uniquely equipped with scientific training and expertise to advise the nation on the best courses of action for solving the "Indian Problem."[110]

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[108] Dorothy Porter, "The Quality of Population and Family Welfare; Human Reproduction, Eugenics, and Social Policy," in her *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (New York and London: Routledge, 1999), 165-195.

[109] Nancy Stepan, *The Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca and London: Cornell University Press, 1991). Yolanda Eraso, "Biotypology, Endocrinology, and Sterilization: The Practice of Eugenics in the Treatment of Argentinean Women in the 1930s," *Bulletin of Medical History* 81, no. 4 (Winter 2007): 793-822.

[110] On Bolivian medical thought on the Indian Problem, see Ann Zulawski, "The Indian Problem": Ethnicity and Medicine in Bolivia, 1910-1920" *Latin American Research Review* 35, no. 2 (2000): 107-129. Bolivian physicians were not unlike physicians in other countries in their confidence that they could improve the population through effective social and medical policies. On the different approaches of Mexican, Argentine, and Brazilian elites to their respective 'race problems', see Nancy Stepan, "National Identities and Racial Transformations," in her *The Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca and London: Cornell University Press, 1991), 135-170. On Brazil, see Julyan G. Peard, "Tropical Disorders and the Forging of a Brazilian Medical Identity, 1860-1890," *Hispanic American Historical Review* 77, no. 1 (1997): 1-44. On popular resistance to physicians' and other elites' "civilizing" plans, see Teresa A. Meade, "Civilizing Rio de Janeiro": The Public Health Campaign and the Riot of 1904," *Journal of Social History* 20, no. 2 (1986): 302-322.

Bolivian doctors overwhelmingly adopted Lamarckian eugenics for a number of reasons: First, Lamarckism opened the possibility that doctors could play a decisive role in the resolution of their society's social and health problems. The application of scientific principles, they believed, could treat the perceived pervasiveness of alcoholism, syphilis and tuberculosis among the lower classes. It could cure and strengthen the sick, depleted population which stymied economic growth and development and left Bolivia's territory sparsely populated.[111] Second, because Lamarckian logic linked race to culture, it provided Bolivian physicians with a scientific discourse that allowed them to define indigenous people as diseased and deserving of their low social position in Bolivian society, while simultaneously denying that their own indigenous heritage affected them negatively in any way. A final and somewhat incidental reason that Lamarckism appealed to Bolivian physicians was the fact that they, like their counterparts across Latin America, commonly completed some portion of their education in France and were therefore able to engage the French debates on Lamarckian eugenics.[112]

Early twentieth-century public health proposals reveal elite Bolivians' angst over the economic, social, and biological influence of Indians on the nation, as historian Ann Zulawski has shown in her analysis of the writings of doctors Nestor Morales Villazón and Jaime Mendoza. Trained as a pediatrician in France, Dr. Morales spent most of his career as an

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[111]Ann Zulawski identified the influence of Lamarckian thought in the writings of Dr. Jaime Mendoza, discussed later in this chapter, and among doctors at the Manicomio Pacheco, Bolivia's mental health hospital in Sucre. For a broader discussion of the appeal of Lamarckism in Latin America, see Nancy Stepan, *The Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca and London: Cornell University Press, 1991).

[112] Stepan contends the tendency of Latin American elite to study in France contributed to the popularity of French scientific thought among physicians. See her *The Hour of Eugenics,* 72. Bolivia physicians, including both Morales and Mendoza, also frequently studied in France and referenced French studies in Bolivian medical journals.

epidemiologist in Bolivia.[113] In order to ensure that Indian men could continue working in the fields and mines and protect the urban populations from the threat of an indigenous scourge, Morales urged the state to send doctors into rural areas to vaccinate the rural populations against common diseases. Dr. Jaime Mendoza, who graduated from the medical school in Sucre in 1901 before continuing his training in Chile, Spain, and France, was a professor of medicine at La Paz's Universidad Mayor de San Andrés in the 1920s. In contrast to Morales, Mendoza envisioned doctors working in rural areas, not simply to vaccinate, but to bring civilization to the barbaric countryside. Mendoza also placed blame for the dismal living conditions of indigenous people at the feet of exploitative mining companies.[114]

Medical journal articles and theses show that Bolivian physicians also turned to puericulture to solve the country's socio-medical ills. Popularized by the French obstetrician Adolfe Pinard, puericulture sought to cultivate healthy children by caring for the mother and child as a unit, what Bolivian and other Latin American physicians would term the *binomio madre-hijo.*[115] Pinard, who acted as head of the Baudelocque maternity clinic and was chair of Clinical Obstetrics at the Paris Medical School, shared the French concern about the national

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[113] Zulawski published an alternate version of her "The Indian Problem": Ethnicity and Medicine in Bolivia, 1910-1920" as "Hygiene and the Indian Problem: Ethnicity and Medicine in the Early Twentieth Century" in her *Unequal Cures: Public Health and Political Change in Bolivia, 1900-1950* (Durham and London: Duke University Press, 2007), 21-51.

[114] Ann Zulawski, "Hygiene and "The Indian Problem": Ethnicity and Medicine in Bolivia, 1910-1920," in *Latin American Research Review* 35, no. 2 (2000): 107-129.

[115] Some Bolivian physicians clearly attributed the science of puericulture to the work of Adolphe Pinard, for example, the works of Dr. Néstor Villazón and Dr. María Amelia Chopitea, discussed in this chapter. Others simply used the term, puericulture when they proposed plans for protecting maternal and infant health and teaching women to be more effective mothers. For example, Saturnino Sandi, C. "Mortalidad infantil y protección a la primera infancia," (Medical Thesis, Univerity San Francisco Xavier de Chuquisaca, 1938). In a 1937 paper presented at a "public session" of the Instituto Médico Sucre, Dr. Aniceto Solares used the term "eugenics" to describe the maternal-infant care programs that others called "puericulture" programs. Ancieto Solares, "Protección al la infancia" conferencia Dr. Ancieto Solares, leída en la sesión pública del 3 de Febrero. *Revista del Instituto Médico Sucre,* 13-23.

decline in birth rates and the decrease in population in the wake of the Franco-Prussian War. When he noticed that destitute expectant mothers who took refuge in an asylum for pregnant women, ended up birthing larger babies on average than those who did not stay in the maternity before birth, he began publishing his advice on "intra-uterine care" and later wrote and taught classes on "extra-uterine care" as well.

Although French puericulturalists did not initially link the "scientific cultivation of the child" to questions of race, the French eugenics movement later advocated puericulture as a mechanism for racial improvement.[116] Puericulture practices, like Lamarckian eugenics policies, aimed to improve the health, strength, and intelligence of the population through both medical interventions and education. Since the health of the child clearly depended on the health of the mother, French puericulturalists advocated premarital disease screening for illnesses, such as tuberculosis and syphilis, which were known to affect the fetus. [117]

In Bolivia, doctors adopted a modified approach to puericulture, and like French eugenists, they saw puericulture as a tool for racial improvement. In the absence of state resources to fund clinics for destitute mothers, Bolivian physicians were largely left to insist that women behave according to prescribed notions of good mothering.[118] Bolivian puericulturalists defined motherhood as women's principal role within the nation and suggested that executing that role properly required that women dedicate themselves completely to the task. Of course,

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[116] Stepan, *The Hour of Eugenics,* 76-78.

[117] William H. Schneider, "Puericulture, and the Style of French Eugenics," *History and Philosophy of the Life Sciences* 8, no. 2 (1986): 265-277.

[118] Health services in Bolivia remained chronically underfunded and understaffed in during the first half of the twentieth century. In 1931, only 1.5% of the national budget went to the national-level health directorate, the *Dirección General de Sanidad Pública*. As a result, in the 1930s, the directorate's entire staff consisted of five people. Even in 1951, the country had no medical facilities at all in small towns. See Zulawski, *Unequal Cures,* 3, 70.

"proper" childrearing required women to adhere to specific cultural forms of motherhood. To produce a eugenic child, the mother needed to be mentally stable and morally grounded as well as physically healthy. In medical journals, doctors concurred that indigenous mothers were too incompetent and callous to carry out their biological imperative. The science of puericulture, therefore, carried profound implications for indigenous mothers.[119]

Further exploration of the writings of doctors Morales and Mendoza reveals that physicians placed special blame for the health and cultural development of indigenous Bolivians on indigenous mothers.[120] In spite of their differences, Morales and Mendoza agreed that another primary reason for the low culture and resulting racial degeneracy of the indigenous population was the negligence of Indian mothers. In 1911, Mendoza offered his assessment of the problems of indigenous people with the publication of a best-selling work of fiction, *En las tierras de Potosí.* In the story, Mendoza castes male miners as proletarian workers, who, in addition to suffering exploitation at the hand of capitalists, are destined to remain sick and ignorant because of the slovenly and negligent mothering practices of their women.[121] Indigenous women, in Mendoza's mind, were both the pure embodiment of Indianness and the

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[119] Néstor Morales Villazón, *Al pie de la cuna* (La Paz, Bolivia: González y Medina, 1919). In the years after the Chaco War, Dr. Aniceto Solares and others increasingly blamed abusive working-class fathers (fathers from the "elemento trabajador") for the miserable condition of their children. Solares, "Protección a la infancia," *Revista del Instituto Médico "Sucre"* no. 64 (June 1937): 13-23.

[120] Few other studies have examined the importance that criollo reformers placed on indigenous women as they proposed solutions to the Indian Problem. One exception is Brooke Larson's "Capturing Indian Bodies, Hearths, and Minds: The Gendered Politics of Rural School Reform in Bolivia 1920s-1940s," in ed. Andrew Canessa, *Natives Making Nation: Gender Indigeneity, and the State in the Andes* (Tucson, AZ: University of Arizona Press, 2005), 32-59.

[121] As Ann Zulawski notes in her discussion of Mendoza's book, the doctor's desire to describe miners as proletarian workers and also as backward Indians highlights the subjective and shifting nature of racial and class categories. See her *Unequal Cures,* 43-48. After the Chaco War, as Laura Gotkowitz shows, rural movements of Indian community members and hacienda workers often described themselves as "workers" when they demanded land and labor protections from the state. Nonetheless, she argues, rural movements' emphasis on class identity "did not efface ethnicity." See her *Revolution for Our Rights,* 132.

root cause of Indian degeneracy. In addition to their poor mothering, the character of the doctor in Mendoza's popular novel is forced to constantly remedy the damage done by the Andean healers, because the ignorant Indian mothers insist on maintaining indigenous cultural practices, including using traditional remedies to treat illness and injury.[122]

In contrast to these images of negligent Indian mothers, Dr. Morales Villazón detailed his views on proper, modern mothering (and his admiration of French puericulture) when he ventured into the genre of medical literature with his 1917 publication of *Al pie de la cuna* ("At the foot of the cradle"). Billed by the author as a handbook on motherhood for Bolivian women, Dr. Morales based his advice on the teachings of Dr. Adolphe Pinard, whose clinic—the Baudelocque Clinic in Paris—he visited while writing the first edition of the book. In two short epigrams on the book's title page, Morales succinctly connected his own work to that of Dr. Pinard, echoing the French doctors' claim that puericulture represented the salvation of "the country, the race, and of all of humanity" and making his own call to Bolivian women to protect the nation's greatness by fulfilling their god-given obligation of motherhood.[123]

A second edition of the book, published in 1919, included a lengthy forward of laudatory reviews from national and international newspapers and thank-you letters from the doctor's friends and colleagues who had received copies of the book. The collective reaction presented in the forward provides a glimpse into a social network of statesmen and doctors that Morales's publishers were eager to showcase, and it also demonstrates that the men of Bolivia's elite fully supported Dr. Morales's effort to teach proper motherhood. Letters written to the doctor

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[122] Ann Zulawski, "Hygiene and the Indian Problem: Ethnicity and Medicine in the Early Twentieth Century" in her *Unequal Cures: Public Health and Political Change in Bolivia, 1900-1950* (Durham and London: Duke University Press, 2007), 21-51.

[123] Néstor Morales Villazón, *Al pie de la cuna* (La Paz, Bolivia: González y Medina, 1919).

congratulating him on the publication of his book came from Bolivian ambassadors abroad as well as from physicians in Bolivia, Chile, Uruguay, Argentina, Peru, Spain, Cuba, and France. Reviews from Bolivian and other South American newspapers lauded the book for its scientific and literary value and lavished praise on the doctor for his wisdom and skill. "The fiancé, the young girl, the wife, [and] the mother of the family should have [this book] on hand to read frequently," wrote one reviewer in the Cochabamba newspaper, *El Heraldo*, following the publication of the first edition. A contributor to *La Razón* in La Paz likewise wrote that the literary form of the book would ensure that women found the doctor's lessons in hygiene pleasing and simple.[124]

The publisher's inclusion of the letters from a circle of transnational scientific and political elites also hints at the opinions that they believed mattered the most. For example, a letter from the French pediatrician, Dr. Bernard-Jean Antoine Marfan, undoubtedly served to reassure a self-conscious elite that Bolivian physicians were capable of scientific production on-par with their European counterparts. In his letter to Dr. Morales, Dr. Marfan promised to write a review of the book in the magazine "*Le Nourrison*" "My first impression," he wrote "is that the book is well conceptualized, well expressed; the ideas developed [in it] seem sound (*sanas*) and exact to me and are in accordance with what I teach."[125]

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[124] "La novia, la joven, la esposa, la madre de familia, deben tener a mano y leer con frecuencia, esta cartilla indispensable en el hogar. Allí encontrarán los conocimientos a cual más indispensables para la atención del niño…" (J.F. Velarde, *El Heraldo.* Cochabamba, 13 de Julio de 1918, quoted in Morales Villazón, XXII.) "La forma literaria del libro, amena si las hay, hará que las mujeres encuentren agradables con extremo esas narraciones higiénicas, escritas con sencillez de estilo, frase florida y un amor a los ninos que supura por todas las páginas del libro." (La Razón, domingo 2 de diciembre 1917, quoted in Morales Villazón, XXV.)

[125] Marfan's letter to Morales V. Published in Morales Villazón, *Al pie de la cuna,* xxi. "Mi primera impresion es que este libro está bien concebido, bien expuesto; las ideas desarrolladas me han parecido exactas, sanas y ellas concuerdan con las que yo enseño." On Marfan and the syndrome for which he is best known, see V.L. Gott,"Antoine Marfan and his syndrome: 100 years later," *Maryland Medical Journal* 47, no. 5 (Nov. 1998): 247-252.

For Morales, motherhood was both a biological and social imperative of all women. Like doctors in the United States during the same period, however, Morales ascribed different physical and mental attributes to women of different classes. Whereas doctors in the U.S. viewed upper-class women as fragile and delicate and therefore prone to nervous disorders like "sick headaches" and "nerves," working-class women were deemed capable of sustaining exhausting hours of paid labor in addition to their family duties. Rather than nervous disorders, therefore, working-class women suffered only from diseases that resulted, in part, from the inadequate housing that their labor afforded them. Instead of moving to improve working and living conditions for the poor, however, many doctors and members of the elite blamed working-class diseases on the stupidity and inherent inferiority of the lower classes.[126]

Morales' book for "Bolivian mothers" contributed to the production of an image of the ideal Bolivian woman. Although Morales purported to offer advice for all Bolivian mothers, his advice on moral and physical hygiene, as well as his implicit and explicit assessments of women's nature, were specific to the presumed uniqueness of his upper-class readers. In his forward to the second edition, he also claimed to have seen the book in the "aristocratic hands of the woman of noble ancestry" and in the home of the humble worker, "where the abnegation of his wife knows only work and the love for her child."[127] Perhaps, Morales did indeed see his book in the hands of the lower classes, but the country's low literacy rates would nonetheless have prevented all but a small percentage of the population from reading the book. His advice

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[126] Barbara Ehrenreich and Deidre English, *Complaints and Disorders: The Sexual Politics of Sickness.* Old Westbury, NY: The Feminist Press, 1973). Mary Poovey, ""Scenes of an Indelicate Character": The Medical "Treatment" of Victorian Women" in *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century,* ed. Catherine Gallagher and Thomas Lacquer (Berkeley, CA: University of California Press, 1986), 137-168.

[127] Néstor Morales Villazón, *Al pie de la cuna,* 6.

was clearly directed at the women of his own class: Young women should shun corsets after marriage, since the garment could potentially cause miscarriage. For the good of her unborn (and even un-conceived) children, a young woman should also rise early, take sunshine, and fill her days with "activities and domestic chores that dignify her." When it came to proper nutrition, Dr. Morales fell into a reverie about the benefits of the good old days, as experienced by upper-class nuclear families. Rather than gorging themselves on banquets and "living to eat," he chastised, women should "eat healthy food without condiments that can unnecessarily excite her delicate nervous system." He instructed young women to look to the dining habits of years past, when a woman's skirt was filled with the "old customs, impregnated with the healthy aroma of patriarchal traditions, [and] dinner, always frugal, was eaten with the family…" while listening to "the war stories of the old men and the noise of the help (*el ruido de la gente moza*)."[128]

In two chapters on "moral hygiene," Morales Villazón spoke not to mothers themselves, but to their husbands, who, he argued, should protect their wives from the types of harmful mental and emotional stimulation that could be found in literature and theater. Although books—presumably including his own—could serve as useful tools, the wrong books could easily ignite the "tyrannical impulses" of the woman's fickle nature. It was the man's job, he wrote, to understand the mysterious spirit of the woman in order to "regulate its excesses" with a firm will. "One has to understand well," he warned,

> that when I say a book, I only refer to the good ones, and not to everything, and not everything that is written can be given with impunity to our young women. No and a thousand times no! And if in life there is anything that needs exact discernment, it is precisely this because a bad book in the hand of a delicate nature that is incapable of

[128] Néstor Morales Villazón, *Al pie de la cuna*, 35-36.

> seeing the things through a prism of reality, constitutes the most frightening of all dangers.[129]

Reference to Morales' book by Dr. María Amelia Chopitea nearly a decade after its original publication indicates that Morales' work influenced the medical thought of future generations of Bolivian doctors. When Dr. Chopitea completed her medical thesis on infant mortality in Sucre in 1926 and became Bolivia's first female doctor, she lamented that the country's persistently high infant death rates were due in part to the fact that so few women had read *Al pie de la cuna* or other works written by Bolivian puericulturalists. Dr. Chopitea continued in the footsteps of Morales in another way, receiving a fellowship from the Bolivian National Congress to continue her studies among the founders of puericulture in Paris.[130]

Chopitea's birth and death statistics from Sucre show that Bolivian physicians' preoccupation with motherhood and childrearing also reflected their concerns about infant mortality. In 1921, 39.4% of babies died within their first year and in 1925, the infant death rate reached 56%.[131] Intestinal infections and whooping cough were the primary causes of infection during those years, according to the doctor. So that physicians could more accurately assess and treat these health problems, she called for the creation of a national statistics bureau to track infant death rates and causes.[132]

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[129] Morales Villazón, 40-41. "Pero hay que comprender bien, que al decir libros no me refiero sino a la parte buena de ellos y que no todo lo escrito se puede entregar impunemente a nuestra joven companera. No y mil veces no!, y si en la vida hay algo que require un indiscernimiento exacto, es precisamente este punto; pues un mal libro en poder de una naturaleza delicada, incapaz de ver las cosas a travéz de un prisme real, constituye el más temible de todos los peligros…"

[130] José María Alvarado, "Breve semblanza de la primera médica en Bolivia," *Archivos bolivianos de historia de la medicina* 4, no. 2 (July-December 1998): 135-139.

[131] María Amelia Chopitea, "Causas de la mortalidad infantil" (Medical Thesis, Sucre, Bolivia 1926), 8.

[132] Ibid.

Perhaps it was the continued inability of the state to carry out major statistical, diagnostic, and public health campaigns that prompted Chopitea to adopt the same position on child health as her predecessors. Although she attributed many infant deaths to congenital defects as well as to other factors, the most prevalent cause, she argued, was the "lack of training in scientific motherhood."[133] Repeating much of Morales' advice to upper-class women, she argued that corsets, high heels, and noisy, crowded gatherings were the most common prenatal threats to the young well-to-do, while overfeeding, unclean bathwater, and dusty bedding risked children's lives after birth. Lack of knowledge about hygiene among the lower classes was a hundred-fold worse, she lamented. In addition to the effects of coca use and alcoholism that poor babies supposedly inherited from their parents, poor infants often slept on filthy sheep skins in the same bed with their parents, siblings, or even animals, where they inhaled the "noxious" breath of their adult family members. The traditional manner of clothing and wrapping their babies, she believed, also hindered proper lung functioning and muscular development: "…the feet straight, as if it were a doll in a box, turns the child into a rigid, immobile stalk; and even if it cries, the mother wraps it, trying specifically to make the wrap as firm as possible."[134]

Dr. Morales and Dr. Chopitea's scientific prescriptions for women contributed to a larger discourse employed by Bolivian political and social elite: Bolivian physicians and politicians employed the new scientific discourse as justification for the exclusion of indigenous women

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[133] Ibid., 35.

[134] Chopitea, "Causas de la mortalidad infantil" (Medical Thesis, Sucre, Bolivia 1926), 35. One study on infant mortality and childrearing in Russia during the late nineteenth and early twentieth centuries provides stimulating suggestions on the cultural, economic, and labor reasons for different childrearing practices among ethnic Russians, Muslims, and Jews. Among poor Russian women in it was customary to swaddle newborns in the "course, used clothing" of the father in order to strengthen the child and ensure that the father would bond with it. Many rituals (baptizing the child in a freezing room, subjecting it to steam baths, and flogging it with birch branches), were meant to toughen the child and prepare it for life's hardships. David L. Ransel, *Mothering, Medicine, and Infant Mortality in Russia: Some Comparisons* (Washington, DC: Woodrow Wilson Center, Kennan Institute for Advanced Russian Studies), 6.

from meaningful, symbolic and political participation in the nation. In the 1920s, '30s, and '40s, elites made indigenous women the targets of regulation and reform campaigns. For example, elites advocated rural school curricula that specifically attempted to resocialize Aymara women to become proper wives and mothers. Influential education reformers held that Aymara families raised girls to be callous, stoic, and to travel far from home, and they argued that, because of this inappropriate gender socialization, Aymara families were unstable and failed to raise their children to be productive members of society.[135]

Morales' and Chopitea's works stand as examples of the ways that physicians discursively excluded indigenous people from their image of a modern nation. Within medical circles, the link Morales and Chopitea made between infant mortality and racial degeneration, on the one hand, and lower-class and indigenous culture, on the other, gained currency in 1930s. Furthermore, despite claiming to speak to all Bolivian mothers, Morales clearly excluded indigenous. As cultural studies scholar Marcia Stephenson has noted, during the first half of the twentieth century, elite Bolivians fashioned a "modern" national identity in their own image through repeated juxtaposition of white Bolivians with the antithetical figure of the indigenous woman.[136] Physicians' scientific advice to mothers was an important part of that process.

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[135] Brooke Larson, "Capturing Indian Bodies, Hearths, and Minds: The Gendered Politics of Rural School Reform in Bolivia 1920s-1940s," in ed. Andrew Canessa, *Natives Making Nation: Gender Indigeneity, and the State in the Andes* (Tucson, AZ: University of Arizona Press, 2005), 32-59. Marcia Stephenson presents additional cases of attempts of elites during the second half of the twentieth century to modify indigenous women's customs in order to mold them into modern citizens. An author of a 1976 book, for example, argued that *pollera* skirts not only racialized indigenous women and prevented them from assimilating, but were costly to wash because of their weight and unhygienic because their many pleats could trap insects and dust. See Stephenson, *Gender and Modernity in Andean Bolivia* (Austin, TX: University of Texas Press, 1999), 146-150.

[136] Marcia Stephenson, *Gender and Modernity in Andean Bolivia* (Austin, TX: University of Texas Press, 1999). Stephenson contends that the construction of a hegemonic national identity based on "criollo" culture during the first half of the twentieth century depended on the creation and perpetuation of tropes of the filthy diseased indigenous woman. She analyzes the scrutiny of the female indigenous body that was central to other processes, including rural education reform, urban hygiene regulations, and elite reflections on hunger strikes. Brooke Larson's study of the rural school reforms between the 1920s and the 1940s draws similar conclusions about the problems elites believed indigenous women posed for the creation of a modern nation.

Bolivian physicians' efforts to modernize and professionalize obstetric and maternal-infant care thus reified racial hierarchies. Here, the Bolivian example differs from European models. According to historian Londa Schiebinger, the rise of obstetric medicine in Europe was part of a scientific logic that defined all women as biologically inferior to men and, therefore, as unqualified for participation in both the sciences and politics.[137] In Bolivia, physicians repeated much of the scientific wisdom about the biological differences between men and women, but in a society characterized by racial and ethnic diversity, gender prescriptions also had strong racial and class connotations. Even though the professional autonomy of matronas, as representatives of both European cultural and medical modernity, was restricted after the 1920s, they still enjoyed official license to continue practicing midwifery. In contrast, neither parteras nor the indigenous mothers they served could legitimately work together within the emerging medical system.

The Medical-State Alliance and the Obstetric Movement in the Post-Chaco Period

Following the medical and political disaster of Bolivia's three-year war against Paraguay (1932-1935), doctors successfully consolidated a medical-state alliance that further empowered their profession. The creation of the Ministry of Hygiene and Health in 1936 and the 1938 constitution formally made health care the responsibility of the state. Although Ann Zulawski has argued that the Chaco War marked an important turning point in Bolivia's public health history because it mobilized political support for the creation of a state-run health system, from

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[137] Londa Schiebinger, "Skeletons in the Closet: The First Illustration of the Female Skeleton in Eighteenth-Century Anatomy" in *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century,* ed. Catherine Gallagher and Thomas Lacquer (Berkeley: University of California Press, 1986), 42-82.

the perspective of the obstetric movement, little changed.[138] If anything, the war only intensified elites' concern over the genetic and social influences of Indians on the nation, because it made visible the ill health and poverty of the country's indigenous population. Increasingly, in the 1930s and into the 1940s, doctors focused their attention on the racial degeneracy of indigenous fathers, the dangerous mothering and birthing habits of indigenous of women, and the practices of the parteras who assisted them.

The war began when liberal president David Salamanca, in an effort to claim largely-unexplored Paraguayan land in the Chaco Desert and to avert public attention from the country's deteriorating economic situation brought on by the world economic crisis of 1929, falsely accused the Paraguayans of having taken a fort in Bolivian territory and promptly declared war. The Bolivian army had already built up a presence along the border in anticipation of the war and possessed greater wealth and manpower than the Paraguayans, and yet, after three years of fighting, Bolivia had lost a sizable chunk of its southeastern frontier, along with 65,000 soldiers.[139]

In addition to exposing the corruption and deception of the president and the incompetency of the military officers, the war also made visible the inadequacy of health care in Bolivia and the vicious disregard with which Bolivia's elite treated the country's indigenous population. Diseases spread rapidly among troops in part because doctors, and the white and mestizo, middle and upper classes, in general, held a paradoxical image of indigenous people: they were both inherently dirty and sick, and also so self-sufficient and impervious to physical hardship that they did not require even basic provisions of water, food, and medical care. As a

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[138] Zulawski, "The Medical Crisis of the Chaco War," in her *Unequal Cures,* 52-85.

[139] Herbert Klein, *Bolivia: The Evolution of a Multi-Ethnic Society* (New York and Oxford: Oxford University Press, 1982), 194.

result, when indigenous men were conscripted from the highlands and sent to the distant lowland border with Paraguay, they died of dehydration, infected wounds, typhus, yellow fever, and malaria without ever seeing battle. The war left survivors injured, sick and traumatized. Their condition drew doctors' attention not only to the veterans but to the indigenous population as a whole.[140]

Articles in medical journals on maternal-infant care published in the first years after the war often circled back to the dysgenic influence of drunken and ill veteran-fathers and neglectful indigenous mothers. Doctors were especially concerned about the potential generational effects of veterans, who they believed would pass their psychological and physical traumas on to their children. In 1937, Dr. Aniceto Solares, a prominent doctor at the medical school of the Universidad San Francisco Xavier de Chuquisaca in Sucre, presented a paper that reflected that concern. He argued that the health problems of veterans, which included malaria, tuberculosis, venereal diseases, and alcoholism, put future generations in jeopardy of "defects, and organic and moral degenerations." The parenting habits of the lower-classes were another source of degeneration, according to Solares and his colleagues. Although lack of food and clothing posed constant challenges for the proper development of lower-class children, parents were equally to blame for creating a "moral environment" that he described as "precarious" and downright "bad." According to Solares, the "material and moral crudeness" in which the majority of working-class and campesino children lived created indifference, at best, and, at worst, hostility.[141]

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[140] Zulawski, "The Medical Crisis of the Chaco War," in her *Unequal Cures.*

[141] Solares, Aniceto. "Protección de la infancia" *Revista del Instituto Médico "Sucre"* No 64. (June 1937), 19.

The solution Solares proposed positioned doctors at the head of a state-driven eugenics program that would "attenuate those adverse factors with the goal of reducing to a minimum their possible consequences."[142] The proposed program would have amounted to a massive state intervention into daily life by treating congenitally transmitted diseases in both potential parents, "normalizing" prenatal checkups, and promoting birthing in newly constructed maternities. It would also promote "lactation hygiene," provide medication for sick children, and monitor the nutrition, living conditions, and education of young children. A final proposed component of the program—a scholarship fund for Bolivian doctors who wished to study pediatric care abroad—underscored the connection Bolivian physicians saw between eugenics and medically-supervised childcare.

The following year, a medical student named Saturnino Sandi C., repeated Solares' concerns in his medical thesis, "Infant Mortality and Protection during Early Infancy." A student at the medical school in Sucre, Sandi repeated the call for doctors to join forces with the state to create a system of "social medicine" that would guard against racial degeneration. Although he acknowledged that grinding poverty and economic exploitation weakened bodies, caused occupational injuries, and made it impossible for families to adequately feed, clothe, and shelter their children, he nonetheless insisted that the biggest threats to national health lay in the inferior genes and moral degeneracy of Indians and "mestizo" miners. To improve the genetic and moral character of the population, he advocated vaccination campaigns, state-mandated, paid maternal-leave (especially to spare women from physically intensive labor during pregnancy), and milk dispensaries to improve child-nutrition. But such measures figured only peripherally in

[142] Ibid., 16.

comparison to Sandi's extended contemplation of the effect of the moral and physical ills of Bolivia's indigenous and mestizo populations on child health.

In an apparent effort to connect his findings to broader international scientific debates about race and health, Sandi linked "social medicine" with eugenics and puericulture. Sandi was certainly familiar with debates about "social medicine" from politically-engaged South American doctors, like Salvador Allende. Sandi and Allende both identified poor nutrition and clothing along with alcoholism and venereal diseases, as common health problems of the poor.[143] But unlike Allende, Sandi clearly resisted the conclusion that unjust political and economic systems were to blame for the ill health of the poor.[144] Instead, the new doctor's interpretation of infant-mortality statistics and scientific debates was designed to blame the indigenous population for the nation's degeneration and to uphold western medicine as a remedy for the "low culture" of the majority of Bolivians.

Statistical analysis in Sandi's study demonstrates that many Bolivian physicians believed they could objectively and empirically verify racial difference. Presenting infant mortality rates among the country's three racial groups, Sandi found that, in the department of Potosí, 56 "white" infants, 399 "mestizo" infants, and 3 "Indian" infants died during the first half of 1938. Whether he understood race biologically or culturally, Sandi nonetheless took the racial categories as objective fact. After neglecting to calculate the deaths as a percentage of the total population, and disregarding the possibility of under reporting among the indigenous population, Sandi's data showed alarmingly high infant mortality rates among "mestizos." In order to explain

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[143] Salvador Allende, "Medical and Social Reality in Chile," *International Journal of Epidemiology* 34, no. 4 (2005): 732-736.

[144] Jadwiga Pieper Mooney writes that Allende interpreted social medicine as an "interventionist and equalizing" strategy that would protect the country's "human capital." See Pieper Mooney, *The Politics of Motherhood: Maternity and Women's Rights in Twentieth-Century Chile* (Pittsburgh, PA: University of Pittsburgh Press, 2009), 29.

the high rate of infant mestizo deaths, Sandi turned to the work of prominent physicians Jaime Mendoza and Juan Manuel Balcazar. Mendoza, like many other Bolivian physicians and intellectuals, argued that mestizos were even more degraded than "Indians," because they had inherited the worst biological qualities and social vices of "whites" and "Indians."[145] Then, quoting Balcazar, Sandi suggested that the loathsome qualities of Indians and mestizos made them negligent parents, who were responsible for the deaths of their children. Indigenous and mestizo children were constrained in dirty clothing, were breastfed only seldom and were sometimes even fed the highly alcoholic *chicha* consumed by their parents.[146]

Sandi also blamed infant and maternal mortality, and therefore the degeneration of the Bolivian nation, on traditional and untrained midwives and insisted that doctors team with the state to remedy the problem. As part of his research, Sandi reported that in Potosí during the first half of 1938, 42 of 488 infants were stillborn. He blamed the high percentage of infant deaths on the tendency of women in Potosí to patronize indigenous healers (*curanderos*) and midwives (*parteras empíricas*). Such practitioners, he argued, were "absolutely unaware of the principles of hygiene."[147] Sandi concluded that the state could reduce the rate of infant mortality by reducing the number of partera-assisted births and by attracting young mothers to maternity centers, where they could be educated in the basic puericultural principles of childrearing.

It was in this context that Dr. Julio Aramayo published his medical thesis on puerperal fever, arriving at the same conclusion as Sandi (just a year earlier) that untrained midwives bore

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[145] Sandi quotes Jaime Mendoza's *En las tierras de Potosí* at length. For a more detailed discussion of Bolivian elites views of the degeneracy of mestizos, see Zulawski's chapter, "Hygiene and the Indian Problem" in her *Unequal Cures.*

[146] Sandi C., Saturnino, "Mortalidad infantil y protección a la primera infancia." Thesis. Facultad Oficial de medicina, Farmacia, y Odontología. Universidad Mayor Real y Pontifica de San Francisco Xavier de Chuquisaca. (Sucre, Bolivia, 1938), 18.

[147] Ibid., 32

primary responsibility for the high rates of puerperal infection among parturient mothers. Dr. Aramayo completed his medical degree at the Universidad Mayor de San Andrés in La Paz in 1937 at a pivotal moment in Bolivia's public health history. The son of a well-respected obstetrician, Aramayo was a student during the war. The new constitution was codified the year after he finished his thesis, and, in 1952, the revolutionary government appointed him to the position of Minister of Health and charged him with expanding the country's health system.

A comparison of Juan D. Martínez's and Aramayo's medical theses reveals that the primary differences in their perspectives on midwives were political and professional rather than scientific. As discussed earlier, Dr. Martínez finished his thesis on puerperal fever in 1913, before doctors began their efforts to restrict midwives' practices. In terms of treatment and prevention of infection, Aramayo's thesis on puerperal fever differed little from Dr. Martínez's thesis. Both doctors stressed the importance of sterilizing hands and equipment to prevent infection and relied primarily on uterine douches with Lysol solutions to treat infections. In the five case studies that Martínez presented in his thesis, it is very likely that a midwife of some type assisted the patient before she sought the attention of a physician. One of his case studies documented the story of a twenty-nine year old cook named Justina Taboada, who went to the gynecological clinic in Sucre, a day after giving birth at home without complications. Dr. Martínez made no mention of a birth attendant of any kind, whether family member, or professional midwife. Instead, the doctor noted only that he treated her for a purulent uterine infection with ice ("*hielo permanente*") and that she was cured. In another of Martínez's case studies, a maid named María Echalar also came to the gynecological clinic after giving birth,

"without any incident but in poor environmental conditions."[148] In spite of Martínez's knowledge that unsanitary conditions and contact from an assistant with unclean hands could cause infection, his recommendations, written in his introduction, comment strictly on the origin of infections, the necessity of sanitation and sterilization to prevent infections, and the effectiveness of the treatments available to him.

Dr. Aramayo's presentation of case studies and his conclusions, in contrast, condemned the poor training of midwives and carelessness and ignorance of unlicensed attendants. "It is with legitimate pride that I say that we have not had to lament a single case of puerperal fever in the hospital service;" he wrote, "all of the cases we have observed have come from the street…"[149] Certainly the vigilant sterilization of equipment in the hospitals during the 1930s did prevent puerperal infections, as Aramayo contended, although it is impossible to know from his comment the length of time that the maternities had remained fever-free. In his enumerated conclusions, Aramayo urged both doctors and licensed midwives to exercise great caution when delivering babies or treating patients in order to avoid spreading infection. He also called for the construction of more maternity centers that could house patients and provide a base office for doctors who would make house calls. In his introduction, however, he blamed infections on medical auxiliaries, like nurses and others attendants with less training than physicians, in spite of the fact that he presented evidence that both doctors and licensed midwives (*matronas*) had caused, or failed to prevent infection. His case studies also indicated that midwives (licensed and not) were still assisting in the vast majority of births, many in homes where the sanitary conditions were beyond their control, making it extremely likely that they would also see the vast

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[148] Juan de D. Martínez, "Fiebre puerperal" (Medical Thesis, Universidad Mayor de San Francisco Xavier, Sucre, Bolivia, 1913), 81.

[149] Julio Manuel Aramayo Maldonado, "Infección puerperal y su tratamiento" (Medical Thesis, Universidad Mayor de San Andrés, La Paz: Bolivia, 1937), 1.

majority of infections. Three of the five case studies he presented were from patients in La Paz (the other two were cases seen during his residency in Madrid). In each of the La Paz cases, a matrona assisted the parturient before she sought the care of a physician because of an infection. In one case, an amateur attendant ("*aficionada"*) had also examined the patient. Of the four female birth attendants (three matronas and one "aficionada") that appear in Aramayo's case studies, the doctor faulted two of them for the infection; he accused the amateur attendant of "crass ignorance" for leaving membranes in the womb to rot because she failed to recognize that her patient's miscarriage had been incomplete. In another case, he judged that a matrona (presumably with official training) had failed to recognize a puerperal infection in a patient because of her "lack of experience."[150] Based on those cases, Dr. Aramayo launched a pointed attack against midwives, writing:

> Our laws must be modified in the sense of imposing the most severe sanctions on all those people, who, without professional title, clandestinely exercise the noble mission of attending to mothers, whose children are the future of the country. And what would I say to those people who, empowered by whatever title they might have, such as nurses or others, risk the lives of mothers? [Those people] deserve, in my opinion, jail or the scaffolds, since, in order to obtain a few miserable cents, they destroy homes and threaten the collectivity.[151]

Physicians' criticism of midwives, and attempts to restrict their practices, continued into the 1940s. Dr. Emilio Fernández M.'s disparagement of unlicensed and traditional midwives in

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[150] Julio Manuel Aramayo Maldonado, "Infección puerperal y su tratamiento" (Medical Thesis, Universidad Mayor de San Andrés, La Paz: Bolivia, 1937), 57-63.

[151] "… la fiebre puerperal, es una enfermedad infecto-contagiosa producida por un variado número de agentes, y no como se creía antes, producida por un agente específico." Juan de D. Martínez, "Fiebre Puerperal" (Medical Thesis, Universidad Mayor de San Frncisco Xavier, 1913), 30. "Nuestras leyes deben ser modificadas en el sentido de imponer las sanciones más severas a todas aquellas personas que, sin título profesional, ejercen clandestinamente la alta misión de atender a las madres, cuyos hijos son el porvenir del País. Y qué diré de aquellas personas que amparadas por cualquier título como enfermeras u otros, atentan contra la vida de las madres?. Ellas merecen, en mi concepto, la cárcel o el patíbulo, ya que por conseguir unos miserables centavos, destruyen hogares, atentan contra la colectividad." Julio Manuel Aramayo. "Infección puerperal y su tratamiento" (Universidad Mayor de San Andrés, Medical Thesis, 1937), 2.

his 1949 thesis medical thesis, for example, demonstrates the continuity in medical thinking on childbirth from the 1930s to the eve of the 1952 Revolution and suggests that doctors of the Chaco Generation had been unable to implement the reforms they began calling for in the 1930s. Though he recognized the economic hardships suffered by working mothers and called for social programs to alleviate some of their stress, Fernández ended his thesis by blaming dirty, old midwives, who kept their patients in the dark, forbade them from touching water, and had them give birth in a praying position, which caused "hemorrhaging and uterine inversion because of the violent expulsion of the fetal projectile and consequent traction on the placenta."[152]

Conclusion

The early years of Bolivia's obstetric movement had implications beyond the new legal restrictions on midwives' practices. Although doctors struggled (and failed) to gain control over the majority of pregnant women, the obstetric movement met with success in other regards. The obstetric movement both restricted legitimate professional spaces for Bolivian matronas, empíricas, and parteras, and constructed a model of ideal femininity at the base of which lay the implicit exclusion of indigenous women from the nation. In their efforts to control childbirth assistance and increase their influence over childrearing, Bolivian physicians linked medical care to women's "natural role" as mothers and to their gendered visions for the ideal nation. At the same time, doctors' worked to create a legal- and social-binary categorization of midwives. Good midwives had scientific training but still deferred to doctors' authority. Bad midwives held insufficient knowledge of science and threatened the public good by continuing to practice on

[152] Fernández M., Emilio. "Protección a la madre y al niño," *Revista del Instituto Medico "Sucre"* no. 85 (February-April, 1949), 17.

their own. These definitions of good and bad midwives went hand-in-hand with medical advice on parenting that distinguished good and bad mothers. Good mothers gave birth under the supervision of physicians and sought their advice on childrearing.

As I show in the next chapters, doctors continued their struggle to harness control over childbirth assistance and childrearing for decades to come. They also continued to engage in international medical debates and seek the assistance of foreign organizations and professionals in an effort to solve the nation's problems. In spite of the continuing criticism of midwives from doctors like Fernández, the *Sistema Cooperativo Interamericano de Salud Pública* (SCISP), an organization jointly funded and administrated by the Bolivian and American medical personnel, temporarily turned the attention of physicians and the country's new Ministry of Health away from their attack on midwives. Instead, they looked to solve the country's maternal infant health problems by using nurses to expand public health system.

CHAPTER TWO

Nurses, Midwives, and Mestizaje: Shifting Professional Boundaries and the Limits of Medical Hegemony, 1940s-1950s

The year before the national revolution of 1952, Adela de Romero, then a young Tarijeña woman in her early twenties, enrolled in a ten-month course in public health nursing in La Paz. De Romero and twenty of her classmates completed the short training on the heels of a four-year general nursing program, both of which existed because of the *Sistema Cooperativo Interamericano de Salud Pública* (SCISP), an organization founded in 1942 and funded jointly by Bolivia and the United States. Public health nurses like de Romero worked in rural and urban SCISP-funded health clinics designed to provide medical services to poor families. Nurses also walked poor urban neighborhoods, making home visits to conduct pre- and post-natal check-ups, administer vaccines, and refer families to clinics or hospitals when necessary.

De Romero and her colleagues performed an important social mission during a time of major political upheaval in Bolivia. The governments of Colonel Gualberto Villarroel (1943-46) and the MNR-led revolutionary government (1952-1964) sought to democratize the political system and to forge a new Bolivian national identity that would unify the country and soothe festering antagonisms between criollos, mestizos, and Indians. Colonel Villarroel famously called the first national Indigenous Congress in 1945, inviting hundreds of indigenous leaders into La Paz to talk directly with him and other representatives of his government about the concerns of rural laborers and *ayllu* members. The MNR backed Villarroel during his short-lived presidency and later led the nation in revolution. Four months after the April 1952 revolution, the MNR nationalized the country's major mines; the following year, the government announced that the state would carry out land reform. Along with the promise of greater economic equality,

the indigenous population also gained full political rights with the 1952 electoral reform decree that extended voting rights to women and illiterate adults.

Nurses worked on the front lines of Bolivian nascent public health system during this period, serving as an "army of women" that expanded the presence of the state and of medical authorities throughout the country. Young Bolivian women, who were trained by SCISP, followed a trend in public health delivery that historians have analyzed in other national contexts.[153] Marching at the head of state-run medical systems, in the mid-twentieth century, nurses and social workers across Latin America were trained to use their feminine, affective power to build relationships between the state and the lower classes. At the same time, nurses' femininity made them the perfect foot soldiers of western medical campaigns since they were educated to work independently and execute doctors' orders without breaking the medical chain of command or diminishing physicians' authority. While that gendered professional role held true for Bolivian nurses as well, I argue that the Bolivian and American doctors, who coordinated through SCISP, envisioned a loftier mission for Adela de Romero and her colleagues: Bolivian nurses mediated the cultural changes necessary to forge mestizo citizens from the indigenous urban-poor, peasants, and miners.

Focusing on the work of public health nurses during this period, I demonstrate that the goals of the obstetric movement overlapped with the politics of race and nation-building

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[153] María Angélica Illanes, *Cuerpo y sangre de la política: La construcción histórica de las visitadoras sociales, Chile, 1887-1940* (Santiago: LOM, 2005), 337-345. Jadwiga E. Pieper Mooney, *The Politics of Motherhood: Maternity and Women's Rights in Twentieth-Century Chile* (Pittsburg, PA: University of Pittsburgh Press, 2009), 38-39. Claudia Agostini, "Las mensajeras de la salud: enfermeras visitadoras en la ciudad de México durante la década de los 1920," *Estudios de historia moderna y contemporánea de México* no. 33 (2007): 90-119. In Ecuador, state campaigns to reduce infant mortality, eliminate venereal diseases, and regulate prostitution similarly employed trained female health practitioners. Kim Clark, *Gender, State, and Medicine in Highland Ecuador: Modernizing Women, Modernizing the State, 1895-1950 (*Pittsburgh, PA: University of Pittsburgh Press, 2012). On nurses in Mexico following the revolution, see Claudia Agostini, "Las mensajeras de la salud: enfermeras visitadoras en la ciudad de México durante la década de los 1920," *Estudios de historia moderna y contemporánea de México* no. 33 (2007): 90-119.

championed by Villarroel and the MNR. National-level, maternal-infant care efforts carried out in the 1940s and '50s by the Bolivian government, in coordination with the United States, reveal the high stakes for Bolivia's new political elite: the expanded public health system promised to eradicate the cultural characteristics of the country's Indians, replacing them with cultural systems modeled by the United States. Ostensibly, international models of western medical practice could heal the sick, protect the healthy, and bring modern hygienic practices to indigenous and lower-class families in rural and urban areas. Midwives, whose profession was characterized by autonomy, specialized knowledge and close relationships with mothers and families, had no place within the new model of medicine and public health created by Bolivian and American doctors and technocrats. During the 1940s and '50s, the Ministry of Health, with the assistance of SCISP, adopted a two-pronged approach to control childbirth assistance: while public health nurses' worked to decrease popular demand for services of parteras and empiricist midwives, and to direct mothers and pregnant women toward state-regulated health services, the Ministry created attempted to crack down on midwives by publishing registries of licensed midwives and other medical professionals and urging physicians to report all unlicensed practitioners to the Ministry.

Continuity During Revolution: SCISP, Villarroel, the MNR, and the Expansion of Bolivia's Public Health System

The governments of Villarroel and the MNR came to power on the wave of political and social discontent that followed the Chaco War. When the war ended in 1935, veterans, indigenous rural residents, urban market women, students, and middle-class professionals all demanded an end to the oligarchic political system that made possible the corruption, deceit and

flagrant disregard for public opinion and wellbeing that characterized the war. The war also highlighted the stark cultural and socioeconomic divisions between the country's rural indigenous population and the urban, upper-class whites who controlled political and economic decision-making. In response, the emerging class of political leaders, composed of military officers and white middle-class professional men, begrudgingly accepted that the country needed to cultivate a new national identity based on racial and cultural unity. The "military socialist" colonels José David Toro and Germán Busch, who acted as heads of state from 1936 to 1939, set the new political tone by advancing the expansion of individual and collective political rights and calling for social measures that would lift the country's indigenous people out of poverty.

Colonel Gualberto Villarroel became the third military socialist president when he took power by coup in 1943. Embarking on a more radical path to political and social reform, Villarroel won tremendous support from the rural indigenous population for backing the organization of the 1945 Indigenous Congress and then decreeing key demands raised by attendees, including the abolition of unpaid service to landlords, known as *pongueaje*. To the chagrin of large landlords and mine-owners, Villarroel famously proclaimed himself, "not an enemy of rich, but more a friend of the poor."[154] His support for fundamental change, along with other unpopular measures, earned him a cross-class alliance of enemies that quickly sealed his fate. Amidst increasing political unrest that spread throughout the countryside and into the cities, in July 1946, Villarroel and other high-ranking members of this government were killed, dragged from the presidential palace in La Paz, and hanged in the Plaza Murillo.

After a six-year interim (1946-1952) in which the Conservative Party controlled the political process and attempted to silence the demands of unionized miners, rural peasant

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[154] Dunkerley, *Rebellion in the Veins: Political Struggle in Bolivia, 1952-1982* (London: Verso, 1984), 33.

organizations, women's organizations, and urban professionals, the MNR seized power through a triumphant, popular revolution. Composed of young, middle-class professionals, who were veterans of the Chaco War, the MNR took a passionate stance against the violence of the regime of Colonel Enrique Peñaranda, following the 1942 massacre of striking miners in Catavi.[155] The party's leaders, Victor Paz Estensorro, Hernán Siles Suazo, and Juan Lechín, spent much of the years between Villarroel's fall and the revolution in exile, or living clandestinely in Bolivia. The MNR won the presidential elections held in 1951; however the incumbent government blocked it from assuming office. In response, the MNR easily galvanized support for a revolution. Immediately after taking power, the MNR consolidated its broad base of support through three key revolutionary reforms: it extended suffrage to women and illiterate adults, nationalized the mines, and carried out land reform. The MNR also immediately began implementing many of the same social policies promoted by Colonel Villarroel.[156]

Colonel Villarroel and his allies in the MNR promoted a significant change in the state's stance toward mothers and families that had important consequences for Bolivia's public health system and the obstetric movement. For Villarroel and his allies in the MNR, protecting family health and wellbeing was the primary way of harnessing the "positive energy of our indigenous and mestizo masses" in order to ensure "the physical and moral rehabilitation of the Bolivian worker."[157] During his short-lived presidency, Villarroel failed to carry out the social programs

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[155] Laura Gotkowitz writes that the MNR was found in 1941 by "middle-class lawyers and journalists in their twenties and thirties; a good number of its founding members were veterans of the Chaco War. In many cases they were also descendants of semi-impoverished oligarchs, sons of ex-presidents, or sons of managers of failed companies." See her *A Revolution for Our Rights,* 167-168.

[156] On the six-year interim period between Villarroel and the MNR (the "sexenio") see James Dunkerley, *Rebellion in the Veins,* 34. On the connections between the Villarroel government see Gotkowitz, *A Revolution for Our Rights,* 164-191. On the major revolutionary reforms, see Herbert Klein, *A Concise History of Bolivia,* 212-217.

[157] Villarroell in "message to the honorable National Convention" in 1944, quoted in Gotkowitz*, A Revolution for Our Rights*, 175.

he promised, but his government succeeded in creating family subsidies and passing laws designed to protect working women's health.[158]

The emphasis on maternal and family care continued under the MNR-led revolutionary government. The MNR president and revolutionary leader Victor Paz Estenssoro expressed the same sentiment about the value of public health programs to the revolutionary project in his New Year's Eve address to the nation in 1952: Through its investment in public health and medicine, he boasted, the government was "defending [Bolivia's] human capital." In 1952 alone, the Ministry of Health invested forty million bolivianos in the completion of a children's hospital in La Paz and over four million bolivianos for the maternal and infant care services.[159] Under both Villarroel and the MNR, in short, health programs received funding and technical support from the United States held the promise of resolving the country's problems of production and economic backwardness.

Both Villarroel and the MNR promoted mestizaje in order to overcome racial and regional divisions and create national unity. Whereas the small white minority of politicians, physicians, and intellectuals in the 1920s hoped to diminish, and ultimately erase, Indian influences through eugenics policies and European immigration, a new perspective emerged during the 1938 constitutional convention: delegates recognized that national unity would be

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[158] Gotkowitz, *A Revolution for Our Rights,* 177. According to Gotkowitz, military-socialist presidents Busch and Villarroel agreed with Bolivian physicians and intellectuals that the indigenous race, and thereby the Bolivian nation, could be improved by reforming indigenous culture. But unlike Lamarckian eugenists who advocated measures like premarital screenings and training in motherhood, the military-socialist presidents, who held power after the Chaco War, believed that new legislation that protected women and children would improve the country's nation stock.

[159] Victor Paz Estenssoro, "Informe a la nación, Mensaje del 31 de diciembre," *Victor Paz Estenssoro: Discursos y mensajes* (Buenos Aires, Argentina: Ediciones Meridiano, 1953), 48. Equivalencies for the boliviano are difficult to obtain in 1952. In 1957, the dollar exchange rate was 8.1. At that rate, the construction of the children's hospital in 1952 cost close to USD $5 million. As James Wilkie reported, inflation rates began to soar in 1950 and did not stabilize until after 1956, when the President Siles Suazo accepted an IMF-directed monetary stabilization program. The annual cost of living in La Paz between 1952 and 1956 skyrocketed by 130%. See, Wilkie, *The Bolivian Revolution and U.S. Aid since 1952,* 5-6, 12.

impossible without integrating the indigenous majority. Villarroel and the MNR held up the mestizo as the solution to the country's exclusionary national identity. Villarroel, in particular, worked to transform the mestiza market women of Cochabamba into a symbol of national identity.[160] Although the new attitude toward indigenous Bolivians was less overtly racist, as Laura Gotkowitz contends, the MNR's vision of mestizaje nonetheless relied on the subordination of indigenous people within the mestizo national imaginary. Within the mestizo national identity promoted by leaders of the MNR, Indians were never portrayed as political actors, nor were their cultural practices celebrated.[161] My focus on maternal-infant care in this chapter confirms Gotkowitz's contention that Villarroel and the MNR's approach to "integrating" the nation reproduced racial hierarchies even as they extended citizenship rights to indigenous Bolivians.

Despite the political upheavals between Villarroel's government and the national revolution, SCISP's public health programs served as a continuous force of cultural mestizaje. The MNR, as Nicole Pacino argues, used public health programs—including those supported by SCISP—as a means of ensuring economic growth and protecting what president and revolutionary leader Victor Paz Estensorro and others repeatedly referred to as the country's "human capital." Public health programs promoted the process of cultural mestizaje among indigenous and lower-class Bolivians in both urban and rural areas. Importantly, as Pacino notes, public health care was not a unidirectional currency for political transaction; while some rural communities often petitioned the president for hospitals or doctors, framing their pleas in

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[160] Laura Gotkowtiz, "Commemorating the Heroínas: Gender and Civic Ritual in Early-Twentieth-Century Bolivian," in *Hidden Histories of Gender and the States in Latin America,* Elizabeth Dore and Maxine Molyneaux, eds. (Durham and London: Duke University Press, 2000), 215-237.

[161] Gotkowitz, *A Revolution for Our Rights,* 166-174

language that marked them as devoted constituents to the revolutionary party, others ignored Ministry recommendations and continued to patronize local indigenous midwives and healers.[162] While this chapter confirms her conclusion that individual women in both rural and urban areas continued to seek the care of parteras, I show that the political value of public health extended beyond the revolutionary period. The work of Bolivian public health nurses transcended political upheavals. Starting with the first cohort in 1943, public health nurses brought the cultural practices of western medicine, along with the authority of physicians and the Ministry of Health, into the lives of poor rural and urban Bolivians.

Bolivia's public health system, along with the public nursing profession, was created through SCISP, a bilateral collaborative effort between the Bolivian and U.S. governments that spanned the political changes of the 1940s and '50s.[163] Initially planned as a two-year program, SCISCP operated until 1962 and invested a total of USD $6,829,960 in Bolivia's health system. The United States paid 53.4 percent, and the Bolivian government committed 42.2 percent of the organization's budget.[164] During the first phase of its mission, the United States sent a team of public health experts to assess Bolivia's health problems and, along with Bolivian physicians, created a plan for the expansion of the public health programs that prioritized preventive care. Although a series of American men acted as director during the first decade of the organization's operation, it nonetheless remained a collaborative endeavor between Bolivian and American

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[162] Nicole Pacino, "Prescription for a Nation: Public Health in Post-Revolutionary Bolivia" (Doctoral Dissertation, University of California Santa Bárbara, 2013), 52-107.

[163] Carlos Ferrufino Burgoa, for example, identifies SCISP as the "cradle (*cuna*) of Bolivia's public health system in "El Servicio Cooperativo Inter-Americano de Salud Pública: Cuna de la Salud Pública en Bolivia," *Archivos bolivianos de historia de la Medicina* 3, no. 1 (1997): 85-97. Gregorio Lozano Mendizábal contends the same in his *Historia de Salud Pública en Bolivia.* (La Paz, Bolivia: OPS/OMS, 2002), 197.

[164] USAID, *Evaluación Integral del Sector de Salud en Bolivia,* September 1978, 451. Biblioteca del Ministerio de Salud y Deportes.

medical experts. The directors, all of whom were American men during the first decade, reported directly to the Bolivian Minister of Health, but the entity otherwise functioned autonomously, both coordinating with the Ministry on projects and sometimes working independently.[165]

SCISP, along with programs that provided funds for education, agriculture and road construction, was a key component of the U.S. foreign policy towards Bolivia during the 1940s and '50s.[166] In the early 1940s, the U.S. promised Bolivia aid in exchange for lower prices on tin, steel, and rubber needed for the war effort.[167] Funds for SCISP were part of that aid, and they served both the strategic purpose of maintaining diplomatic relations and the more pragmatic purpose of ensuring that Bolivian workers were healthy enough to maintain production.[168] Funds for SCISP continued after World War II, although with a new political purpose; by the 1950s, U.S. extended aid to Bolivia as a type of insurance policy against the spread of communism in the country.[169]

The Bolivian state and the medical profession benefited in many ways from the partnership with the U.S. As I discussed in the last chapter, doctors had successfully influenced the government headed by Germán Busch following the Chaco War, so that, in 1938, the

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[165]Carlos Ferrufino Burgoa, "El Servicio Cooperativo Inter-Americano de Salud Pública: Cuna de la Salud Pública en Bolivia," *Archivos bolivianos de historia de la Medicina* 3, no. 1 (1997): 88. Antonio Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959* (La Paz, Bolivia: Ministerio de Salud Pública, 1959), 1-2.

[166] Nicole Pacino, "Prescription for a Nation: Public Health in Post-Revolutionary Bolivia" (Doctoral Dissertation, University of California Santa Bárbara, 2013), 162-63. Pacino calls SCISP and the other US-funded "servicios" "servicio diplomacy" because the United States used aid to Bolivia as a way to create close economic, cultural, and political ties with the country.

[167]Laura Gotkowitz, *A Revolution for Our Rights: Indigenous Struggles for Land and Justice in Bolivia, 1880-1952* (Durham and London: Duke University Press, 2007), 213-214.

[168] Antonio Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959* (La Paz, Bolivia: Ministerio de Salud Pública, 1959), 1.; USAID, *Evalución Integral del Sector de Salud en Bolivia*, September, 1978, 450-457.

[169]During the 1950s, Bolivia received more U.S. aid than any other country. Siekmeier, *The Bolivian Revolution and The United States, 1952 to Present* (University Park, PA: The Pennsylvania State University Press, 2001), 7.

country's new constitution made health care the responsibility of the new state bureaucracy, the Ministry of Hygiene and Sanitation.[170] SCISP's programs provided the Bolivian government with essential technical and financial support for disease eradication programs and infrastructural and institutional development.[171] Health programs especially targeted the workforce for Bolivia's export sectors (miners in the Andes and rubber workers in the remote Northeastern lowlands). The organization funded hospitals in urban areas, and health centers and traveling 'mobile units' based in Potosí and Tarija in order to expand the provision of both curative and preventive health care. It helped establish the Institute of Occupational Health to study and provide recommendations on safety in mines. It financed programs for the eradication of yellow fever, yaws, tuberculosis, malaria, and other diseases that weakened the workforce. It also funded in-country medical education for physicians, nurses, and other medical auxiliaries and provided scholarships for continued studies in the United States.[172]

The prioritization of maternal-infant care within SCISP's programs complemented both Villarroel's and the MNR's claims that families should receive special attention and protection from the state. The primary activities within SCISP's health centers and two mobile units (*unidades mobiles*) were those designed to protect maternal and infant health. By intervening directly in family life, SCISP hoped to cultivate permanent cultural change in Bolivian families,

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[170] Ann Zulawski, *Unequal Cures: Public Health and Political Change in Bolivia, 1900-1950* (Durham and London: Duke University Press, 2007), 83-84.

[171] USAID, *Evaluación Integral del Sector de Salud en Bolivia,* September 1978, 451-453. Biblioteca del Ministerio de Salud y Deportes.

[172] USAID, *Evalución Integral del Sector de Salud en Bolivia,* September, 1978, 452. Antonio Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959* (La Paz, Bolivia: Ministerio de Salud Pública, 1959), 1. In 1952, Bolivian government, earmarked three million bolivianos to control typhus, and expanded its participation in the malaria campaign. Victor Paz Estenssoro, "Informe a la nación, Mensaje del 31 de diciembre," *Victor Paz Estenssoro: Discursos y mensajes* (Buenos Aires, Argentina: Ediciones Meridiano, 1953), 48.

which in turn would bring about better health.[173] Over its twenty years of operation, SCISP constructed eighteen health centers in both urban and rural areas and created mobile health units in the departments of Potosí and Tarija.[174] The mobile health units consisted of a doctor, a sanitation inspector, and a driver who was also responsible for vaccinations (*chófer vacunador).* In addition to medical equipment, and supplies for rural medical posts, the teams traveled with equipment and educational films.[175]

SCISP-Trained Public Health Nurses and the Expansion of Public Maternal-Infant Care

The "sanitary education" that the mobile units and health centers provided used the "mother-child unit" as an entry point from which to promote preventive and curative services among rural and mining worker families. Health centers were designed to provide pre- and post-natal care services, vaccinations for infants and children, hygiene education, and tuberculosis and venereal disease treatment.[176] To ensure that workers would "protect their own health" and visit the health centers for advice and treatments instead of seeking the assistance of a curandero or empiric, SCISP also invested in "sanitation education" for adults and school children **Figure 5**).[177]

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[173] In financial terms, SCISP's malaria eradication campaign absorbed the majority of its budget. The malaria eradication campaign cost 5,590,550 bolivianos, or about $4 million US dollars, according to USAID. USAID, *Evalución Integral del Sector de Salud en Bolivia,* September, 1978, 451-51. Dr. Antonio Brown, associate director of SCISP projected a malaria budget for 1959 that totaled a full 52% of the organization's budget. Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959,* 1.; USAID, Evalución Integral del Sector de Salud en Bolivia. September, 1978, 13.

[174]USAID, *Evalución Integral del Sector de Salud en Bolivia,* September, 1978, 454. Although USAID reported the creation of 15 centers under SCISP, and Dr. Antonio Brown's 1959 report on SCISP's operations in Bolivia reported that, to date, SCISP had created 18 centers and had transferred 5 of them to the Ministry of Health.

[175] Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959,* 14.

[176] Antonio Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959,* 1.; USAID, *Evalución Integral del Sector de Salud en Bolivia*, September, 1978, 11.

[177] Antonio Brown, 6.

Figure 5. SCISP Maternal-Infant Care Programs. Left, mothers consult with a physician and a nurse. Right, sanitaria education designed to "awaken the sanitary consciousness" of Bolivians. Source: Antonio Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959* (La Paz, Bolivia: Ministerio de Salud Pública, 1959), 7.

Under the guidance of nurses from the United States, Bolivia's new nurses received training to deal with the country's most pressing public health issues, principal among which was maternal-infant care.[178] SCISP provided public health specialization programs for certified nurses as well as programs for lesser-trained "auxiliary nurses" (*enfermeras auxiliares*) and "sanitation educators" (*educadores sanitarios*). Two American nurses, "Señoritas" Rosina Romero and Emilia Saucedo, taught the first training program for nurses in La Paz in 1943, and as the number of trained Bolivian nurses grew, Bolivian women took over instruction. Cochabamba also became a center for nursing education.[179] Other public health nursing courses,

[178] Carlos Ferrufino Burgoa, "El Servicio Cooperativo Inter-Americano de Salud Pública: Cuna de la Salud Pública en Bolivia," *Archivos bolivianos de historia de la Medicina* 3, no. 1 (1997), 91.

[179] Ibid.

which ran between four and twelve months, followed in La Paz in 1944, 1951 and 1958, producing 59 new Bolivian nurses. Shorter courses that typically lasted between 8 weeks and 5 months had produced 52 auxiliary nurses by 1959.[180] SCISP's budget also included funds for construction and administration of the National Nursing School (*Escuela Nacional de Enfermería*) in La Paz, as well as for the administration of the nursing school in Cochabamba.[181]

Public health nurses' emphasis on maternal infant care also put them in direct competition with midwives. Nurses gave smallpox vaccinations and looked for symptoms of contagious diseases within families, reported cases to the Department of Contagious Diseases within the Ministry of Health, and then educated families on disease prevention; however their primary responsibilities were related to maternal and infant care. Nurses gave nutritional advice during early stages of pregnancy, helped ensure that the expectant mother received medical and dental care throughout her pregnancy, encouraged the mother to make arrangements for the delivery, and checked that the family had clothing for the new child. After delivery, nurses helped the new mother heal. If the mother intended to deliver at home, public health nurses made home visits to "inspect the arrangements that the mother has made."[182]

Adela de Romero belonged to one of the first generations of Bolivian nurses who received training through SCISP-funded programs. At 19 years old, de Romero was still living in her hometown of Tarija, when she received a call from a family friend who was the director of the department-level health ministry (*Unidad Sanitaria*). The Ministry of Health was offering

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[180] Antonio Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959,* 18.

[181] Carlos Furrfino Burgoa, "El Servicio Cooperativo Inter Americano de Salud Pública. Cuna de La Salud Pública en Bolivia," *Archivos bolivianos de historia de la medicina* 3, no. 1 (Jan-June 1997): 94-95; Mendizábal, Gregorio Lozano, *Historia de Salud Pública en Bolivia.* (La Paz, Bolivia: OPS/OMS, 2002), 197.

[182] Ministerio de Previsión Social y Salud Pública. Unidad Sanitaria Tarija, *Manual de Procedimientos de Enfermería de Salud Pública* (Tarija, Bolivia, 1959), 8.

three scholarships to young women from Tarija to attend the School of Nursing in La Paz. Years before, de Romero had learned first aid at a course offered through the pre-military school and had taken a liking to medicine. The director gave her a pamphlet on the nursing school in La Paz and asked her to tell friends about the scholarship. De Romero recalled that the pamphlet itself, rather than her previous first aid training, made her want to become a nurse. "On the front there was a photo of a beautiful, well-dressed nurse, with a marvelous uniform," she recalled with a chuckle. "That really made an impression on me."[183] She and two of her friends joined a class of seventeen other young, unmarried women from around the country at the National Nursing School in La Paz in 1946 to begin a four-year nursing course. All of the students were boarders (*internadas*), who lived in university housing in Obrajes, a twenty minute drive from the medical school and general hospital in Miraflores.

The new nursing programs modernized the options for women's participation within the nation without breaking from earlier norms of feminine behavior. In this sense, Bolivia's public health nurses followed a model of health care promotion and delivery that was common throughout the Americas and Europe during the late nineteenth and twentieth centuries. In Porfirian Mexico, for example, public health authorities relied on nurses to act as "messengers of health" by monitoring and instructing lower-class mothers during home visits. Their work was seen not only as a way to decrease infant mortality but also as a critical part of post-war reconstruction.[184] In early twentieth-century Chile, male politicians and physicians deployed an "army of women" to both police and care for lower-class mothers and their families. The effectiveness of these nurse-social workers, who monitored infant health and instructed mothers

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[183] Adela de Romero. *Interview* with Author. May 19, 2012. Tarija, Bolivia.

[184]Claudia Agostini, "Las mensajeras de la salud: enfermeras visitadoras en la ciudad de México durante la década de los 1920," *Estudios de historia moderna y contemporánea de México* no. 33 (2007): 90-119.

in proper childcare, stemmed from their scientific training and their willingness to uphold the existing expectations about proper womanly behavior. Health officials expected the women they employed to work independently, but also to accept and maintain their subordinate relationship to physicians. [185]

Bolivian nurses were similarly trained to uphold a gender hierarchy that extended from the medical profession to the society as a whole, but their profession also served to transform the Bolivian nation along "racial" lines. Like their religious predecessors of the nineteenth century and the first secular nurses of the early twentieth century, public health nurses of the 1940s and '50s were valued for their self-abnegation, modesty, and obedience to the authority of physicians as much as for their scientific knowledge and medical skills. But beyond that, western medical science wielded by nurses served as both a bond between indigenous people and the state and as an acculturating agent that would radically transform racial relations. While they ushered in changes in race relations, Bolivian nurses also embodied continuity in gender expectations.

In this respect, nursing was like other professions open to women in 1950; it required, to borrow historian Elizabeth Hutchinson's words, "labors appropriate to their sex."[186] Census data from 1950 suggests that, if women did not become teachers, their second best option for a professional career was nursing. While primary and secondary education was, by far, the profession that employed the most women in 1950, nursing employed the second largest group

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[185] María Angélica Illanes, *Cuerpo y sangre de la política: La construcción histórica de las visitadoras sociales, Chile, 1887-1940* (Santiago: LOM, 2005), 337-345. Jadwiga E. Pieper Mooney, *The Politics of Motherhood: Maternity and Women's Rights in Twentieth-Century Chile* (Pittsburg, PA: University of Pittsburgh Press, 2009), 38-39. Claudia Agostini, "Las mensajeras de la salud: enfermeras visitadoras en la ciudad de México durante la década de los 1920," *Estudios de historia moderna y contemporánea de México* no. 33 (2007): 90-119. In Ecuador, state campaigns to reduce infant mortality, eliminate venereal diseases, and regulate prostitution similarly employed trained female health practitioners. Kim Clark, *Gender, State, and Medicine in Highland Ecuador: Modernizing Women, Modernizing the State, 1895-1950 (*Pittsburgh, PA: University of Pittsburgh Press, 2012).

[186] Elizabeth Quay Hutchinson, *Labors Appropriate to Their Sex: Gender, Labor, and Politics in Urban Chile, 1900-1930* (Durham and London: Duke University Press, 2001).

of women. While women earned money in many ways, including property management, street-side vending, agricultural work and prostitution (the census listed 57 *"mujeres públicas"*), few professions were open to women. Within medical fields, women could become midwives, nurses, dentists, or chemists, but only two percent of physicians and surgeons were women. In other fields, such as law and civil engineering, no more than two percent were women (see Appendix D).[187]

The 1952 revolution did little to change these gender imbalances; despite women's mobilization in support of the MNR, the revolution was strikingly un-revolutionary in terms of gender. Women gained suffrage in 1952 but were otherwise expected support the revolutionary process through traditionally-feminine roles. Scholars like sociologist Gloria Ardaya have shown that the women's branch of the MNR, the *Comando Nacional Feminino del MNR*, helped mobilize support for the revolution but did not make political demands that diverged from the goals of the male party leadership.[188]

While public health nursing gave young women some of the same freedom of mobility, and economic independence enjoyed by matronas, it also required them to adhere to the standards feminine obedience and morality. The nursing schools in La Paz and Cochabamba, along with the nursing program in Catavi (and decades later, the programs in Sucre and Tarija that I discuss in the next chapter) consistently attracted cohorts of young women who became country's nurses. By all accounts, nursing schools often occupied women's lives around the

[187] República de Bolivia, Ministerio de hacienda y estadística. Dirección general de estadística y censos, *Censo Demográfico, 1950* (La Paz: Editorial "Argote," 1955), 231-252.

[188] Gloria Ardaya, "La mujer en la lucha del pueblo boliviano: Las Barzolas y el Comité de amas de casa," *Nueva Sociedad* 65 (Marzo-Abril 1983): 112-126.

clock, and the professional lives of trained nurses proved no less demanding.[189] Not unlike the nuns, young nursing students lived, ate, slept, and worked together. A private bus picked them up in the morning at seven o'clock for classes and took them to the city center, where their classes were held in the offices of the General Directorate of Health (*Dirección General de Salud)*, the building that now houses the Ministry of Public Health. At twelve-thirty, they were taken back to Obrajes for lunch, and in the afternoons, a shuttle drove them to the Miraflores neighborhood to work in the hospital. The scholarship, she recalled, covered room, board and tuition, and "left us with about 80 bolivianos per year, which was enough for three roundtrips home and a pair of nylon stockings." [190] After finishing the four-year nursing program, de Romero and her classmates completed a ten-month course in public health. In addition to course work, the nurses paid home visits to poor neighborhoods in La Paz.

As a public health nurse, home visits were a key part of de Romero and her classmate's job. "During the home visits," recounted de Romero, "we interviewed mothers who had sick children to see if they were capable of taking care of their child alone or if they needed help. Or when they went to the health centers for Well Baby visits, the doctors sometimes gave them a lot of recommendations, and sometimes they didn't understand it all. So we would clarify what the doctors had told them and make sure they were following through… For example, sometimes they would take their babies in for one vaccination and then never return."[191]

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[189] Ana María Maldonado Canedo's work argues that the long hours and exhausting nature of nursing in Bolivia is part of the gendered hierarchical structure of the profession that keeps nurses subordinate to doctors. Interviews with Bolivian nurses and *enfermeras-obstetrices* supported Maldonado's conclusions. Ana María Maldonado Canedo, *Miradas desde adentro. Una reflexión para el debate* (La Paz, Bolivia: Colegio de Enfermeras de Bolivia, 2003).

[190] Adela de Romero. *Interview with Author*. May 19, 2012. Tarija, Bolivia.

[191] Ibid.

In 1959, the Ministry of Health published a procedures manual for public health nurses that placed home visits at the center of a public health nurses' duties and the work of nurses at the center of the expansion of the country's public health system. The "Procedures Manual for Public Health Nurses," written with the assistance of a Bolivian nurse and SCISP employee, Señora Delicia Aramayo de Mendoza, provided step-by-step instructions for home-visits. Home visits, according to the authors, were "indispensable to the proper advancement of a public health program."[192] Home visits allowed nurses to secure the trust of families, who would otherwise avoid going to health centers, both because health care was often prohibitively expensive, and because instructions were at best unclear and at worst, tinged with racist condescension. Nurses were instructed to listen carefully to the patient and to make the patient feel she could talk openly to them. The length of visits remained open-ended in order to allow enough time to treat each family's needs. The home visits also allowed nurses to make notes about the patient's family relationships, as well as the conditions within the home and the challenges of daily life. Like Adela de Romero, public health nurses of the late 1950s conducted home visits on maternal, infant, and child health, and venereal and contagious diseases.[193]

Nurses' instructions for clinical consultations also stressed both the feminine, affective nature of her work and her position within the medical chain of command. Nurses were instructed to treat patients with "care and courtesy." Within the health centers, the nurse was responsible for creating "a favorable environment that offers mental and physical security for

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[192] Ministerio de Previsión Social y Salud Pública, Unidad Sanitaria "Tarija", *Manual de Procedimientos de Enfermería de Salud Pública*, 1959, 2. The prologue for this publication includes at note that the manual was edited in 1959 in La Paz by Señora Delicia Aramayo de Mendoza, a public health nurse, with collaboration from the General Supervisor and supervisors of the Health Center "La Paz." Aramayo de Mendoza was listed as an "enfermera consultora" for the Medical Division of SCISP by Ferrufino Burgoa, who was himself a SCISP employee. Carlos Furrfino Burgoa, "El Servicio Cooperativo Inter Americano de Salud Pública. Cuna de La Salud Pública en Bolivia," *Archivos bolivianos de historia de la medicina* 3, no. 1 (January-June 1997): 93.

[193] Ministerio de Previsión Social y Salud Pública. Unidad Sanitaria "Tarija," *Manual de Procedimientos de Enfermería de Salud Pública* Tarija, Bolivia, 1959.

everyone," making sure to call patients by their names rather than their numbers.[194] Although nurses treated patients when they arrived at the clinic in need of assistance and clarified instructions on the use and purpose of medications prescribed by doctors, education was their primary objective within the clinics.[195]

The manual's detailed professional standards and work instructions also underscore the tension between dependency and autonomy that characterized public health nurses' work; although they typically worked independently, their work was routinized and their appearance highly regulated. Nurses were required to wear marine-blue suits, white blouses, sturdy black shoes with low heels, and nylons. If she was married, a nurse could wear her wedding ring in addition to a wrist watch, but regulations permitted no other adornment. Hair had to be kept short or pulled back in a neat bun, and the briefcase she carried with her during home visits was to hang at her side from one hand. The instructions also laid out precise steps for the public health nurse to follow during home visits, which she made three days per week. In the outside pocket of her briefcase, she tucked a folded newspaper alongside a collection of paper products. The paper bags for disposal were next to the paper towels and napkins, which she carried alongside a paper mask and apron and her educational materials. When she arrived at the house, she removed the newspaper and set it on a table or other stable, flat surface. Placing the suitcase on top of the newspaper, she unfolded a napkin alongside it and placed on it any items she needed for the checkup. Sometimes that meant she removed the oral thermometer, which was stored in a tube of alcohol, gauze to refresh the bandage on an umbilical cord, or, in some cases, a vaccination syringe. Then she removed the charts she carried that detailed the last visit to the family home,

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[194] Ministerio de Previsión Social y Salud Pública. Unidad Sanitaria Tarija, *Manual de Procedimientos de Enfermería de Salud Pública* (Tarija, Bolivia, 1959), 5.

[195] Ibid, 6.

including treatments and conversations with the patient and the family. She closed the suitcase. If the family had running water, she used it to wash her hands with the soap she carried and dried her hands with her towel. When the family had no running water, she asked someone to pour stored water over her hands, allowing her to avoid further contamination by touching the vessel.[196]

Yet, even though nursing was physically demanding and restrictive in gendered terms, the expansion of nursing also "modernized patriarchy" by offering young women of limited economic means the opportunity for a career, and occasionally, for continued education beyond the nursing degree.[197] Nurses also managed to marry and raise families in spite of their exhausting schedules. After completing the four-year nursing program, de Romero and several of her classmates completed a ten-month course in public health. She returned to Tarija to work for a state-run health center, but as part of the collaboration between the United States and Bolivia through SCISP, she and three other nurses were hired to work at the Cedar Valley Hospital in Iowa City.[198] Her three colleagues married U.S. citizens and remained in the United States to work and raise their families, but Adela returned to Bolivia after two years in Iowa, because she had already accepted another scholarship from the Public Health Directorate (*Dirección de Salud Pública)* to study hospital administration in Syracuse, New York. Because of her education and tenacity, de Romero went on to reform the nursing care protocol at the San Juan de Dios Hospital in Tarija, and, in the early 1970s, she led a complete overhaul of the nursing education system in

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[196] Ministerio de Previsión Social y Salud Pública. Unidad Sanitaria Tarija, *Manual de Procedimientos de Enfermería de Salud Pública* (Tarija, Bolivia), 1959.

[197] Ana María Maldonado Canedo, *Miradas desde adentro.* Susan Besse, *The Modernization of Patriarchy: Restructuring Gender Inequality in Brazil, 1914-1940* (Chapel Hill and London: University of North Carolina Press, 1996).

[198] Between 1943 and 1959, 22 nurses trained by SCISP received scholarships from the organization to continue their studies abroad. Antonio Brown, *Resumen de las actividades del S.C.I.S.P. en Bolivia, 1942-1959,* 1959[?], 18.

the country to the chagrin of many doctors. In the midst of it all, de Romero, like many of her colleagues, married and had children. Although the vast majority of nurses did not climb the professional ladder to the heights of administration, de Romero's experiences nonetheless highlight the professional opportunities made available to young women in the 1940s by an influx of financial support from SCISP.

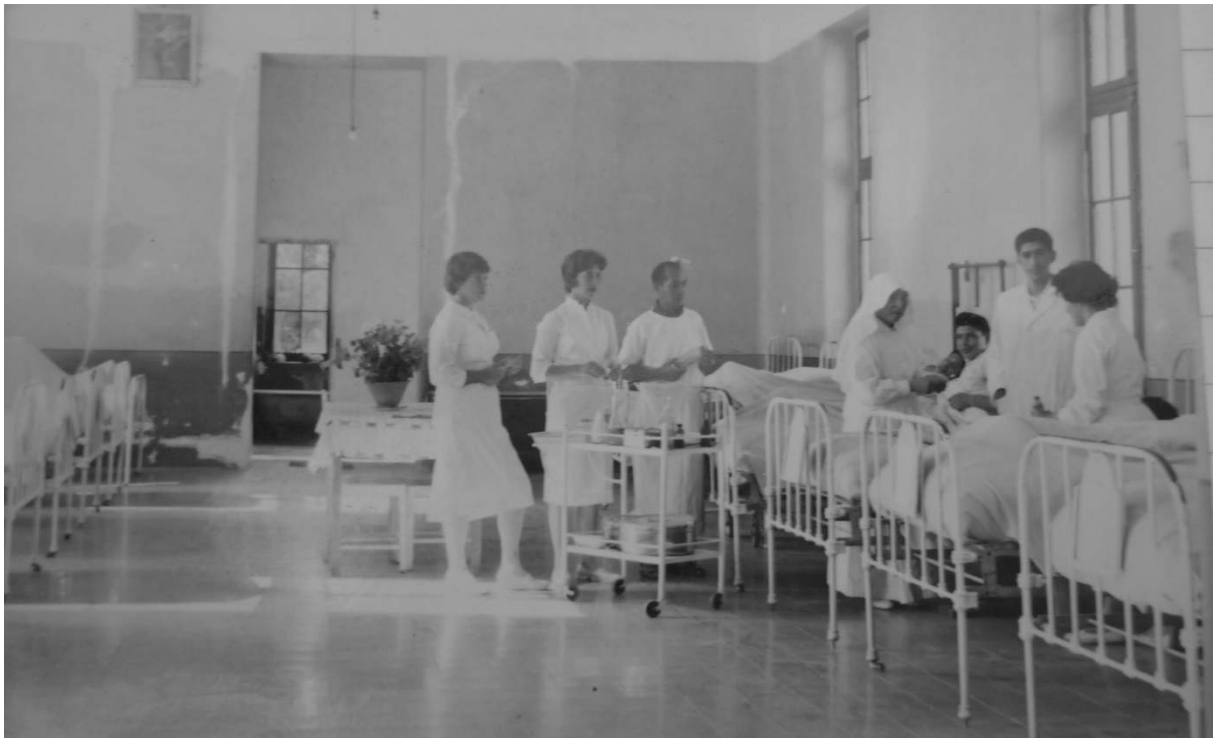

Figure 6. Nurses and Nuns in Tarija. Alina de Rivera (right) along with two American nurses (left) and a Santa Ana nun at the San Juan de Dios Hospital, Tarija. Photograph courtesy of Alina de Rivera.

Medical Regulation, Childbirth and Efforts to Overcome the Rural-Urban Divide

Infrastructural expansion and the promotion and provision of medical services carried out by public health nurses went hand-in-hand with physicians' struggle to regulate medical practice. In 1946, the Ministry of Health published a registry of physicians and auxiliary professionals. On the opening page of the registry (*Guía de profesionales médicos y ramas anexas*), the Ministry included a brief note to the user:

Sir Professional (*Señor Profesional):*

> For your own interest and the protection of your professional prestige, help us combat the clandestine exercise of the medical profession and auxiliary professions (*ramas anexas*) by reporting all persons that unscrupulously threaten public health to the Department of Bio-statistics and Personnel" of the General Sanitation Directorate ("Salubridad" Building, Plaza del Estudiante, La Paz, Bolivia).[199]

In case physicians had any doubt about the seriousness and authority of the registry, the subsequent pages included the section of the Ministry's 1938 Statute on the exercise of the medical professional, which affirmed that all those wishing to practice the professions of physician (*médico-cirujano),* pharmacist, dentist, or midwife (*obstetriz*) must hold a diploma from a Bolivian university and register with the Ministry of Health.[200] The registry proper included the practitioner's name, department of residence, address, the university at which he or she studied and the graduation date (*fecha del título*)*,* followed by the date he or she received his or her state certification (*fecha de la resolución suprema)*. An executive decree from the same year, which set the penalty for illegal practice or for knowingly facilitating the practice of an unlicensed individual, was included on a following page. The Ministry threatened to impose a 1,000 boliviano fine for first-time offenders who illegally provided medical services or marketed their services in an attempt to do so. Subsequent offenses carried a 5,000-boliviano fine.[201]

Under the revolutionary government, the Ministry of Health continued its efforts to eradicate medical practice by unlicensed healers. During the MNR's first year in power, the

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[199] Ministerio de Trabajo, Salubridad y Previsión Social, *Guía de profesionales en medicina y ramas anexas,* December, 1946.

[200] These decrees may not have been widely enforced but were enforced on some occasions. During the Chaco War, public health authorities attempted to prosecute unlicensed healers in cities, even though licensed physicians and pharmacists had pulled to the frontlines, often leaving urban residents with no other options for care. Zulawski, *Unequal Cures,* 72-73.

[201] Ministerio de Trabajo, Salubridad y Previsión Social, *Guía de profesionales en medicina y ramas anexas,* December, 1946.

Ministry of Health published the 1938 *Estatuto Orgánico del Ejercicio Profesional,* which limited medical practice to formally trained and licensed biomedical practitioners and penalized licensed practitioners who used their position to abet or conceal the practice of an indigenous or unlicensed healer ("*de un curandero o empírico*"), in the newspaper *El Diario*.[202] Days after *El Diario* published the Statute, the newspaper's director, José Carrasco Jiménez published the Ministry's move to crack down on what he called the "illegal and dangerous" practices of curanderos and unlicensed doctors.[203]

New public maternities provided evidence of both the growing political power of physicians who specialized in obstetric care and the centrality of maternal-infant care regulation to state expansion. After 1952, the revolutionary government heeded the call of physicians who urged the creation of public maternities in urban areas. One of the first public maternities that opened after the revolution was in Santa Cruz. After years of unsuccessfully petitioning funds from every government between Villarroel and the MNR, Dr. Percy Boland, an obstetrician from Santa Cruz, finally received the political support he needed to create a separate maternity ward within the Santa Cruz public hospital. In part, Boland's success reflected the MNR's prioritization of maternal-infant care within its revolutionary project. It also arose from the consolidation of physicians' power under the MNR. The Minister of Health, Dr. Julio Manuel Aramayo, was a personal friend of Boland and their common specialty in obstetrics elevated the importance of childbirth assistance within the national health program. Boland, who had completed his medical education in Argentina and returned to Santa Cruz in 1943, also benefited

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[202] "Ministerio de Higiene y Salubridad. Estatuto Orgánico. Del Ejercicio Profesional," *El Diario,* 3 July 1952, 8. "Será considerado como ejercicio ilegal de la medicina y estará sujeto a las mismas penalidades todo aquél que teniendo título legalmente expedido para ejercer la medicina en cualquiera de sus ramas lo utilice para cohonestar o encubrir las actividades de un curandero o empírico o profesional no autorizado legalmente."

[203] José Carrasco Jimenez, "Ejercicio Ilegal de la Profesión" *El Diario,* 7 July 1952, 4.

from the relationship between the U.S. and Bolivia under SCISP. In 1947, in the midst of his long battle to build a maternity in Santa Cruz, he received a scholarship from SCISP to complete further studies in obstetrics and gynecology at Harvard School of Public Health. Over the next several years, the Boland worked to win the confidence of women who sought care during their pregnancies, to expand the number of beds in the maternity and, as Bolivian physician and historian Dr. Gregorio Mendizábal wrote, "to replace traditional midwives that still remained" with nurse midwives.[204]

In 1955, paceño newspaper editorials directed at their upper-class readers heralded the opening of a new public maternity ward, the Dr. Natalio Aramayo Maternity Institute, as a godsend for "working class" mothers. Named after the prominent obstetrician and father of the Minister of Health and located in the Miraflores General Hospital, the new maternity stood as a powerful symbol of the alliance between physicians and the state, which would act as both mother and midwife to a new unified, mestizo nation. The opening of the maternity ward was a great relief according one editorialist of the newspaper *Última Hora,* who praised the Institute's creation as a "social work with enormous importance for the working classes" that would "position [the city of La Paz] among the most advanced in the South American community." "The working woman," he continued, "will not have any reason to fear the consequences and responsibilities of childbirth, knowing that there exists a state institution that will hold her to its breast to provide her the help she needs."[205]

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[204] Gregorio Mendizábal Lozano, *Historia de la salud pública en Bolivia: de la juntas de sanidad a los directoRíos locales de salud,* 188-189.

[205] "Como su enunciado lo expresa, este nuevo servicio llenará funciones de primera importancia y positiva trascendencia en nuestro medio, elevando de paso la jerarquía de la ciudad de La Paz, que de tal modo camina a colocarse entre las más adelantadas de la comunidad sudamericana." "La mujer obrera no tendrá por qué temer a las consecuencias y responsabilidades del alumbramiento, sabiendo que existe una institución del Estado que la acogerá en su seno para brindarle la ayuda necesaria." "Instituto Materno-Infantil," *Última Hora*, 1 September, 1955.

Patient records from the maternity ward show that class and ethnic integration occurred within the hospital on a level that the government tried to create on a national scale. The Ministry of Health succeeded in attracting the city's "working-class" women, along with indigenous women, newcomers to the city, and longtime residents, some of whom had never before given birth in a hospital or clinic. Who were these "working-class" mothers? Some 800 women gave birth in the hospital in 1955 and most managed to answer demographic and health history questions before delivering. When time permitted, hospital personnel (most likely either the "matrona" or medical intern on duty) indicated the woman's age, "race" (*raza*), marital status, occupation, education, and city of origin. Although nearly half of the records indicated simply that the patient was engaged in housework (*labores de casa*), many others were occupied in a variety of paid, domestic work such as servants, cooks, seamstresses, or vendors of some kind (*comerciante, negociante, frutera*). Only roughly thirty percent of patients said they were originally from La Paz.

Of the 700 patients who received a racial classification, roughly two-thirds (456 of 700) were identified as "mestiza," leaving the other third roughly equal between "white" women (*blanca*) and indigenous women, whom hospital personnel identified with an "*i"* or occasionally with the word "*indigena"*[206] The revolutionary government eliminated the legal category "Indio" as part of a larger strategy to assimilate indigenous people into a new mestizo national identity, but Bolivia's medical community clearly still believed that the category was socially and medically significant.[207] Racial classification depended on the recorder's subjective

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[206] The record of Martha Fernández de Condori is one example. Fernández de Condori was described by hospital staff as a twenty-eight year old, married, indigenous woman ("*indig"*) who sold fruit in the city. Instituto de Maternidad "Professor Dr. Natalio A. Aramayo", March 31, 1955. ALP.

[207] Canessa, Andrew. "Introduction" in *Natives Making Nation: Gender, Indigeneity, and the State in the Andes.* Edited by Andrew Canessa. (Tucson, AZ: The University of Arizona Press, 2005), 15.

assessment of a number of factors. When medical personnel made racial classifications, questions about the educational level of the patient influenced their perception of the patient's race.[208] In this case, however, hospital personnel likely based their racial classifications on women's dress, Spanish-language proficiency, skin tone and place of origin. Women classified as "Indian" who were not originally from La Paz, commonly indicated their hometown, rather than their department of origin, illuminating their identification with local communities, rather than on the official political boundaries of the departments.

The appearance of many experienced mothers in the Miraflores maternity in 1955 indicates that public health efforts to attract women to the hospital —including home visits by public health nurses— were successful. In February and March of 1955, half of the women who had previously given birth, were doing so outside of the home for the first or second time. Berta Miranda de Illanes, a "blanca" woman from Oruro gave birth to her first three children at home in La Paz before checking herself into the maternity. Another woman, listed as a 35-year old single, white woman from Sucre, had given birth to her first four children in her home with help of a matrona. The records do not indicate the reasons women chose to seek hospital care for their deliveries, but regardless of their motives, their presence in the hospital indicates a growing confidence in urban hospital care.

Women identified as "indigenous" by hospital personnel also sought care at the Miraflores maternity. Benigna Castillo Lima, a 32-year-old married woman, who worked as a

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[208] In her use of patient documents from the Manicomio Pacheco in Sucre during the 1930s and '40s, Ann Zulawski found that "a patient's race could often change, apparently because of social or economic considerations." See her, *Unequal Cures,* 178. Marcia Stephenson also points to the malleability of race in Bolivia in that hairstyles, clothing, and occupation of public spaces mark women's racial and cultural differences, and that the *chola*— urban women identified by their multilayered *pollera* skirts, shawls, bowler hats and long braids—are seen neither as mestiza nor indigenous, but fall into third non-white category. Recorders, then, likely classified women based on a loose set of criteria that included attire, the mothers comfort with Spanish, city of origin, and occupation.

"comerciante" and was described by hospital staff as "deficient in nutrition and hygiene," checked herself into the maternity ward on November 24, 1955 to deliver her fifth child. She had given birth four times before under the care of a matrona, three times in the Miraflores General Hospital and once in Puerto Guaqui, a tiny town on the shores of Lake Titicaca. Giving birth in a clinic had not saved her children from the hardships of an impoverished life in a country with little medical infrastructure. Although her first child was still alive in 1955, her second had died of pulmonary disease. Her third died at only four months of age of scarlet fever, and her fourth succumbed to measles a year after birth. Although her fifth child was born healthy and without incident, the records do not indicate if expansions of preventive health care in La Paz helped the child to avoid the same fate as its siblings.[209]

Other cases, however, show that many indigenous residents of La Paz were still reluctant to deliver in maternities. On the morning of June 8, 1955, family members brought Leandra Asistiri to the maternity in Miraflores. According to the medical intern, Guerillermo Méndez Rodríguez, who admitted her and later wrote a report on her case, Asistiri arrived in an extremely grave state and immediately began convulsing. Dr. López Vidal, who had studied gynecology in La Paz and was acting director of the maternity at the time, was in the hospital when Asistiri arrived. The doctor and intern managed to transfer her to a delivery table, where she "shook and then remained immobile." They detected no heartbeat either in Asistiri or in the baby, and further examination showed that Asisitiri had suffered horrifically from a failed delivery before coming to the hospital. The unborn child, a girl, was positioned laterally in the uterus, and only her left arm had successfully passed through the vaginal canal. The doctor ordered intravenous

[209] Instituto de Maternidad "Professor Dr. Natalio A. Aramayo", October-November, 1955. Patient record for Benigna Castillo Lima. Statistics for "Indians." Archivo Histórico de La Paz (ALP).

Cardiazol and "artificial respiration" in an attempt to save her, but his efforts were in vain. During a post-mortem examination, examiners found that Asistiri's uterus had ruptured. [210]

If doctors had the most power in urban centers like La Paz, their authority was still far from absolute, and in smaller cities and towns, their ability to enforce the medical hierarchy decreased within hospitals. In urban areas, even formally-trained matronas were slow to comply with the state's certification requirements. Some of the sixty-three midwives (*obstetrices*) in the registry had been practicing for decades without formal certification from the state. Ester Gutiérrez v. de Pando, for example, completed her studies in 1900 in Universidad Mayor San Andrés (UMSA) in La Paz but did not register with the state (*fecha de r. suprema*) until 1929. Other midwives with extensive careers before their state certification included Zaida Claros L. (a 1910 graduate of UMSA) and Delmira Cándano de P. (UMSA, 1915). The most junior midwives on the registry had gained their state certification promptly after graduating, indicating that universities were communicating the new laws to their students. Aurora Saez Imaná graduated in 1943 from Sucre and was licensed the same year.[211]

The concentration of registered matronas in urban areas further illustrates the limited geographic reach of western medicine. All of the midwives in the registry graduated from midwifery programs at the UMSA in La Paz, the Universidad Mayor de San Francisco Xavier in Sucre, or the Universidad Simón Bolívar in Cochabamba. In all of the cases for which there were local addresses (33 of 63), all but two lived in urban areas in the city where they had attended school. Two other addresses indicate that matronas were working in mining clinics, although oral

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[210] Guerillermo Méndez Rodríguez, "Historia Clínica. Informe y Protocolo de Autopsia," Instituto de maternidad "Professor Dr. Natalio A Aramayo," June 8, 1955. ALP.

[211] Ministerio de Trabajo, Salubridad y Previsión Social, *Guía de profesionales en medicina y ramas anexas,* December, 1946, 99-103. Biblioteca del Ministerio de Salud y Deportes.

histories suggest that many more certified midwives did the same.[212] Luisa v. de Balderrama graduated from the university in Sucre in June 1923 and registered with the state four years later.[213] The registry indicated that she lived "en Catavi," a mining center in the department of Potosí. Similarly, in March 1943, Isabel Arce Villegas received her diploma from the university in Cochabamba, formalized her profession with the state in 1944 and was working in the "Mina S. José" in Oruro in 1946.[214] It is possible that a number of the midwives who were eligible for certification worked in rural areas but had simply not registered. In that case, the absence of any rural address in the registry would nonetheless demonstrate the inability of the state to account for the total number of trained medical personnel.

Even within hospitals, doctors had not yet consolidated a hierarchy of expertise based on formal training. The maternity at the Miraflores General Hospital in La Paz kept a matrona on shift, day and night, and patient records show that matronas assisted in all births, except for the rare cases in which a doctor was called in to apply forceps or perform a cesarean. Records do not indicate who these professional matronas were, if they were Bolivian or foreigners, or if they had received formal training, but in both Tarija and Sucre during the 1950s, the hospitals also relied on empirically-trained midwives to attend births.

The long career of Spanish-speaking midwife, Irene Galviz Escobar stands out as an example both of the diversity of practices among Bolivian midwives and of the incoherent nature of obstetric medicine in Bolivia during the first half of the twentieth century. Born in the

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[212]Ana María Maldonado Canedo, *Interview with Author.* La Paz, Bolivia, 22 May 2012. Maldonado Canedo said that midwives of her generation found immediate work in the mines but that others had also worked in the mining areas decades before her.

[213] Ministerio de Trabajo, Salubridad y Previsión Social, *Guía de profesionales en medicina y ramas anexas,* December, 1946, 99. Biblioteca del Ministerio de Salud y Deportes.

[214] Ibid, 99.

Postrervalle in the department of Santa Cruz in 1911, Irene Galviz Escobar began assisting her neighbors during childbirth, shortly after the birth of her first child at the age of fifteen. Postrervalle was a rural area roughly halfway between the cities of Santa Cruz and Sucre, and, in the early part of the twentieth century, the town had no health centers to serve its dispersed population of small, Spanish-speaking farming families. Galviz's granddaughters recalled that their grandmother first began to learn about natural remedies for healing and techniques for assisting in childbirth from a book on natural medicine that she found as a teenager. Her career as a midwife started by chance when a neighbor went into labor with only Irene to assist. By the time she left her husband and moved to Sucre with her two daughters, Escobar had already developed a reputation as a respected and skilled midwife.[215]

After moving to Sucre from Postrervalle, Galviz established a thriving private practice among upper- and lower-class sucreña families and also worked periodically at Sucre's Santa Bárbara Hospital through the 1950s, even though her only training was based on her own experiences assisting women and her book on natural remedies.[216] In spite of her lack of formal medical training, Galviz worked in the public Santa Bárbara Hospital in Sucre for twenty years. She did not retire from her work until the 1960s, when her arthritic hands made prenatal massage, and the precarious job of catching new-born babies, too difficult.

Galviz's midwifery practices reflected her experiences both with natural healing techniques and the biomedical system. During gestation, she massaged the fetus into position for birth. Once contractions had started, she fed her patients a drink of raw egg and parsley to speed dilation and contractions. Some of her practices also point to her experiences with medical

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[215] Lenny Villagomez Sosa, (granddaughter of Irene Galviz Escobar), *Interview with Author.* Sucre, Bolivia. 24 February 2012.

[216] Ibid.

doctors. She never used gloves, but washed her hands with soap and rubbed them with alcohol. She used scissors to cut the umbilical cord, which she sanitized with alcohol or by holding them over a flame. She never used forceps, but would, in difficult births, insert the middle and index finger of each hand stretch to the vaginal opening and pull the head of the baby. Unlike biomedical procedures for delivery, however, Galviz did not put her patients in the gynecological position. Instead, she advised women to take a position that would be easiest for them, depending on the position of the baby and the comfort of the parturient. Often that meant that Irene's patients gave birth in a squatting position. Over the course of her career, Irene delivered approximately 1200 babies.[217]

In Tarija, one of the two midwives at the public hospital, San Juan de Dios, was an empirically-trained midwife named Josefa. Alina de Rivera, a graduate of Tarija's Midwifery School, who worked under Josefa's supervision, described her as a tiny, dark-skinned woman "from the *campo*", who was strict and struck fear into most of the students. De Rivera had more positives memories of Rosita Salamón, the other matrona on staff at San Juan de Dios. A native Tarijeña, whom de Rivera described as a "turca,"[218] Salamón's popularity among young mothers earned her credibility throughout the town, and she frequently attended births in homes when she

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[217] Lenny Villagomez Sosa, (granddaughter of Irene Galviz Escobar), *Interview with Author.* Sucre, Bolivia. 24 February 2012.

[218] The 1950 census recorded 900 foreign-born residents that might have been classified as "turcos," or Turks, in daily life. The census classified Lebanese, Palestinian, Syrian, and Turkish residents, more than half of whom in each category were men. República de Bolivia, Ministerio de hacienda y estadística. Dirección general de estadística y censos. *Censo Demográfico, 1950* (La Paz: Editorial "Argote," 1955), 125. Although Rosita Salamón was born in Bolivia, her chosen career would have been familiar to family members in the Ottoman Empire. Midwifery in the Ottoman Empire went through a similar process of professionalization and subordination to state and male medical authorities in the mid- to late-nineteenth century. Tuba Demirci and Selçuk Akşin Somel, "Women's Bodies, Demography, and Public Health: Abortion Policy and Perspective in the Ottoman Empire of the Nineteenth Century," *Journal of the History of Sexuality* 17, no. 3 (September 2008): 377-420.

was not on shift at the hospital. As a formally-trained midwife, Salmon reportedly paid great attention to sterilization, even in private homes.[219]

Matronas, and even western-style empirics, faced little pressure in complying with the state's regulations because they were still the preeminent specialists in childbirth assistance. Only 25 of 587 registered doctors (4.25 percent) listed their area of specialization as obstetrics (*obstetricia*) in 1946. Bolivian universities at the time did not offer extended training in any branch of medicine. All physicians graduated as general practitioners, and unless they had continued their education abroad, their stated area of expertise was simply the area in which they had informally specialized and preferred to practice.[220] Nonetheless, nearly half of those physicians who specialized in obstetrics resided in the city of La Paz. The others were dispersed throughout the departments of Potosí, Oruro, Cochabamba, Sucre, and Santa Cruz, leaving the rest of the country without any obstetricians at all. "Obstetricians" were also highly concentrated in urban areas. Only four of the twenty-five in the registry resided outside of major urban areas.[221]

In rural areas, physicians' limited presence left them little hope of exerting professional authority. Both hospitals and trained medical personnel were concentrated in urban areas,

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[219] Alina de Rivera, *Interview with Author.* Sucre, Bolivia. 9 May 2012.

[220] Dr. Gonzalo Virreira, *Interview with Author.* Sucre, Bolivia, 16 April, 2012.

[221] For example, Eduardo Eguia, lived in Tupiza, in the department of Potosí. A graduate 1906 graduate of the university in Sucre, Eguia would have been in his sixties and most likely approaching retirement when the registry was published. He listed his specializations in gynecology, obstetrics, and venereal diseases. Ernesto Urquizo P. worked in the Potosí mining town of Llallagua. He graduated from the Sucre in 1924. Twenty years his junior in terms of professional experience, Jorge Yáñez Ortíz also studied in Sucre and worked in Huanuni, Potosí. Alberto Zubieta Cardona studied in at the Universidad de Simón Bolivar in Potosí and worked in country's salt flats region of Uyuni. Decreto Ley, N. 2990, March 4, 1952 under Gen. Hugo Ballivián, President of the Military Junta made one year of rural service mandatory for any physician who wished to work for the Ministry of Health. *Biblioteca y Archivo Histórico del Congreso Nacional.* Costa Ardúz writes that, following the revolution, the MNR broadened the one-year rural service mandate to apply to all graduates of national medical schools. See his *Ministerio de Trabajo, Salubridad y Previsión Social,* 86; *Guía de profesionales en medicina y ramas anexas,* December, 1946, 6-53. Biblioteca del Ministerio de Salud y Deportes.

making it exceedingly difficult for the Ministry of Health to regulate medical practice outside of cities. In places with little or no access to western medical services, people could hardly be expected to seek medical attention exclusively from licensed practitioners. Urban areas and mining centers had the vast majority of medical facilities, including both public and private maternities. In the department of La Paz, for example, eighty-eight percent of all hospital beds were located in the city of La Paz, even though the city was home to only one quarter of the population in the department.[222] Even within urban areas, access to care was unequal. The city of La Paz, for example, had a total of 1,037 hospital beds in private clinics while the public sector provided only 595 beds. Private institutions like the *Clínica Alemana,* the *Clínica Americana* and the private clinics of paceño physicians provided more comfortable care for those who could afford it. The rest of the department's rural provinces that were carved out across eighty-square miles of the Andean highlands and the semi-tropical Yungas region, had three hospitals health centers, three maternity centers and a total of 133 beds.[223]

Bolivia's geography and limited resources for transportation infrastructure further frustrated doctors' desires to make biomedical care the norm for all Bolivians. The second national census in 1950 showed that sixty-six percent of the country's population lived in rural areas, leaving the white and mestizo urban minority that made up the political and economic

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[222] *Guía de profesionales en medicina y ramas anexas,* 1946, 112-113. The Departmaent of Bio-statistics and Personnel listed the total number of hospital beds for the city of La Paz at 1,037, while the total number in the department reach only 1,175. The population for the capital of La Paz was 301,000 people and the entire population for the department was estimated at 1,198,300. Populations totals for the provinces were likely under-reported, however, since for a number of towns, the registry indicated that no population numbers were available (*no hay datos de población*). Biblioteca del Ministerio de Salud y Deportes.

[223] Ministerio de Trabajo, Salubridad y Previsión Social, *Guía de profesionales en medicina y ramas anexas,* 1946, 112-113. Biblioteca del Ministerio de Salud y Deportes.

elite, to rule over a population that was both geographically and culturally distant.[224] Roads and railway only minimally connected the country's towns and cities. Foreign travelers to Bolivia in the 1940s and '50s wrote about their difficulties in visiting Bolivia's incredible landscapes. In his guide for U.S. travelers, T.R. Ybarra provided a brief rundown of the country's principal roads and railways. Roads connected La Paz and other main cities and towns in the western Altiplano and central valley region—Oruro, Cochabamba, Sucre, Potosí, and Tarija—but travel to Santa Cruz, the country's principal eastern lowland city was possible only via Yacuiba, a remote town on the country's Argentine border. A trip from La Paz to Santa Cruz would require traveling 350 miles southeast to Sucre, and then continuing another 400 miles southeast to Yacuiba, before finally traveling almost due north for 350 miles to Santa Cruz. Even more direct roads between cities and towns were often extremely perilous. Ybarra cautioned travelers that "even the best of them usually have long stretches in bad condition" and that, in 1946, the road between Sucre and Cochabamba "was in such a poor state as to make travel on it a hazardous adventure."[225] Swiss traveler, Arnold Heim, wrote of the infamous steep, narrow, curving "Death Road" that connected La Paz to the Yungas region. In 1953, the 75-mile trip from La Paz to the small town of Chulumani, in the South Yungas region, took over four hours, if the road was passable at all.[226] Bolivia's eastern departments were still difficult to reach from the Andean highlands. Construction of a paved two-lane from the city Cochabamba to Santa Cruz de la Sierra was finally completed in 1954, a full decade after the project was started. Old dirt roads that

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[224] According to the 1950 Census, Bolivia's total urban population stood at 1,023, 354, while the rural population totaled 1,995,365. República de Bolivia, *Censo Demográfico 1950* (La Paz, Bolivia: Editorial "Argote," 1955), 12.

[225] T.R. Ybarra, *Lands of the Andes: Peru and Bolivia* (New York: Coward-McCann, Inc, 1947), 180.

[226] Arnold Heim. *Südamerika: Naturerlebnisse auf Reisen in Chile, Argentinien und Bolivien* (Bern and Stuttgart: Verlag Han Huber, 1953).

connected Santa Cruz to the rest of the country, had often become flooded, or, because of their narrowness and instability, sent travelers plunging over precipices.[227] The department of El Beni, in the northern Amazon region, remains isolated from the country even today.[228]

The experiences of Dr. Gonzalo Virreira during his year of rural medical service in 1952 highlight the limitations of the Ministry of Health and the medical profession as a whole, in reaching beyond urban major areas, even with the infrastructural and personnel growth made possible by SCISP. As a young doctor, who had just completed his seventh and final year of course work and hospital rotations, Dr. Virreira traveled from Sucre to Culpina, a town in the agricultural and wine-growing region of the Sud Cinti Province in the Department of Chuquisaca. Although the population of the town was "rather large," in Dr. Virreira's words, he was the only formally-trained medical professional in the area. Built between 1946 and 1952, only the doctor himself and a local man staffed the small, three-bed hospital.[229] The closest hospital in Vacamargo was a three-hour trip, depending on the weather. In spite of the Ministry's attempt to prevent medical practice by unlicensed professionals and enlist doctors to police the profession, adherence to the regulations was seldom possible. Dr. Virreira described his assistant as local man, "not a professional, but someone who made his living that way." Trained by one of

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[227] Victor Hugo Limpias Ortiz, *La ferrovías y la carretera que transformaron el oriente boliviano, 1938-1957: Vías de integración y desarrollo* (Santa Cruz de la Sierra, Bolivia: Editorial El País, 2009), 51-62.

[228] Plans to construct a highway through the TIPNIS National park in order to connect Cochabamba to El Beni sparked major protests in 2011. See Linda C. Farthing and Benjamin H. Kohl, *Evo's Bolivia: Continuity and Change* (Austin, TX: University of Texas Press, 2014), 52.

[229] The *Guía de profesionales en medicina y ramas anexas* lists only six health centers in the department of Chuquisaca, the Hospital Santa Bárbara and the "Manicomio Pacheco" mental institution, and hospitals in the towns of Camargo, Padilla, Tarabuco, and Monteagudo.

Dr. Virreira's predecessors, the man operated as the hospital's pharmacist, nurse, and, on at least a few occasions, as the doctor's surgical assistant.[230]

The doctor's physical presence in rural areas was only part of the battle for control over medical practice; Andean Bolivians' understanding of childbirth differed significantly from doctors' obstetric-based knowledge both in cultural and physiological terms. As a result, beyond the formidable challenge of constructing and staffing health centers and hospitals in rural areas, doctors faced the struggled to convince indigenous women and their families to accept radically different birthing practices. Indigenous women and their families repeatedly chose to patronize parteras rather than physicians, which suggests that, although indigenous Bolivians may have supported political movements that promised expanded citizenship rights and protections, they often rejected the cultural assimilation missions forwarded by the politicians they supported.

Indigenous women who became parteras did so because another member of their family had been a partera, or because they experienced a divine calling to practice. The careers of parteras like Cleta Calle, an Aymara-speaker from the Provincia Pacajes in the department of La Paz, and Petrona Coca Ordóñez, a Quechua speaker from Potosí, serve as examples.[231] According to her granddaughter, Coca Ordóñez was one of the best-known midwives in Potosí. Rasguido Coca insisted that her grandmother had lived 122 years. The lack of birth records, especially for indigenous Bolivians of rural Potosí during nineteenth and early twentieth centuries, makes it impossible to verify the year of Petrona Coca Ordóñez's birth, but she was already a grandmother in 1967, when her daughter (Rasguido Coca's mother) died in the 1967

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[230] Dr. Gonzalo Virreira, *Interview with Author.* Sucre, Bolivia, 16 April, 2012.

[231] María Rasguido Coca, *Interview with Author,* La Paz, Bolivia, February 2012. Cleta Calle Calle, *Interview with Author,* La Paz, Bolivia. March 2011.

massacre of miners in Siglo XX.[232] Coca Ordóñez gave birth to her own twelve children on her farm in rural Potosí sometime during the 1930s and '40s and had most likely assisted in many births when the MNR took control of the government in 1952. She and her husband raised sheep, cows, pigs, and chicken in addition subsistence crops. Both grandmother and granddaughter assisted women with techniques passed down to them by older parteras of the family, but like many Andean healers in Bolivia, Rasguido Coca insisted that both she and her grandmother had received their innate ability to heal from lightning strikes. She said that both she and her grandmother received from the lightning the ability to read the fate of pregnant woman in coca leaves. The coca told them if the delivery would go well, if the birth would be difficult and if the partera would have the ability to save the mother and baby's lives.[233]

Cleta Calle told a similar story of the way she became a midwife. April 26, the day of her birth, stuck in her memory, but the year, likely around 1945, she could only guess. Her Aymara-speaking family herded sheep and llamas near their rural home on the Altiplano, south of the city of La Paz. As a small child, her mother had told her she was destined to become some kind of healer, because she had been born in the breech position. Years later, while walking with her first daughter, she received the second sign: A bolt of lightning struck her hand and the small body of her young daughter, the burn launching the child from her grasp to her death.[234] In the week

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[232] Rasguido Coca recalled that both of her parents were killed in a massacre at Siglo XX in 1966, a slip in memory that indicates both her age at the time of her parents death, and the violence suffered by mining families during the period. Siglo XX suffered two massacres under the government of General Barrientos, one in 1965 another, even more brutal one, in 1967. Domitila Barrios de Chungara offered her memory of the second massacre in her testimonial. Domitila Barrios de Chungara with Moema Viezzer. *Let Me Speak!* New York: Monthly Review Press, 1978.

[233] María Rasguido Coca, *Interview with Author,* La Paz, Bolivia, February 2012.

[234] Lightning strikes are a common divine event reported by Andean Bolivians. Parteras María Rasguido Coca, Cleta Calle, and healer Cliver Leyton, all of whom I interviewed in 2012 reported that they had received healing power from lightning strikes. Ethnographic researchers have also shown the significance of lightning within Andean

following the lightning strike, Calle's oldest son, the first of her fourteen children, fell ill. Because of the lightning strike, she said, she knew exactly what was wrong with him, exactly where the problem in his body resided, and with her touch and a combination of herbal medicines, she cured him. She began curing others in the same way, using the wisdom sent down to her body through the lightning to heal illnesses and injuries from car accidents. After some years, word of her abilities had spread and pregnant women began to seek her so that she could adjust their babies' position in the womb and help them during delivery.[235]

Parteras from different communities have practices that reflect local cultural differences and diverse interactions with non-Andean knowledge systems, but common characteristics nonetheless crosscut the practices of parteras like Petrona Coca Ordóñez and Cleta Calle. As the anthropologist Joseph Bastien first relayed to western readers in the 1980s, Andean healers (*kallawayas*) classify illnesses in a manner that resembles Greek humoral theories. They consider the body "dry" and believe that fat and blood "fluids" animate the body. Diseases produce excessive heat, cold, wetness, or dryness in the body and must be corrected either through remedies that have the opposite quality (i.e., wet remedies for dry diseases) or, in a manner similar to western homeopathy, through the application of remedies with the same quality (i.e., applying "heat" to remedy hot ailments).[236] Following Andean healing principals, Cleta Calle gave massages during gestation, using salves of grease and medicinal herbs (*andres huaylla*), like coca and rosemary, not only to adjust the baby's position, but also to create heat to assist in

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healing systems. See of example, Joseph Bastien, *Drum and Stethoscope: Integrating ethnomedicine and biomedicine* (Salt Lake City: University of Utah Press, 1992), 88.

[235] Cleta Calle Calle, *Interview with Author,* La Paz, Bolivia. March 2011.

[236] Joseph Bastien, *Healers of the Andes: Kallawaya Herbalists and their Medicinal Plants* (Salt Lake City, Utah: University of Utah Press, 1987).

delivery. During labor, she fed the mother herbal teas of chamomile, rosemary, and coca to maintain heat in the body and speed contractions. As Jacqueline Portugal Michaux reported from her 1987 ethnographic research, Aymara speakers from the Provincia Pacajes understood childbirth as a process that chills the body.[237] To correct the chill and speed the birth process, parteras—or the husband or family member assisting the parturient—offered herbal teas to heat the body. Calle also noted that her practices had changed with access to products from the city. In the later years of her practice, she began using soap to wash her hands and a Gillette razor to cut the umbilical cord. Previously, she said she had used only alcohol to clean her hands, a thread to tie the umbilical cord, and a broken piece of ceramic pot to cut it.[238] For delivery, she had mothers squat down and then recline themselves slightly. After delivery, she advised women to avoid washing themselves for two days, and then to wash with rosemary-infused water. During recovery, mothers under Calle's care ate bland foods, rice with *chuño* (freeze-dried potatoes), soups and meat with little salt or spice.

In contrast, Petrona Coca Ordóñez, like other Quechua-speakers of Potosí, understood pregnancy and childbirth as causing intense heat in the body, but instead of counteracting the heat and bringing the body back into balance, Coca Ordóñez fed her patients herbal teas of coca

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[237] Jacqueline Portugal Michaux, "Embarazo y parto en el Norte Pacajes," in *Reunión Anual de Etnología*, (La Paz, Bolivia, Museo Nacional de Etnografía y Folklore, 1987). Joseph W. Bastien's foundational anthropological work on Andean medicine provides a lucid discussion of the logic of Andean humoral theories. See his chapter, "Andean and Greek Humoral Theories," in his *Healers of the Andes: Kallawaya and their Medicinal Plants* (Salt Lake City, UT: University of Utah Press, 1987), 45-52.

[238] Tristan Platt, "El Feto Agresivo. Parto, formación de la persona y mito-história en los Andes," *Anuario de Estudios Americanos* 58, no. 2 (2001): 633-678. Platt found that parteras in Potosí commonly used urine to cleanse their hands, particularly if a difficult birth required them to insert their hands into the vagina. Marcela Barragán, a Bolivian prenatal physical therapist and researcher of birthing techniques in La Paz also noted that, traditionally, many indigenous parteras wash their hands with urine before assisting in birth. For more of her work, see I. M. Barragán Loayza, I. Solá and Juandó Prats C., "Biofeedback for pain management during labor," *Cochrane Collaboration,* 2011, doi: 10.1002/14651858.CD006168.pub2.

and chamomile to fuel the heat necessary for delivery.[239] She also visited women before birth, massaging the belly and instructing the mother how to sleep in order to prevent leg swelling and to bring the baby into position for birth. During labor, she fed her patients herbal teas (*mates*) made from plants collected along the way or grown at home. Some herbs she harvested, dried, and stored in ceramic, lidded jars. Like Calle, she instructed her patients to squat or kneel during delivery. Besides herbs, the only instrument Petrona Coca Ordóñez brought with her to assist in a delivery was a piece of a broken ceramic plate or piece of llama bone to cut the umbilical cord. Although the choice of tool for cutting the umbilical cord likely arose to avoid tetanus, Coca Ordóñez's granddaughter explained that metals, unlike ceramic and bone, are "cold" and can cool the body, producing the symptoms medical doctors associate with post-partum, puerperal fever—chills, sweating, and fever. Raguido Coca's explanation of the need to prevent contact with "cold" instruments and maintain the body's heat throughout the delivery highlights a different interpretation of childbirth common in the Potosí region. As anthropologist Tristan Platt showed, Quechua-speaking mothers, fathers, and midwives in the Macha territory in Potosí believe labor and delivery heats the parturient, and that successful delivery depends on maintaining the body's heat. "In the old days," Coca Ordóñez's granddaughter explained, "we didn't cut the umbilical cord with scissors or a knife, because with metal, whatever happens, in

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[239] Tristan Platt has argued, based on his work with families and midwives in Quechua-speaking Potosí, that whereas typically remedies for ailments would require restoring a balance of heat and cold in the body, during childbirth, women consume *mates* (herbal teas) in order to increase the heat in the body, which is seen as necessary for expelling the fetus and placenta. Another description of childbirth assistance among miners in the 1950s can be found in June Nash's *I Spent my Life in the Mines: The Story of Juan Rojas, Bolivian Tin Miner* (New York: Columbia University Press, 1992). The subjects of the testimonial, Juan Rojas and his wife Petrona, talk about a number of her births at home. Although the couple often sought the help of a midwife, Juan himself always assisted his wife during delivery in some way, and because of his skill, occasionally assisted his sister-in-law as well. Juan Rojas and his wife discussed many of the same practices for detailed by the parteras whom I interviewed, including the importance of teas, the preference for cutting the umbilical cord with a ceramic pot shard rather than with metal, the belief that a woman's pores are open after birth, and that she must be kept covered, warm, and must not bathe. See pages 115-120 and 136-139.

one hundred years, it will still be there. For that reason, because metal is very cold. In the umbilical cord are a lot of sensitive veins that can become infected when they're cut with metal, that's what my grandmother said. For that reason, people slowly become sick. Every human was born from nature, so we have to commune with the same things. That's why we have to cut with the llama bone."[240]

Rasguido Coca's explanation of her grandmother's practices—particularly with her assertion that scissors "infect" veins—illustrates the harmonious incorporation of western medical terminology into an Andean healing system, but not all differences are so easily reconciled. Coca Ordóñez's treatment for vaginal hemorrhaging would certainly have received criticism and contempt from Bolivia's doctors at the time. To close up uterine tears and stop bleeding, she fed patients tacos made with boiled condor meet, or the woman's own vaginal blood. Her granddaughter insisted that the condor meat, in particular, was consistently effective in stopping hemorrhaging and commonly followed the same recipe as her grandmother for her own patients.

These fundamentally distinct understandings of childbirth made relationships between doctors and patients even more complicated in rural areas like Culpina, as Dr. Virreira's account reveals. Local families often sought Dr. Virreira's help only after their own efforts, or the efforts of a partera, to assist the parturient had failed. Dr. Virreira characterized the parteras of the area as witches (*brujas*), because "they would cast spells so that the baby would be born. They would give [the parturient] grass (*pasto*) or charcoal so that the baby would be born." Perhaps local

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[240] "En realidad, en tiempos antiguos nosotros no cortamos con tijera ni con cuchillo el obligo. Por tal motivo que el fierro, pase lo que pase, en cien años, siempre está. Entonces por tal motivo no se cortaba antes con cosas de fierro porque es frío. En el ombligo allí están las venitas más sensibles, entonces se contaminaba cunado se corte con fierro, eso decía mi abuela. Por eso la gente… se enferma. Por tal motivo todo el ser humano ha nacido de la naturaleza y con si mismos tiene que hacer. Por eso hueso de la llama tiene que hacer." Interview. María Rasguido Coca. La Paz, Bolivia. February 2012.

families placed equally little trust in the local parteras, and certainly, word of Dr. Virreira's skill made its made its way around the community. During his year of service, no women died in his care, in spite of being called to complicated deliveries and performing two cesareans in the small hospital. According to Virreira, families sought his assistance because they had no other options (presumably other than the "witches"). Although his practices undoubtedly varied drastically from those of local parteras, his work as a community physician required him to consider the desires of the patient and her family more than he would have in an urban hospital. Instead of bringing women to the hospital to give birth, family members would retrieve Dr. Virreira from the hospital, sometimes traveling considerable distances with a donkey to transport the doctor back to the laboring woman. In his year of service, he estimates that he delivered at least fifty babies.[241]

Although many doctors would have shared Dr. Virreira's assessment that indigenous midwives were little more than witches, women throughout the countryside wanted parteras to assist them during and after childbirth. Notable parteras often traveled to attend to women in remote communities where no other parteras existed and husbands and female family members attended to women during delivery. Parteras like Cleta Calle and Petrona Coca Ordóñez often provided the only assistance to rural mothers-to-be during gestation and delivery and often traveled to neighboring communities, sometimes covering considerable distances by foot to do so. As far as Calle knew, no midwives assisted women in her community until she began helping women. Her mother had given birth to her and her two siblings at home, most likely with the assistance of her grandmother. Each of her own fourteen children were born at home as well. She received no prenatal care. The closest clinic (*posta de salud*) did not yet offer such services, as

[241] Dr. Gonzalo Virreira, *Interview with Author.* Sucre, Bolivia, 16 April, 2012.

far as she knew, and she did not see any need for the help of a doctor anyway. In 2011, Calle guessed that she had helped deliver around thirty-five babies in other communities in the Pacajes province, in adjacent provinces of the department of La Paz, and in the neighboring department of Oruro.[242]

Petrona Coca Ordóñez also traveled considerable distances to attend to women, although she was not the only partera in the area. In addition to others of her generation, Coca Ordóñez had a number of students, generally mothers who had been helping others deliver their children and wished to improve their skills and knowledge. These women then helped Coca Ordóñez attend to her patients, since she had more than she could attend alone. As her granddaughter, María Rasguido Coca recalled, "Sometimes she would travel three to five hours and would stay there over night. Everything was by foot. She had to cross rivers and mountains… she must have assisted thousands of births because I remember that in 1966 or 1968, 1970, they had only just built the hospitals, but not for poor women, rather there were only cheaper hospitals. Now there are more hospitals in Potosí. But then it was difficult. The midwives were sought out."[243]

Conclusion

The economic goals of the U.S. and Bolivian governments, the nation-building dreams of Villarroel and the MNR, and the professional aspirations of physicians all depended on the feminine work of public health nurses; their combination of scientific training, self-abnegation, and obedience in combination with their lack of professional autonomy, made them the ideal soldiers for an army of women whose mission it was to promote mestizaje and extend the reach

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[242] Cleta Calle Calle, *Interview with Author,* La Paz, Bolivia. March 2011.

[243] María Rasguido Coca, *Interview with Author,* La Paz, Bolivia, February 2012. María Rasquido Coca was also a partera, and at the time of research, held the position of Director of the Vice-Ministry of Traditional Medicine.

of medical authority and the state. Medical records from the Instituto de Maternidad "Professor Dr. Natalio A Aramayo" indicate the Ministry's efforts achieved some success. In urban areas, women who had never given birth in hospitals before did so for the first time in La Paz's new maternity clinic.

Public health nurses also played a central role in Bolivia's obstetric movement. While the Ministry of Health attempted to crack down on unlicensed midwifery, nurses promoted state-regulated maternal-infant care programs during their in-home consultations with pregnant women and new mothers. In spite of the work of public health nurses to establish relationships with lower-class and indigenous families and to provide affordable and accessible care, and the Ministry's efforts to crack down on unlicensed childbirth attendants, they were unable to enforce professional regulations of midwifery. In rural areas, indigenous parteras attended to their patients in nations of their own, separated physically and culturally by Bolivia's geography, by linguistic and ethnic diversity, and by knowledge systems and worldviews that clashed with medical doctor's culture and science-based knowledge. Even when indigenous women did have the option of seeking medical care, time and again, they sought out the care of parteras, whose practices matched their own cultural worldview. As a result, even in urban areas, empirically-trained and unlicensed midwives continued to practice in spite of the Ministry's regulations.

In the next chapter, I turn to a new phase of the struggle for the control of childbirth in Bolivia. In the 1960s, the cities of Sucre and Tarija were home to the country's two midwifery schools. Competing transnational trends in obstetric care fostered a brief expansion of the programs and professional prominence of the matronas who graduated from them.

CHAPTER THREE

Matronas, Miners, and Medical Knowledge: The Transnational Politics of Health and the Rise and Fall of University-Educated Midwives in Bolivia, 1950s-1970s

"An educational programme is needed which will not only prepare a competent technical worker but enable the student to develop into a good citizen, capable of managing her own affairs and of making her maximum contribution to society. A main objective of the training is to ensure that the midwife has a preparation for work which enables her to obtain satisfaction and to remain in her profession, even after marriage"

–World Health Organization Expert Committee on Midwifery Training, 1955.

"We were the ones who attended the births, but now that is part of the training of the residents who are studying gynecology and obstetrics. There were the first residents and then, little by little the residents started taking charge of childbirth assistance." –Juana Gómez, Bolivian nurse-midwife

The early 1970s marked the end of an era in obstetric care in Bolivia. At the start of that decade, the universities in Sucre and Tarija ended their midwifery programs in favor of training nurses. For graduates of the last midwifery programs and for many younger nurses, the restructuring reduced the range of career choices and eroded the prestige and authority of medical professions for women. Many of those same women blamed the closure of the schools on the jealousy of physicians who viewed midwives as competitors.[244] In this chapter, I trace the rise and fall of the midwifery programs in Sucre and Tarija, not only to weigh in on the reason for the elimination of the midwifery programs, but also to explore the connections between professional struggles and international and national politics of health.

Specifically, I examine how multiple trajectories of obstetric modernization between the 1950s and 1970s shaped midwifery education and practice in Bolivia. On the one hand, Bolivian physicians, who administrated the country's two main midwifery programs at the universities in Sucre and Tarija, sought to model midwifery education on international standards of "modern

[244] In an online article for the United National Population Fund (UNFPA), one journalist wrote that "resistance from the country's doctors led to the cancellation of the former midwifery training programme." See, Jon Pelling, "Bolivia: Training Midwives to Treat Indigenous Women with Respect," *UNFPA,* May 3 2009, http://www.unfpa.org/public/home/news/pid/2614. In an interview, Bolivian nurse Elva Oliveira reported the same.

medicine" that they saw in foreign university curricula and in World Health Organization (WHO) recommendations. The WHO stressed that midwifery training and practice should position midwives to act as key public health functionaries and independent health providers, particularly in countries with weak medical infrastructure. Some Bolivian physicians agreed with the WHO's assessment and viewed their relationship with the new generation of midwives as a strategy for establishing, at long last, professional hegemony over remote areas of the country. Alongside their instructions in childbirth assistance, midwives who studied in Sucre and Tarija took courses in puericulture, a subject that prepared them to take the values of mestiza motherhood from the classroom to the homes of indigenous families. On the other hand, however, research in obstetric medicine throughout Latin America during the same period focused on improving and increasing technical, medicalized interventions in childbirth. This international trend in obstetric medicine convinced other Bolivian doctors that physicians with training in obstetrics should exercise even greater control over "normal" deliveries and should, therefore, reduce the professional responsibilities of midwives.

I argue that those two trajectories in obstetric modernization collided to produce unique professional struggles over childbirth assistance in the 1960s and '70s. In line with WHO recommendations, young women who attended the midwifery schools in Sucre and Tarija in the 1960s, studied nursing alongside midwifery. When they graduated, they found immediate work as midwives in hospitals and clinics that served mining families, as health educators, or as department-level directors of public health programs.[245] While working in hospital maternity wards, making house calls, attending home deliveries, and establishing health centers in poor

[245]Ana María Maldonado Canedo guessed that matronas had worked in the mines even before the nationalization of the mines in 1952. She had begun some investigation of the topic but could not find archival sources. Maldonado Canedo, *Interview with Author.* La Paz, Bolivia. February 2012. I was able to interview some of the matronas who worked in the mines during the 1960s and '70s.

neighborhoods, nurse-midwives became important mediators between mining families and the state. They thus fulfilled their professional mandate of expanding the reach of the public health system and battling, as one doctor wrote, "the nefarious labor of the healers, empiricists, and *aficionados* that do so much damage."[246] But in other ways, the midwives pushed the professional boundaries that physicians defined for them. My analysis supplies evidence in support of the accusations made by some graduates of the former programs that midwives' professional independence frustrated physicians' efforts to consolidate control over obstetric care, and that, in response, many Bolivian physicians advocated the elimination of midwifery training programs. Bolivian nurses who saw new career opportunities in the expansion of the nursing profession helped in that effort.

Midwifery and International Politics of Health

In the 1950s, young women who wished to become matronas could attend three-year programs at the universities in Sucre and Tarija. Founded in 1913 as a subdivision of the Medical School, the School for Midwives (originally called the *Escuela de Matronas*) at the Universidad San Francisco Xavier de Chuquisaca was the country's oldest, consistently-operating midwifery school by the 1950s.[247] In Sucre, young girls who had completed primary

[246] Sánchez Pórcel, Jaime. Correspondencia. Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. 15 November 1967. Centro Bibliográfico Documental Histórico (CBDH).

[247] Other midwifery schools existed at different times. For example, three-year courses for midwives were offered intermittently in La Paz during the first half of the twentieth-century. Starting in 1898, Dr. Claudio R. Aliaga created a three-year program for matronas in La Paz. Training for the four students who completed the program was focused exclusively childbirth and childbirth assistance, in contrast to programs in subsequent decades. Students took anatomy, and physiology of pregnancy and normal births in the first year, pathological and difficult births in the second, and in the third year, they studied "obstetric interventions." Gregorio Mendizábal Lozano, *Historia de la Salud Pública en Bolivia* (La Paz, Bolivia: OMS/OPS, 2002), 106. Luís E. Quiroga writes that a school for matronas was founded in Cochabamba in 1917, but other documents indicate that a school was operating in the city at least a few years earlier. In the 1946 *Guia de professionales en medicina y ramas anexas,* published by the Ministry of Health, nine of the sixteen registered matronas who completed their studies at the Universidad Simón Bolívar in

school and had the relatively small amount of money for registration, simply signed up for classes. The school did not require prospective students to take admissions exams until 1964, and as a result, many students failed to pass the first-year courses in anatomy, physiology, and bacteriology. In the second year, midwifery students, who took most classes within the Santa Bárbara General Hospital, took their first-year obstetrics course together with seventh-year medical students. In the same year, they also studied hygiene and puericulture. Practical training was an integral part of their education from their first day in the program; midwifery students worked night shifts throughout their three years of training. In contrast, medical students only worked in the maternity during their seventh year of school. Tarija's Institute of Midwifery and Social Workers (*Instituto de Obstetricia y Visitadoras Sociales*) began training its first cohort in 1947. Like the school in Sucre, the Universidad San Misael Saracho in Tarija also accepted primary students and did not require an entrance exam. With courses in hygiene, puericulture, first aid, physiology and anatomy in the first year, many students found the program overwhelming. Of the fourteen students who began classes in 1947, only half graduated three years later. During the second and third year of the course, students completed obstetrics training in 'normal births', in addition to radiology, psychology and social medicine. Although the Tarija program emphasized general nursing training more than Sucre's program, Tarijeña students' practical training in the maternity of the San Juan de Dios Hospital nonetheless gave them extensive practical training in childbirth assistance.[248]

Bolivian midwifery schools in the 1950s and '60s followed the recommendations made by a 1955 World Health Organization report on midwifery training which stressed that midwives

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Cochabamba earned diplomas in 1915. See Luís E. Quiroga, "Historia de la facultad de medicina de Cochabamba," *Gaceta Médica Boliviana* 32, no. 2 (2009), 80.

[248] Datos sobre La Escuela de Enfermería y Obstetricia "Dr. Alberto Baldivieso". Courtesy of Lic. Miriam Vargas Vargas, Vice-Decan of Facultad de Ciencias Médicas at the Universidad San Misael Saracho in Tarija.

should continue to play a key role in maternal-infant care. Comprised of physicians, midwives, and nurses from around the world, the committee's report strongly commended the work of "fully-trained midwives" and presented general recommendations for the growth of the profession. Committee members stressed that training programs should produce professionals who had mastered the "art and practice of midwifery," and had knowledge of physical and biological sciences and "sufficient understanding of the nursing art," in addition to being able to recognize emergencies that required medical attention. When assistance from a doctor was delayed or unavailable, trained midwives needed to be able to carry out "simple emergency measures."[249] In addition to stipulating the technical skills midwives should possess, the committee defined the model midwife as an independent professional with an important socio-political role in her society. "An educational programme," they wrote, "is needed which will not only prepare a competent technical worker but enable the student to develop into a good citizen, capable of managing her own affairs and of making her maximum contribution to society. A main objective of the training is to ensure that the midwife has a preparation for work which enables her to obtain satisfaction and to remain in her profession, even after marriage."[250]

The WHO committee also envisioned a special relationship between "fully-trained midwives" and "traditional birth attendants" in countries where maternity services were "less well developed." This perspective complemented the vision Bolivian physicians had for reshaping the midwifery profession in their country. According to the committee, the fully-trained midwife should have "sufficient understanding of the social structure in which she will work and the social, cultural, and economic factors influencing health to enable her to function

[249] WHO, "Expert Committee on Midwifery Training. First Report" (Geneva, Switzerland: World Health Organization, 1955), 8.

[250] Ibid., 8.

effectively in the community." Her cultural sensitivity would also allow her to work together with traditional birth attendants, and incorporate "harmless" traditional customs in childbirth assistance into her own biomedical pratices as a way of "gaining the confidence of the mother and her family."[251] In this way, the committee argued, fully-trained midwives would eventually succeed in replacing traditional birth attendants all together. Bolivian physicians shared the committee's conviction that matronas could replace 'traditional' birthing practices with 'modern' medical ones, but they saw little value in retaining indigenous birthing practices. Dr. Jaime Sánchez Pórcel, a prominent physician and the director of Sucre's midwifery school in the 1960s, reflected that the school had "upheld its social mission, producing professionals, who dispersed throughout the country to battle, if only in part, the nefarious labor of the healers, empiricists, and aficionados that do so much damage."[252]

At the same time that some Bolivian and foreign physicians argued that properly trained midwives could play key roles in expanding and improving maternal-infant care, others sought to give physicians greater control over childbirth. During the 1950s, doctors across Latin America published research on new technologies for managing birth. At the Third Latin American Congress of Obstetrics and Gynecology, held in Mexico in 1958, Bolivian physicians heard no fewer than six papers on the use of oxytocic drugs for the induction and acceleration of labor. Another paper, presented by the Spanish physician Dr. Santiago Dexeus Font, assessed the state of the obstetric profession and argued that, "our current obstetric prosperity has to be maintained

[251] Ibid., 4.

[252] Sánchez Pórcel, Jaime. Correspondencia. Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. 15 November 1967. CBDH.

and, if possible, grown."[253] For Dr. Dexeus, the growth of the obstetric profession required that physicians and personnel under their command adhere to strict sterilization standards in order to prevent infections. Careful attention to sterilization practices was important for protecting parturient women from infections, but Dr. Dexeus also suggested that low infection rates would provide proof of physicians' superiority over their competitors. If obstetricians let down their guard with respect to hygiene and sterilization practices, he warned, "the matrona of thirty years ago, or the modern-day uncertified, empiricist midwife (*aficionada*), confined to remote districts, fearless practitioner of primitive knowledge, unaware of the most elemental scientific developments, will not have any reason to envy the modern obstetric practices of the surgeon."[254] He also called for further advancement of technologies for managing delivery and argued that controlling childbirth and *alumbramiento* (placental delivery) through the use of oxytocic drugs in combination with sedatives, would make delivery safer, faster, and more comfortable for both the mother and the physician. The use of pharmaceuticals and technologies like the "vacuum extractor" also gave physicians an advantage of over midwives. Dr. Dexeus proposed, as an example, the range of technologies available to the modern physician to facilitate delivery: A combination of intravenous "*petocin*" (Pitocin) and sedatives followed by an episiotomy and vacuum extraction of the fetus, represented, "without exaggeration" a "benign resource" for the mother and the fetus. However, all physicians agreed that only physicians should be allowed to use these new technologies. "In general terms," he wrote, "the opinions [about the use of

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[253] Santiago Dexues Font, "El actual momento obstetrico: Encrucijada estratégica" (paper presented at III Congreso Latino Americano de Obstetricia y Ginecología. Mexico City, Mexico, June 8-14, 1958), 111.

[254] Santiago Dexues Font, "El actual momento obstetrico: Encrucijada estratégica" (paper presented at III Congreso Latino Americano de Obsetetricia y Ginecología. Mexico City, Mexico, June 8-14, 1958), 115-16. "La obstetricia moderna del cirujano partero nada tendrá que envidiar a la somera práctica de la matrona de hace treinta anos o de la actual aficionada, no diplomada, confinada en distritos lejanos, ejecutante impávida de realizaciones primitivas, desconocedora del más elemental movimiento científico."

intravenous Pitocin for the induction of labor and regulation of contractions] are favorable, although many authors correctly insist that the control of the dosage should never be entrusted to auxiliary personnel (*personal subalterno).*"[255]

Bolivian physicians adopted new technologies like vacuum extraction and practices like drug-induced labor in the 1950s, but oral histories from both physicians and matronas suggest that the technologies failed to give physicians the kind of professional advantage Dr. Dexues had imagined. Dr. Gonzalo Virreira, who graduated from the medical school in Sucre in 1952 (see Chapter Two), recalled that, at the beginning of his career, he and his colleagues frequently used the vacuum extractor for difficult deliveries. In spite of Dr. Dexeus's insistence that vacuum extraction was a "benign resource," doctors later abandoned it after it became clear that its use could cause cephalohemotoma (cerebral bleeding) in the infant. Even cesarean sections, routine by the 1950s, and intravenous Pitocin were not the exclusive tools of the nascent obstetric profession, because many Bolivian midwives had skills that far exceeded those necessary for attending normal births. Emma Rivera, who began studying midwifery in the late-1940s and continued her studies in Chile, learned from her Chilean instructors (all matronas) how to extract the placenta manually, perform and stitch an episiotomy, rupture the amniotic sac in placenta previa cases, and administer intravenous Pitocin to induce and regulate contractions. From a Bolivian obstetrician, she also learned to perform cesareans and, on at least one occasion, did so herself rather than risk the parturient mother's life while waiting for the doctor to arrive.[256] As the Instructor of Practical Training, who supervised young midwifery students in the Santa

[255] Ibid., 122, 123.
[256] Emma Rivera, *Interview with Author.* Sucre, Bolivia. 5 April, 2012.

Bárbara maternity, Rivera sometimes taught her favorite, or most skilled, students those advanced techniques.[257]

Physician-instructors and administrators at the universities in Sucre and Tarija in the late 1950s and early 1960s shared the WHO Expert Committee's vision and imagined their young female graduates as bearers of modernity in rural and poor urban areas. In Sucre, university rector Dr. Oscar Frerking, then the rector of the University of San Francisco Xavier in Sucre, led the movement to add general nursing education to the midwifery curriculum, so that graduates could perform a broader role in public health. With increased emphasis on public health nursing courses, young women, he wrote, could be molded into "competent professionals" who would "serve the country as nurses and as midwives," through their "sanitary, social, and moral activities."[258] In 1958, Dr. Frerking began to advocate the creation of a joint nursing-midwifery program. The change, he wrote in a letter to the director of the College of Medical Sciences, would provide Bolivian women with professional opportunities and training "in a specialization that, day by day, gains more importance and fulfills an essential role in modern medicine and hospital attention."[259] Having just returned from a trip around the country, the rector attached curricula he had requested at the nursing schools in La Paz and Tarija. Tarija's program development followed an erratic trajectory between the 1950s and the 1970s, switching from

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[257] Juana Gómez, *Interview with Author.* Sucre, Bolivia 1 May, 2012.

[258] Correspondencia. Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. 15 November, 1967. CBDH.

[259]Frerking Salas, Oscar. Correspondencia de La Facultad de Ciencias Médicas Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. 8 November 1958. "Lo interesante sería dar una mejor posibilidad a la mujer chuquisaqueña y a la mujer boliviana en general, en una especialidad más, que día a día cobra mayor importancia y de contribuir a una necesidad esencial de la medicina moderna y de la atención hospitalaria actual." Frerking Salas, Oscar. Correspondencia de La Facultad de Ciencias Médicas. Correspondencia. Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. 8 November 1958. CBDH.

midwifery, to a combined program, and finally to nursing in the 1970s.[260] Tarija's plan of study inspired Dr. Frerking because it placed equal emphasis on general nursing and midwifery, even though the school dubbed itself an "Escuela de Enfermería." Perhaps, suggested Dr Frerking, the School of Midwifery in Sucre could take advantage of the professional expertise of professors of universities medical school to create a joint program.[261]

Some Bolivian physicians outside of the university system argued that midwives could play a valuable role in public health. In 1965, Dr. Emilio Fernández M., a well-known Bolivian physician, proposed a comprehensive rural public health program within indigenous communities that would promote socio-economic growth within the agricultural sector. Dr. Fernández envisioned his plan orchestrated in top-down fashion from the Ministry of Health, through physician-directors at three regional centers, to a team of university-educated and certified midwives, who would act as "agents of change" as they implemented programs at the local level. Nurse-midwives, he advised, should carry out sanitary education and instruct rural families in the principles of maternal and infant hygiene. He argued that, by teaching indigenous Bolivians to wash their bodies and clothes with soap, eat with plates and spoons, comb their hair, and abandon the habit of chewing coca leaves, their work would decrease incidence of infectious disease and improve personal health[262]

And yet, tensions over professional boundaries between physicians and midwives in Bolivia surfaced in debates about midwifery education. Many physicians believed that the

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[260] Datos sobre La Escuela de Enfermería y Obstetricia "Dr. Alberto Baldivieso." Courtesy of Lic. Miriam Vargas Vargas, Vice-Decan of the Facultad de Ciencias Médicas at the Universidad San Misael Saracho in Tarija.

[261] Oscar, Frerking Salas, Correspondencia de La Facultad de Ciencias Médicas Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. 8 November 1958. CBDH.

[262]Fernández M., Emilio, "Salud Pública en Areas Rurales," *Boletin Médico.* No. 47, 1965: 35-38.

midwifery programs should be eliminated. In 1967, Dr. Sánchez Pórcel noted that some officials within the Ministry of Health advocated prioritizing nursing over midwifery and giving "less and less importance to matronas, so that they disappear." Sánchez Pórcel objected to the trend. University-educated midwives were, he wrote, "indispensable to our country, in which the empíricas continue botching birth assistance (*siguen malatendiendo el parto*), especially in [rural] provinces."[263] He and his colleagues nonetheless agreed to strengthen the public health and nursing components of the curriculum: they added courses in medical pathology; applications of physiopathology for public health; public health sanitation administration, supervision and education; ophthalmology; ear-nose-throat care; oncology nursing and physiotherapy; neurology and "rehabilitation of the invalid"; and math and biostatistics. In order to provide practical training in so many new areas of study, Sánchez Pórcel proposed sending graduates of the school to La Paz or abroad for additional training with the contractual stipulation that they return to Sucre to teach for a number of years after completing their continued education.

When a new WHO "expert committee" on midwifery convened in 1965 with the goal of reassessing the role of "The Midwife in Maternity Care," committee members suggested that tensions over professional boundaries were not unique to Bolivia.[264] In the decade since the

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[263]Sánchez Pórcel, Jaime. *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia. 15 November, 1967. CBDH.

[264] World Health Organization, *"*The Midwife in Maternity Care. Report of a WHO Expert Committee," (Geneva, Switzerland: World Health Organization, 1966). The Spanish version of the report bore the title "*función de la partera en la asistencia a la madre.*" In Bolivia during the 1960s, doctors and midwives commonly used the terms "partera" and "empírica" to refer to midwives, generally indigenous, whose knowledge and practice of childbirth assistance came from tradition and from empirical (observational) study. Women who studied at the universities in Sucre and Tarija, on the other hand, earned the title of "obstetriz" and either used that term or, more commonly, referred to themhselves as "matronas." The authors of the report chose to use the term "partera," to refer to midwives who had received formal, science-based training of some kind. See Organización Mundial de la Salud, *"*Comité de expertos de la OMS sobre la funcción de la partera en la asistencia a la madre: Informe de un Comité de Expertos de la OMS," (Ginebra: OMS, 1966).

publication of the previous report, the 1965 committee noted, the medical profession had taken "increasing interest in normal midwifery." The trend of physician-assisted 'normal' deliveries "affected the work of the midwife in that she now work[ed] much more closely with the doctor."[265] The committee argued that midwives could still fulfill an important function within public health systems, because their intimate contact with families allowed them to participate in broader public health efforts, including orienting the family toward additional health services, encouraging childhood vaccination, providing nutrition education, and promoting family planning. True to the pattern of professional development in Bolivia, the committee noted that the midwifery profession increasingly intersected with nursing and encouraged health planners to coordinate training programs for midwifery and nursing to prevent professional redundancy.

Youth, Class, and Mestizaje in a New Generation of Midwives

Class and Youth

The midwives who completed their studies in the 1950s and '60s embodied a transformation of the western medical profession (and thereby the public health system) along class and age lines. Whereas renowned matronas of the late-nineteenth and early-twentieth centuries often had European surnames and bore titles like "doña señora" that marked them as established, married women, the new generation of matronas were often teenage girls from lower- and middle-class families. This transition was intentional. Architects of midwifery schools in both Sucre and Tarija designed the programs to attract young mestiza women from middle- and lower-class backgrounds. They aimed to mold young women into model citizens

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[265] WHO, *The Role of the Midwife in Maternity Care*, 1966, 5.

with middle-class mestizo values to form the front lines of a "modern" medical system. Like nursing, midwifery required tiring, physical labor, and although it allowed women to live independently and raise families, the modest salaries marked it as a profession unsuited for upper-class women with the means to lead more comfortable lives.

University administrators intentionally kept costs of attending the midwifery programs low in order to accommodate students of limited means. In his report on the state and needs of the new joint midwifery-nursing program in Sucre, Dr. Frerking presented the low cost of university attendance in Sucre as a selling point for the program. He reported that the average cost of living for a "regular family" in Sucre was USD $50 to $60 per month and estimated that a student could manage on USD $20 to $25 per month, which would cover the cost of food and housing. Some students must have managed on far less, however, since only a limited number of students received a "pension" at the university cafeteria for USD $4 per month. All students paid registration and fees (*derechos*), but those amounted to no more than $2 USD per year, he reported. The university bookstore sold books on credit for those students who could not purchase their course texts outright.[266]

The low cost of attendance at midwifery programs in Sucre and Tarija attracted young women from both the country's middle and lower-middle class mestizo and white families. When Emma Rivera attended the *Escuela de Obstetricia* in Sucre in the late-1940s at age fourteen, she initially did so without the knowledge of her parents. Since the school did not yet require that students possess high school diplomas, Rivera secretly signed up for classes, paid the small fees with the money she had, and used money her parents had given her for notebooks for

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[266] Frerking Salas, Oscar, "Estudio de necesidades y facilidades para una escuela de enfermería y obstetricia (Sucre)" *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia, 1961, 2. CBDH.

high school (*secundaria*) to purchase books for her courses. In the 1960s, tuition in Sucre's university also remained low. Mery Gallo de Machicado's father, a telegraphist from Sucre, and her mother, who owned a small hotel in Monteagudo in the Chaco region, easily paid the tuition for their two children. Even Juana Gómez's father, who worked at Sucre's cement factory, earned enough money to support his wife and five children, all of whom attended the university without need for scholarships.[267]

Many students were only able to study because they received scholarships from a range of sources, including municipal governments, the Ministry of Health, and mining companies. A government grant allowed Alina de Rivera to attend the San Misael Soracha University in Tarija possible. When she enrolled in the School of Nursing and Midwifery in 1956, the school, like the program in Sucre, still had not implemented high school education requirements. At twelve years old, de Rivera was both the youngest and least educated in her program, but her determination to succeed, along with her scholarship money, gave her a competitive advantage over her classmates. Poor girls from rural areas outside of the city of Tarija often worked as live-in maids for wealthy Tarijeña families to fund their education. De Rivera recalled that her scholarship check from the state came in the mail once per month. Although she gave the check directly to her mother and did not recall the exact amount of the payment, she recollected that it was a considerable sum, more than enough to cover the cost of her tuition, fees, and the cost of her uniform and books. The extra money went to help support de Rivera's siblings.[268]

Young women from the mining regions often received scholarships from COMIBOL subsidiaries to study in Sucre and Tarija. In the 1990s, the nursing school at the Tomás Frías

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[267] Mery Gallo de Machicado, *Interview with Author.* Potosí, Bolivia. 21 April, 2012; Juana Gómez, *Interview with Author.* Sucre, Bolivia. 1 May, 2012.
[268] Alina de Rivera, *Interview with Author.* Tarija, Bolivia. 9 May, 2012.

Autonomous University in Potosí supplanted Sucre and Tarija as the most important educational institution for generations of nurses needed in mining hospitals. During the 1950s and 1960s, however, Sucre, a short four-hour drive from Potosí, was the closest and most prestigious educational establishment for young women of mining centers. In 1958, for example, the Catavi Mining Company, part of the nationally-owned mining conglomerate *Coperación Minera de Bolivia* (COMIBOL), funded seven of the school's forty-seven students.[269] The university's rector reported the exam scores for each student to the company, showing first year students' scores for their courses in anatomy, physiology and bacteriology, and second year students' performance their in hygiene, puericulture, and obstetrics classes.

Students also found other solutions to fund their educations, when scholarships or family resources were unavailable. While she studied, Alina de Rivera worked at the bottom of the medical hierarchy as an assistant at Tarija's San Juan de Dios Hospital. The work was exhausting on top of her studies and practical training, but after her mother died and her oldest brothers abandoned the family home, de Rivera's work in the hospital, in addition to her scholarship, allowed her to support her younger siblings.[270] In Sucre, as nursing-midwifery students passed exams and acquired new skills, they earned money on the side performing services like inserting IVs, drawing blood, or giving injections.[271]

Education, Control, and the Morality of Students

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[269] *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia.14 January and 21 April 1958. CBDH.

[270] Alina de Rivera, *Interview with Author.* Tarija, Bolivia. 9 May, 2012.

[271] Frerking Salas, Oscar, "Estudio de necesidades y facilidades para una escuela de enfermería y obstetricia (Sucre)" *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia, 1961, 5. CBDH

For doctors, training capable nurse-midwives required far more than providing education in medical sciences. In the eyes of Dr. Sánchez Pórcel and his Bolivian and foreign colleagues, the nurse-midwife performed a social role that hinged on her embodiment of feminine virtues of morality and obedience. As he contemplated the future of the nurse-midwifery program in Sucre, Sánchez Pórcel insisted that, "a nurse must not only be virtuous and tend to her vocation, rather she must be a living example of skill, culture, and irreproachable morality."[272]

Molding women into models of culture and morality required control and surveillance, along with education in sciences and humanities. The young age of the students made them more malleable in the face of doctors' professional prestige and masculine authority. In other countries, doctors also negotiated the nexus of protection and control, culling midwives, nurses and other healthcare assistants from other socially-vulnerable female populations. University-educated midwives in Ecuador, for example, were largely illegitimate children or orphans who could not depend on the social or financial support of a male guardian. For such women, midwifery programs represented one of the few ways for them to learn an honorable profession and achieve both financial security and social advancement.[273] While available sources do not suggest that Bolivian midwifery students of the 1950s and '60s did so to overcome illegitimacy, their sex and young age nevertheless marked them as a group in need of protection, supervision, and guidance.

In Bolivia, some doctors saw boarding houses as a crucial mechanism for educating and controlling students. Unlike the nursing schools in La Paz and Cochabamba, the midwifery

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[272] Sánchez Pórcel, Jaime, *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia. 15 November, 1967, 8. CBDH.

[273] A. Kim Clark, "Midwifery, Morality, and the State," in her *Gender, State, and Medicine in Highland Ecuador: Modernizing Women, Modernizing the State, 1895-1950* (Pittsburg, PA: University of Pittsburg Press, 2012), 112-142.

schools in Sucre and Tarija had never required their students to live in boarding houses. Dr. Frerking and his colleagues acknowledged the lack of boarding houses as a shortcoming in his 1961 report on the feasibility of creating a joint program, but rejected the notion that it represented a weakness. He noted that "generally, groups [of students] live in private homes of reputable families, or in private boarding houses (*internados particulares*), like the *Internado Americano* (under the control of the Methodist Church Mission), in the Santa Clara Boarding House, or in the Santa Eufrasía (Catholics), and others."[274] Five years later, however, Dr. Sánchez Pórcel argued that the lack of boarding houses had posed a major problem for the school's ability to properly educate its young students. In the old schools, he wrote, "[d]iscipline and humanist education could not be inculcated in the students because of the lack of a boarding house where the young women can be housed and molded, as occurs in the nursing schools of the world."[275] To modernize the program and bring it up to the level of nursing schools in other parts of the country and the world, Sánchez Pórcel urged the school to create an *internado*: "Only that way will we secure control over discipline and morality, in addition to teaching them good manners and expanding their social-cultural knowledge (*bagaje socio-cultural).*"[276]

Mestizaje through midwifery and puericulture

[274] Frerking Salas, Oscar, Benigno Valda G., Mario Rivera Cortés, "Estudio de necesidades y facilidades para una escuela de enfermería y obstetricia (Sucre)" *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia 1961, 5. CBDH.

[275] Sánchez Pórcel, Jaime. *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Centro Documental Histórico. Sucre, Bolivia, 15 November, 1967, 2. CBDH.

[276] Ibid., 5.

Because physicians at the university expected nurse-midwives both to model proper mestiza womanhood and to teach it, the social-cultural knowledge of the young women was particularly important. From Emma Rivera's class in 1940s Sucre to Ana María Maldonado's in 1970s Tarija, midwifery students embodied the new nation that leaders of both the revolutionary and post-revolutionary periods had hoped to create; they spoke Spanish, styled their hair according to the latest trends in the U.S. and Europe, and wore western-style skirts rather than the multi-layered *polleras* and long braids that marked urban "cholas."[277] Although some students came from poorer sectors of the population, most were from the country's small middle class and were daughters of mestizo and white families. Some, like Ruth Clavijo and Mery Gallo de Machicado, had indigenous grandparents from mining areas, but they were nonetheless mestiza women who had attended school and aspired to a middle-class lifestyle. Ana María Maldonado Canedo, who studied in the joint midwifery-nursing program in Tarija in the early 1970s, recalled that even students from the *campo* were not *indígenas*: "In those years, I don't think there was such a difference in social class in that area. Really, most people were from the *clase media*. There were very few people with haciendas. There were people from the *campo* and people from the middle class. And the people that lived in the *campo,* they are much different than they are around here in La Paz. There they speak Spanish."[278]

Scholarship records, in addition to demonstrating the financial need of some students, suggest that applicants were concerned with proving that they were not Indians, even though the university did not restrict admission based on race. Three of the students who applied for university scholarships in 1965, included proof that their fathers were veterans of the Chaco War,

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[277] Lesley Gill, ""Proper Women" and City Pleasures: Gender, Class, and Contested Meaning in La Paz," *Ethnologist* 20, no. 1 (1993): 72-88.

[278] Ana María Maldonado Canedo, *Interview with Author*. La Paz, Bolivia. 22 May 2012.

and reminded reviewers that their fathers' service to the nation entitled them to greater consideration than other applicants. As Andrew Canessa has argued, military service provided one of the primary ways that indigenous men could gain mestizo status, but the records of two applicants suggest that students whose fathers served in the Chaco War also wanted to distinguish themselves from the mass of conscripted indigenous soldiers accused of spreading disease during the disastrous war.[279] For example, Betty Beltrán Miranda, a midwifery student, and Roberto Muñoz V.G., a medical student, were both children of Chaco veterans and both included additional documentation that described them as having "*piel blanco*." Although Muñoz' application made no mention of his father's (or mother's) profession, the patriarch's military service records indicate that he was released after eleven months of service because of an injury, and it is possible that his injury left him unable to provide for his "numerous family." Betty Beltrán's father, who moved with his family to Sucre from La Paz when Betty was still in primary school, worked inconsistently as a carpenter and was unable pay for his daughter's tuition while supporting his five children and stay-at-home wife. The fact that Beltrán and Muñoz were the only applicants in the existing records who included information about their skin color suggests that they both felt that belonging officially to the "raza blanca" improved their chances of winning the scholarship.

For those from mestizo homes, the midwifery schools refined and reinforced students' cultural Europeanness. The required uniform was similar in Sucre and Tarija and consisted of a white, knee-length dress and apron, and a white cap with a red band. Students also wore white shoes and white or skin-toned stockings; for warmth as much as a dramatic flair, blue capes with

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[279] Canessa, Andrew, "The Indian Within, the Indian Without: Citizenship, Race, and Sex in a Bolivian Hamlet" in *Natives Making Nation: Gender, Indigeneity, and the State in the Andes,* ed. Andrew Canessa, (Tucson, AZ: The University of Arizona Press, 2005), 130-156.

red collars (see Figure 7). Because neither midwifery school had boarding facilities like the nursing school in La Paz, students rented rooms in private homes (or, like some of Alina de Rivera's classmates, worked for their room, board and tuition), or boarded with nuns. In Sucre, at least through the 1970s, the *Siervas de María* ran a large boarding house for young, female university students, whose parents had the means to pay for the kind of safe, orderly housing the nuns provided. Although boarding schools (schools with internados) ensured greater control over the daily lives of nurses-in-training, midwifery students' long days and nights in classes and in the hospital immersed them in their professional roles and the culture of western medicine.

Figure 7. Mery Gallo de Machicado leading her midwifery-nursing classmates in the annual parade celebrating the first call for independence from Spain (*El Primer Grito Libertario*). The students march past the Plaza 25 de Mayo in Sucre, Bolivia. May 25, 1964.

Courses in puericulture, matronas trained to remedy the persistent "Indian Problem," taking their lessons on mestiza motherhood from the classroom to the homes of indigenous families. Matronas and nurse-midwives, who studied in the 1950s and '60s, remembered that their puericulture classes simply taught them how to care for infants and children and prepared

them to pass their knowledge on to mothers. Most midwives, in other words, saw puericulture as yet another strategy for improving the health and wellbeing of children with few, if any, larger political implications. A wider perspective on prescriptions for motherhood in Bolivia during the second half of the twentieth century, however, reveals that puericulture courses were intimately connected to elite Bolivians' persistent concern about the Indian Problem.

Puericulture texbooks used in Tarija demonstrate that curriculum planners of the 1950s and '60s sought to mold all Bolivian women into westernized mothers. The majority of the textbooks instructors of puericulture used in Sucre and Tarija came from publishers in Argentina, Chile, and the United States, and all of those authors traced their definition of puericulture to the French physician, Adolfe Pinard (see discussion in Chapter One).[280] Used by instructors at the universities in Sucre and Tarija, the 1953 textbook, *Nociones de Puericultura* by Argentine physician F. Escardó, relayed Pinard's definition of puericulture: "the science that has as its objective the study and investigation of the relative causes of the conservation and improvement of the human race" and distinguished in from its sister "science," eugenics, which focused on improving the race by sterilizing people with diseases or certain genetic traits.[281]

Such textbooks defined good mothers as those who adhered to European ideals of femininity, domesticity and the kind of consumption and leisure affordable only to middle- and upper-class urban women. Dr. Escardó stressed that future mothers should get eight hours of

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[280] I came across such textbooks in May 2012, just as the director of the small, one-room library for the Nursing School at the San Misael Saracho University in Tarija was preparing to archive a collection of old nursing and obstetrics books used by the former midwifery and midwifery-nursing programs. The dusty, insect-ridden boxes included several puericulture textbooks dating between the 1930s and the 1950s that likely served as course reading material, or, alternatively, as resources for instructors of puericulture, throughout the 1950s', '60s,' and '70s.

[281] F. Escardó, *Nociones de Puericultura* (Buenos Aires, Argentina: El Ateneo Editorial, 1963), 10. Author's translation. Escardó quotes Pinard: "La ciencia que tiene por objeto el estudio y la investigación de las causas relativas a la conservación y al mejoramiento de la raza humana." On the influence of Pinard on French Eugenics: Schneider, William H. "Puericulture, and the French style of Eugenics. History and philosophy of the life sciences, 1986; 8(2): 265-77.

sleep each night, bathe daily, and eat a nutritious and varied diet that "stimulates the appetite." Furthermore, in the last month of gestation, pregnant women should avoid all forms of work in order to "ensure the best conditions for the child" as well as to prepare for the transition from her previous role as "wife," to the role of "mother."[282] Chilean physician Arturo Scroggie gave similar advice in his "class notes" from courses taught at the University of Chile in 1948. Scroggie included meal plans for women during the sixth and ninth month of pregnancy that included fresh fruits and salads, European favorites like wheat toast with butter, brand-name consumables like "Quáker" with milk, as well as items not easily obtained or stored in rural areas, like shredded cabbage with mayonnaise and "Sorbete de leche."[283]

At least one Bolivian doctor, Dr. José Napoleón Medrano, published a book on puericulture that restated the advice of North American, Argentine and Chilean doctors without questioning the feasibility of asking poor, rural families to follow such rules. Instead, Medrano revealed the cultural transformation he hoped puericulture would bring to Bolivia in the prologue: "We do not intend to bring to light original or new ideas, but rather useful ones, collected from everything that has been written on the subject, and in accordance with our long experiences as Children's Doctor, based on observation in our own reality. Bolivian mothers, rear our children healthy and strong, educate them from birth for the happiness of your home and exaltation of the homeland!"[284] The children and future patriotic citizens Medrano envisioned performed complimentary roles according to their sex; proper childrearing practices would

[282] F. Escardó, *Nociones de Puericultura* (Buenos Aires, Argentina: "El Ateneo", 1953), 42.

[283] Arturo Scroggie, *Puericultura: Apuntes de Clases* (Santiago, Chile: Editorial Universitaria, S.A., 1951), 28-29.

[284] José Napoleón Medrano, *Puericultura elemental* (Cochabamba, Bolivia: Imprenta Universitaria, 1952). "No pretendemos lucir ideas propias ni nuevas, pero sí útiles, recopiladas de todo lo que se ha escrito sobre el particular, y de acuerdo a nuestra larga experiences como Médico de Niños, basada en la observación de nuestro medio ambiente. ¡Madres bolivianas criad a vuestros hijos sanos y robustos, educándolos desde que nacen, para la felicidad de vuenstro hogar y el engrandecimiento de la Patria."

produce "healthy and robust men for work and defense of our rights," who acted with dignity, justice, honor, and discipline, and "beautiful, healthy women, who know how to be good daughters, good sisters, good wives, and good mothers…" [285] Fostering these culturally-European, gendered citizens required indigenous mothers to reject the traditional manner of dressing and carrying their babies and adopt European-style houses with multiple rooms and furnished nurseries, complete with easily-washable wood floors and walls pleasantly tinted with oil-based paint. He criticized the "Indo-American" swaddling methods that involved, according to his view, so violently wrapping the babies that they look more like "Egyptian mummies or rigid, hard Cuban cigars" than like human beings. Instead, he urged mothers to take up the parenting practices of the "foreign families that live in our country" and to dress their babies in loose layers of shirts, jackets, and hats.[286] Furthermore, rather than carrying babies, a cultural practice of all indigenous women and practical necessity given the precarious sidewalks and streets even in large cities like La Paz, Medrano warned that mothers who carried their babies risked infecting them with a slew of life-threatening illnesses, such as flu, tuberculosis, diphtheria, and meningitis and advised them to use strollers. In addition to purchasing a stroller, the doctor strongly urged mothers to purchase a crib of iron or other metal, and when possible, to reserve a separate bedroom for the child. Acknowledging that many families did not have a second room in their house, much less a second bedroom, Medrano recommended only that mothers not hang wet clothes inside the house as the humidity produced in drying could easily give the child a cold.

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[285] José Napoleón Medrano, *Puericultura elemental* (Cochabamba, Bolivia: Imprenta Universitaria, 1952), 9.

[286] Ibid., 24.

Matronas in the Middle of Labor, Capital, and State Negotiations

Matronas who graduated in the 1960s and early-1970s found immediate work in the hospitals of COMIBOL, in smaller mining cooperative hospitals, and in public health centers that served mining families.[287] As employees of state-funded hospitals and health centers, matronas mediated miner-state relations, although not in the ways described in political and economic histories. Foundational scholarship on Bolivia has framed political developments in twentieth-century Bolivia in terms of the conflicts between the state (comprised of the powerful economic elite, the military, political parties) and miners.[288] "Bolivian tin miners," wrote historian June Nash, "have the reputation for being the most revolutionary segment of the working class."[289] James Malloy and Eduardo Gamarra placed equal importance on miners, arguing that "[n]othing set the tone for the Barrientos period—and all subsequent periods as well—more than the relationship between the state and organized labor, particularly miners."[290]

The historiographical focus on miners is warranted. Soldiers in the Chaco War were pulled from the mines of Potosí and Oruro, and those who survived formed a movement against the oligarchic ruling class, known as the *rosca.* In 1952, an armed mobilization of miners tipped

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[287]Ana María Maldonado Canedo guessed that matronas had worked in the mines even before the nationalization of the mines in 1952. She had begun some investigation of the topic but said she had not found any good archival sources on the matter. Many matronas who worked in the mines during the 1960s and '70s are still around and I was able to interview them.

[288]Herbert Klein, *Bolivia: The Evolution of a Multi-Ethnic Society* (New York: Oxford University Press, 1992). James M. Malloy and Eduardo Gamarra, *Revolution and Reaction: Bolivia, 1964-1985.* (New Brunswick, NJ: Transaction, Inc., 1988). Laura Gotkowitz's *A Revolution for Our Rights: Indigenous Struggle for Land and Justice in Bolivia, 1880-1952* (Durham: Duke University Press, 2007) is a recent addition to Bolivian historiography that corrects the almost exclusive focus on the role of miners in the lead up to the revolution of 1952.

[289] June Nash, *We Eat the Mines and the Mines Eat Us: Dependency and Exploitation in the Bolivian Tin Mines.* New York: Columbia University Press, 1979.

[290] James M Malloy and Eduardo Gamarra *Revolution and Reaction*, 9.

the scales of the national revolution, when they took up arms and marched to La Paz to support the MNR. In response to the demands of miners, the MNR took control of 163 mines and creating a national mining company, *Corporación Minera de Bolivia* (COMIBOL). COMIBOL's initial board of directors consisted of seven members, two of which were from the main mining union, the *Federación Sindical de Trabajadores Mineros de Bolivia* (FSTMB), but tensions between miners and the state-run enterprise remained high.[291]

Power struggles between miners and the state continued following the coup of 1964 that ousted the revolutionary MNR government. Between 1964 and 1982, a series of military generals held presidential power. Within that period—from 1964 to 1969—General René Barrientos and General Alfredo Ovando, engaged in a two-man political tug-of-war over the presidency, with Barrientos maintaining power for the majority of the half decade until his death in a helicopter crash in 1969. Barrientos assumed a hard-line approach to negotiations with miners. In the year following the coup, Barrientos exiled FSTMB-leader of Juan Lechín Oquendo and abolished the national workers union, the *Central Obrera Boliviana* (COB). Under the new regime's orders, the army occupied mining camps to suppress protests and union activity. With workers struggling to reorganize, the government decreased wages by as much as 50% and ended subsidies at camp stores (*pulperías*).[292] Tensions between the government and miners reached a bloody climax in 1967 with the massacre of miners at Siglo XX. In a carefully-planned operation that took place on the same day as a scheduled meeting of the FSTMB,

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[291] James Dunkerley, *Rebellion in the Veins: Political Struggle in Bolivia, 1952-1982* (London: Verso, 1984), 58. Thomas C. Field, Jr. shows that U.S. foreign policymakers, influenced by modernization theory, saw communist miners as the primary threat to U.S. hegemony in Bolivia. To combat them, the U.S. supported Víctor Paz Estensorro's growing authoritarianism, using U.S. development aid through the Alliance for Progress and USAID to suppress communist organizers and control miners. See Field, *From Development to Dictatorship: Bolivian and the Alliance for Progress in the Kennedy Era.* Ithaca and London: Cornell University Press, 2014.

[292] Dunkerley, *Rebellion in the Veins,* 123-125. Malloy and Gamarra, *Revolution and Reaction,* 9-14.

soldiers dressed in civilians clothes quietly filed into the camp around dawn, following the night-long annual winter celebration. Soldiers then opened fire, the sound of their bazookas and machine guns briefly mixing with the festive noise of fire-crackers and cannons. At the end, the army had killed eighty-seven men, women, and children, including midwife María Rasquido Coca's parents, in addition to injuring seventy-one others.[293] Ovando conceded power in 1970 to Juan José Torres, who was overthrown 10 months later, in August 1971, by General Hugo Banzer. Banzer exercised dictatorial power until 1982. Ovando and Torres both attempted to improve relations with organized labor, during their brief presidencies. Ovando allowed unions to operate openly once again, removing the army from mining camps and permitting Lechín Oquendo to return from exile. Torres, who held power for only ten months, initiated a political swing to the left but failed to control the resulting radicalization of workers, peasants and students.[294] The primary shortcoming of many political and economic histories of Bolivia is their tendency to analyze only the actions of male miners and their struggles over wages and working conditions.

My analysis of childbirth assistance in the mines, in contrast, deepens our understanding of the field of negotiations and conflicts between miners and the state. Bolivian doctors' interpretations and adaptations of international health politics shaped both the professional opportunities available to the country's young women and the kind of care available to expectant mothers during pregnancy and delivery. The work of matronas was of equal importance; their work with the women of mining areas, mediated the relationship between miners and the state.

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[293] Dunkerley, *Rebellion in the Veins,* 148-149; Barrios de Chungara, *Let Me Speak!,* 115-117; Malloy and Gamarra, *Revolution and Reaction,* 15.; María Rasguido Coca, *Interview with Author.* La Paz, Bolivia. 24 January, 2012.

[294] Malloy and Gamarra, *Revolution and Reaction,* 41-70.

Maternity care was part of a larger package of health services through which the state attempted to meet the demands of workers. The Social Security Code of 1953 obligated COMIBOL and other employers to offer healthcare services to workers and their families. Whereas many major industries and unions set up independent *cajas,* or social security offices, for their workers, COMIBOL instead routed worker claims for disability compensation and retirement, through the National Security Office (*Caja Nacional de Servicios Sociales*). To provide medical care, COMIBOL established a system of hospitals and clinics in mining areas that often provided better care than hospitals in non-mining towns. These COMIBOL facilities treated sick and injured miners, but they also provided health care (including maternity care) to miners and their families, as well as to local residents who lacked insurance through another caja. [295]

Following the Ministry of Health's structure of healthcare facilities, COMIBOL ran large hospitals, small hospitals, "health centers" (*centros de salud*) and "medical posts" (*puestos de salud*). Larger hospitals had the best equipment, and offered specialized medical care, and assistance from medical and nursing students. Basic hospitals provided routine hospitalization, and in-home consultations. Health centers (*centros de salud*) had a small number of beds for urgent care and provided four main areas of attention, including general medicine, general surgery, pediatrics, and obstetrics and gynecology. Cases requiring specialized care or difficult surgeries were generally transferred to large hospitals. Medical posts (*puestos medicos*) were the lowest level in the hierarchy of medical facilities, employing only one general physician, nurse, or nursing assistant in order to provide patient consultations, conduct home visits and

[295] Flavio Vásquez Luna and Marco Antonio Vásquez, "Hospitales de la COMIBOL," *Archivos Bolivianos de Historia de la Medicina* 11, n.o 1 - 2 (January- December 2005): 94-100. June Nash, *We Eat the Mines and the Mines Eat Us: Dependency and Exploitation in the Tin Mines* (New York: Columbia University Press, 1979), 98-105.

direct health promotion and preventive care projects. By 1976, COMIBOL ran 31 large and medium-sized hospitals, five health centers, and 37 medical posts and provided medical services to 12 different mining companies, two industrial plants and staff at the COMIBOL headquarters in La Paz. In total in that year, COMIBOL provided medical services for 119,750 people, second only to the *Caja Nacional de Salud,* which served nearly one million Bolivians that year.[296]

The number of midwives that worked in many mining hospitals and health centers is difficult to ascertain, as are other specific details about hospital operations before the mines were closed in 1986. But regardless of their numbers, health administrators for mines hired midwives because of their specialized expertise and ability to work independently of doctors in the majority of cases. Ana María Maldonado Canedo, who graduated in the early 1970s from the last program in Tarija for midwives, remembered that midwives were in high demand and that none of her colleagues ever faced unemployment. In 1976, only a few years after Maldonado Canedo accepted employment at a health center south of the city of Potosí, COMIBOL employed 151 "enfermeras," in addition to 194 doctors.[297] Such statistics make it impossible to say how many of those "nurses" were, in fact, nurse-midwives employed primarily in maternities, but oral histories suggest that their numbers were significant.

The work of matronas in mining centers hinged on their ability to gain the trust of indigenous families. Maldonado Canedo spent three years in a COMIBOL hospital south of the city of Potosí but most of her time was spent outside of the hospital. "We attended in houses in the position that the woman chose," she recalled. "Usually on the floor. I never had a child or a

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[296] Flavio Vásquez Luna and Marco Antonio Vásquez, "Hospitales de la COMIBOL," *Archivos Bolivianos de Historia de la Medicina* 11, n. 1 - 2 (January - December, 2005): 94-100. In his *Historia de la salud pública en Bolivia* (La Paz: OPS/OMS, 2002) Gregorio Mendizábal Lozano also discusses mining services and appears to reference the same 1976 health service statistics as do Vásquez Luna and Vásquez, although his lack of citations makes the sources of his information unclear.

[297] Gregorio Mendizábal Lozano, *Historia de la salud pública en Bolivia* (La Paz, Bolivia, OPS/OMS: 2002), 229.

mother die and very few ever had to go to the hospital." She trained a Quechua-speaking assistant, who normally worked as a cleaner, to help her during the delivery and to communicate with the mother when necessary, but often, she recalled, the words used with the mother were far less important than gestures and a caring tone of voice. Ruth Clavijo also attended many home births during her work for a small hospital in the mining town of Pucro, in the Department of Potosí. Clavijo had begun her studies in 1970 in Sucre, when the program still offered joint midwifery-nursing degrees. Ruth graduated without the midwifery title in 1975, because the school began offering only nursing degrees before her graduation. Nonetheless, because she had experience as a midwife, she found immediate employment. The hospital in Pucro had been constructed to bridge the cultural divide between western medical births and the family-centered birthing customs of indigenous women. It had a separate room for the family with a kitchen, so that family members could make tea and food for themselves and the parturient mother. In spite of the extraordinary effort to make the hospital environment more welcoming to indigenous families, Clavijo recalled that she and the doctor, a young man completing his mandatory year of rural service, had to go door-to-door to introduce themselves. With a suitcase containing obstetrical tools like scissors, soap, alcohol, and disposable gloves to ensure a sterile birth, Clavijo recalled that she attended around 100 births during the year she spent in the area. The thatched-roof, dirt-floor houses were normally divided between two rooms and women usually preferred to give birth on the floor in a squatting position over a soft sheep skin. Over the course of the year, however, Clavijo and the doctor with whom she worked convinced a greater number of women to give birth in the hospital and gently began encouraging them to give birth in the reclined, obstetrical position. Both Clavijo and the doctor spoke Quechua and their ability to communicate with mothers in their preferred language most likely earned the family's trust.

Sucre's school required matronas-in-training to take classes in basic Quechua, and their language skills often proved useful during consultations, deliveries, and educational outreach.[298]

In some cases, public health programs would have failed without the work of Quechua-speaking matronas. Matronas established contact with indigenous women and informed them of medical services and procedures within the hospital through the type of door-to-door outreach Clavijo did in Pucro, as well as through Ministry of Health programs. As a health educator and coordinator of a health center for the Unidad Sanitaria in a lower-class neighborhood of Potosí, Mery Gallo de Machicado educated indigenous women about basic hygiene, as well as prenatal and infant care. In addition to holding educational talks, the health center also provided vaccinations and prenatal checkups. Her success at the health center also derived from her persistence; Gallo de Machicado turned the center—initially an empty four-room building with no staff members or doctors—into a thriving clinic with an exam table, medical equipment, and benches for educational talks. The clinic attracted poor, Quechua-speaking women who had migrated with their husbands to Potosí from rural areas to take jobs in the mining industry. After she began working at the center, Gallo de Machicado commonly took the bus uphill on her way to work but made the return trip by foot, on a route that familiarized her with her patients' neighborhoods. The women who came to the center were very timid, she recalled. The center's location on the periphery of the city, closer to neighborhoods of mine workers ensured the success of the programs, because the women felt uncomfortable traveling all the way into the

[298] Not all programs placed equal value on language skills, however. Tarija's program did not include a language requirement, nor did the National Nursing School in La Paz require that students learn Aymara, the dominant indigenous language of the region. Matronas who studied in Sucre, therefore, had an advantage, in many situations, over their colleagues from Tarija (although some midwifery graduates of Tarija understood Quechua from family heritage). Regardless of the providence of their language abilities, indigenous language skills increased midwives' effectiveness as "agents of change" and increased their professional value within the public health system. In contrast, the National Nursing School in La Paz did not teach any indigenous languages but did require their students to take 30 hours of religious instruction.

city-center, where the major hospitals stood only blocks away from the stately colonial buildings of the central plaza. Moreover, educational talks absolutely had to be given in Quechua. Otherwise, she noted, they were a complete waste of time, because the women understood only a limited amount of Spanish. Having learned Quechua as a child from her grandmother, Gallo de Machicado found her language skills useful early on in her career. After her second year in the program, in 1963, she took time off to follow her husband, a graduate of Sucre's medical school, during his obligatory year of rural service. During that time, she often acted as a translator between her husband and the families in rural areas of the department of Sucre.

The outreach and educational work of matronas in rural areas and urban outskirts prepared women to give birth in larger hospitals, where university-trained midwives ran the maternities. In larger hospitals, like the medium-sized facility in Llallagua and the central mining hospital in Catavi, a short ten-minute drive away, midwives worked in shifts around the clock and sought the assistance of doctors only when a parturient mother required a cesarean or other emergency procedure. After a year in Pucro, Ruth Clavijo took a better position at a medium-sized hospital called COPOSA in her hometown of Llallagua. The hospital, a cooperative health-center funded by miners of the *Empresa Minera Catavi,* operated in coordination with the main COMIBOL hospital in Catavi, sending patients to the larger hospital for complicated surgeries or, in obstetric emergencies, for cesareans. During her four years, the cooperative hospital, Clavijo worked with three other matronas, all graduates from the schools in Sucre or Tarija. At that hospital, she recounted, it was no longer necessary to do outreach because people already patronized hospitals. Women knew the rules of the hospital because they had been informed during prenatal checkups. If they were unwilling to "accept the changes," Clavijo noted, then

they delivered at home.[299] For women accustomed to giving birth in a squatting or kneeling position, fully-clothed, in their small, dimly-lit homes with the assistance of a close relatives, usually including husbands and mother-in-laws, the changes they had to accept to give birth at the hospital were major; maternities prohibited family members in the delivery room, women were generally made to disrobe and wear a gown in spite of the cold, spacious construction of most maternities, and at least when it came time to push, most matronas required the mother to recline with her feet in the stirrups.

In both small, rural hospitals and large urban ones, matronas ran the show in maternities. South of Potosí, Ana María Maldonado Canedo worked with other matronas, all graduates of the programs in Sucre or Tarija. The hospital had no doctors, so the midwives were left to handle difficult births as best they could, or sent the patient to the closest larger facility, if timely transfer was possible. Maldonado Canedo and her colleagues worked around the clock in eight-hour shifts and depended on assistance from local women who often lacked medical training. At the main hospital in Catavi, a large, modern facility that provided specialized treatment and surgeries, Ruth Clavijo worked for nine years as Head Matrona, starting around 1980. The maternity included a neonatal ward with eight cribs and two rooms for post-partum patients that held twenty-eight beds. At that hospital, one matrona worked six-hour shifts with the company of two assistants and one servant (*personal de servicio*). The male obstetrician made rounds each morning for six hours to check on the status of patients, but for the remaining 18 hours of each day, matronas attended patients alone, and called for the doctor—who lived close to the hospital—only in emergencies.

To entice young matronas to mining areas, COMIBOL offered compensation that made it possible for matronas to raise their own families. In the small mining hospital south of Potosí, where Maldonado Canedo worked for three years in the 1970s, the company provided housing, free schooling for children, and credit for basic goods at the company grocery store (*pulpería*), in addition to her salary. She also received overtime pay, surely a welcome benefit when assisting first-time mothers during characteristically long laboring periods. Ruth Clavijo worked first as Head Matrona in Catavi for COMIBOL and later for the National Health Service (*Caja Nacional de Salud)* in La Paz. She noted that even though COMIBOL offered a much lower salary, the benefits still made it possible to support a family. "At COMIBOL," she said, "they gave us a lot of benefits, really cheap groceries, meat and bread, everything was really very cheap… we also had free housing outside of the hospital, in the city of Catavi." Clavijo's position as Head Matrona surely earned her a higher salary than the other midwives under her command, but like Maldonado Canedo, she recalled that although salaries differed, a career as a matrona allowed women to act as primary breadwinners of their families.[300]

Professional Power and Medical Expertise of Nurse-Midwives

Midwifery and nursing offered a highly marketable career, economic independence, and opportunities for world travel and continued education, and many nurse-midwives used the available avenues for advancement to become experts in their fields. Many graduates of the schools for nursing and midwifery received additional training outside of the country, after completing their degrees. Emma Rivera, one of Sucre's best-known midwives, completed an additional three-month training in obstetrics at the *Escuela de Obstetricia* in Santiago, Chile,

[300]Ruth Clavijo, *Interview with Author*. La Paz, Bolivia. 23 May, 2012.

after completing her studies around 1950 at the age of seventeen. By 1950, the Chilean school had educated matronas for more than a hundred years and transformed childbirth assistance in the country from a feminine trade to a branch of medicine that wielded all of the power of other masculine sciences.[301] When she returned to Bolivia, Rivera taught obstetrics to both medical and midwifery students at the university in Sucre. She later held the position of Instructor of Practical Training in Sucre for more than a decade, during which time she occasionally traveled to international medical conferences. When the military dictator Hugo Banzer closed the universities following his coup in 1971, "Miss Rivera"[302] passed up an offer of employment in Chile and accepted a position at a public maternity in São Paulo, Brazil, where she worked for the next fifteen years. Similarly, after completing her first degree, Alcira Vaca, who began her studies at Tarija's School for Nursing and Midwifery in 1958 but graduated with only the nursing title because of program changes, took advantage of opportunities to further her education as a midwife. In 1965, along with four other Bolivian nurses (two from La Paz, one from Oruro and one from Potosí), she won a WHO scholarship to study in Cali, Colombia and after several months of work in a public maternity in Cali and study at the University del Valle, she returned to Tarija and accepted a position as instructor of obstetrics at her alma mater.

Midwives' extensive practical and theoretical training made them experts in the hospital and in the classroom. Emma Rivera passed on the training she received in Chile, as well as her experiences gained over years of assisting Bolivian obstetricians, to the midwifery students in Sucre. Juana Gómez, who was a student of Miss Rivera in 1970, recalls that Rivera began giving her additional instruction during her shifts at the hospital. As a result, during her fourth year in

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[301] María Soledad Zárate, *Dar a luz en Chile, Siglo XIX,* 221-260.

[302]In her eighties at the time I interviewed her at her home in Sucre, Emma Rivera, who never married or had children, still preferred to be called "Señorita Emma."

the program, Gómez began substituting as Head Matrona in the maternity at the public San Juan de Dios Hospital, where midwifery students completed their practical training. Another student of the Sucre program, Mery Gallo de Machicado, recalled that the knowledge of midwives-in-training often surpassed that of their male counterparts from the medical school. She remembered with a hint of exasperation that the medical students with whom the midwifery students sometimes worked in the maternity never knew how to measure cervical dilation or find the baby's heartbeat. In such situations, midwifery students were quick to set their male colleagues straight, because their intensive work in the maternity during their four years of study left them far more equipped to conduct prenatal exams and to assist women in childbirth than the young men who might someday become their bosses. Gallo de Machicado and Gómez both partially attributed their professional preparation to a rigid chain of command in the maternity. During every shift, a student from each of the four years worked at the maternity. Juana Gómez remembered the rigidity of the division of labor with a laugh: "So, what was the job of the first-year student?" she asked. "If someone rang the doorbell," she continued "then it was the first-year who had to open the door. The second admitted the patient, the third-year observed the birth, and the fourth-year assisted in the delivery." The midwifery students also took classes with the medical students, but their studies split after completing the course on "normal births." The medical students additionally took a course on "pathological births," which included instruction in manually extracting the placenta in cases of retention, and cesarean operations.[303]

Matronas' expertise eroded the rigid hierarchy that doctors hoped to maintain between themselves and midwives. Both Emma Rivera and Mery Gallo de Machicado told of direct

[303] Juana Gómez, *Interview with Author.* Sucre, Bolivia. 1 May, 2012. Mery Gallo de Machicado, *Interview with Author.* Potosí, Bolivia. 21 April, 2012; Juana Gómez, *Interview with Author.* Sucre, Bolivia. 1 May, 2012.

conflicts with doctors regarding childbirth. Although their stories differed considerably, they suggested that only a powerful feeling of anger over a doctor's misjudgment had brought them to verbally break rank. Miss Rivera told of instances when she completely disagreed with a doctor's diagnosis and the tension it caused when she insisted to him that he was wrong. Gallo de Machicado did not contain her frustration, when she told of one particular incident assisting a doctor during delivery. The doctor, who only showed up for the delivery after Gallo de Machicado had spent hours guiding the parturient mother through labor, yelled at the patient for crying out in pain as her first child crowned. Gallo de Machicado said she later told the doctor she would never work for him again because he did not treat mothers with the gentleness and patience they deserved during the painful, but "sacred," moment of birth.

Quechua language skills also allowed midwives to work more effectively with patients and make independent decisions about how best to assist parturient mothers. Juana Gómez told of a particularly impressive birth that occurred while she acted as Head Matrona at the San Juan de Dios maternity in Sucre. A rural, indigenous woman came to the hospital alone in the middle of the night, having already progressed so far in her labor that she was nearly ready to push when Gómez came to assist her. When the woman indicated she did not want to deliver on the bed in the gynecological position, Gómez disregarded official medical procedures that stipulated that she require the parturient mother to recline for delivery and simply asked, in Quechua, how she would prefer to deliver her baby. The woman said she wanted to deliver in a squatting position on the floor, and with Gómez to catch the baby and a nun, who was on duty, to support the mother, the child was born in a matter of minutes. After that encounter, Gómez said, she never understood why anyone ever asked women to deliver in the gynecological position.[304]

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[304] Juana Gómez, *Interview with Author.* Sucre, Bolivia. 1 May, 2012.

Closing the Spaces of Power: From Midwifery to Nursing

The matronas who studied during the 1960s were Bolivia's last generation of university-trained midwives. The termination of the programs marked the end of an era in obstetric care in Bolivia. In 1972, the schools in Sucre and Tarija made the complete conversion to nursing. The elimination of midwifery programs and consolidation of a national nursing program ultimately occurred as part of the nation-wide restructuring of the university system mandated under General Hugo Banzer, but the process of reforms had been well underway when he overthrew General Juan José Torres in August 1971.

Both international and domestic pressure to terminate the midwifery degree won out in the early 1970s. Pan-American Health Organization (PAHO) technical advisers suggested that nurses would better meet public health needs than would midwives. In response to a request for funds from Dr. Frerking, health consultants from the PAHO advised that the midwifery school in Sucre dedicate the first three years of the program to nursing, in accordance with the "latest advancements in the profession… and the realities of the country...", and that students be given the option of studying midwifery only in the last year of the program.[305] In comparison, the joint midwifery-nursing program required both theoretical and practical training in midwifery over the course of the four years of study.[306] Echoing the PAHO recommendations, officials at the Ministry of Health, including obstetrician, Dr. Jorge Doria Medina, and Director of Nursing, Señora Aída de Bretel, recommended that the school "eliminate midwifery and stimulate

[305] *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia. 14 Jan, 1963. Letter forwarded by office of Dr. Luis Sauma K. to Dr. Oscar Frerking Salas. CBDH.

[306] Mery Gallo de Machicado, *Interview with Author.* Potosí, Bolivia. April 21, 2012.

instruction in nursing, giving progressively less importance to matronas, so that they disappear."[307] The director, Dr. Frerking, in contrast, insisted that matronas were necessary to eliminate demand for the services of untrained midwives (*empíricas).*

In spite of Dr. Frerking's and Dr. Sánchez Pórcel's support of midwifery education, preparations for a full transition to nursing began in earnest in 1967, following an assessment of the school carried by a commission of faculty and students from the School of Medical Sciences (*Facultad de Ciencias Médicas)*. The commission, which was comprised of doctors Jaime Sánchez Pórcel, Mario Rivera Cortés, Rodolfo Mendoza, and student representatives both from the Medical School and the Midwifery-Nursing School made one major recommendation: that the school find more formally-trained nurse-instructors. Both student nurses and doctors of the commission argued that the school desperately needed more nurse-instructors in order to ensure that they graduated with the level of competence and skill of their counterparts at the country's other nursing schools.

Nurses themselves also actively shaped and expanded the nursing profession during the 1960s and '70s. Vilma Valda de Ríos was one nursing student who seized the opportunities for career advancement in nursing. In order to fill Sucre's need for nurse-instructors, the School of Medicine sent Valda de Ríos, a graduate of the joint program, to the National Nursing School in Santiago Chile, to complete advanced study for nursing education.[308] Upon her return in 1968, Valda de Ríos accepted an appointment as instructor of nursing ("*docente de enfermería*") and

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[307]Sánchez Pórcel, Jaime. *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia 15 November, 1967. CBDH.

[308] *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Centro Documental Histórico. Sucre, Bolivia. 17 July, 1967.

advocated of the complete conversion of the program.[309] In 1970 and 1971, student representatives sent a flurry of letters to the university rector, invoking the increased value of their profession to demand improvement to the program. In 1970, representatives of the student association, the Association of Nursing Students (*Centro de Estudiantes de Enfermería*), requested an increase in the annual allotment of fifteen scholarships, given that "the School of Nursing and Midwifery has a social composition of girls that need economic assistance in the form of a scholarship in order to continue with their studies."[310] The following year, students participated in a successful campaign to convince the university to provide the school with its own building. Until that time, midwifery-nursing students had attended classes at locations throughout Sucre, in the medical school, at the *Instituto Médico Sucre*, and in the Santa Bárbara Hospital.[311]

Tarijeña nurse Adela de Romero took advantage of Banzer's overhaul of the university system to push forward national-level reforms to the nursing programs. Having completed her studies at the National Nursing School in La Paz in the 1950s and in the U.S. thereafter (see Chapter Two), the lack of practical instruction doctors gave nursing students in the hospital in Tarija appalled de Romero. She was offered a position as director of the nursing program, when the universities reopened following the coup, and she seized the opportunity to institute a

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[309] *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia. 31 July, 1968. CBDH.; Emma Rivera, *Interview with Author.* Sucre, Bolivia. 5 April, 2012.

[310] *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia. 22 June, 1970. CBDH. University Students Elvira Fernández M. and Nancy Manjón C. to Dr Alfredo Arce Arce. Ms. Manjón was director of the Escuela de Enfermería in Sucre at the time of research in 2012. I am indebted to her for her assistance in locating and accessing archival materials and obtaining interviews with obstetricians and former midwifery students in both Sucre and Tarija.

[311] Oscar Frerking Salas, Benigno Valda G., Mario Rivera Cortés, "Estudio de necesidades y facilidades para una escuela de enfermería y obstetricia (Sucre)" *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia.1961, 4. CBDH.

regulation that stipulated that nurses, rather than doctors, must provide all practical and theoretical instruction pertaining specifically to nursing. Many nursing schools had already adopted similar policies, but in Tarija, all directors of the nursing school had been male medical doctors, and medical doctors had also taught all nursing classes. "Sometimes I wonder where I got the confidence to confront all those doctors like that," mused de Romero. "I thought they were going to kill me," she laughed. [312]

Bolivian doctors had a professional interest in phasing out the midwifery programs as well. By the late 1960s, a growing number of doctors graduated with specialized training in obstetrics and gynecology, and those doctors saw university-educated midwives as competitors for limited positions.[313] Competition was not only a matter of job placement but also a matter of training. While the midwifery schools were in operation, the Head Matrona of the public hospital assigned both midwifery students and medical students to births. With the increase in medical students specializing in obstetrics, however, competition for practical experience in hospitals increased. In cities like La Paz that did not have midwifery schools, medical students replaced even trained matronas; by 1956, medical students had taken over birthing assistance in the maternity of the Miraflores General Hospital.[314]

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[312]Adela de Romero, *Interview with Author.* Tarija, Bolivia. 19 May 2012. In a 1967 letter to University Rector, Dr. Alfredo Arce, the student representative of the commission that reviewed the midwifery-nursing school urged the University Counsel to hire nurse-instructors in accordance with the practice of other nursing schools in Bolivia and abroad: "…habiéndose resuelto que las Cátedras de Enfermería de los tres primeros cursos sean dictadas por enermeras instructoras, al igual que en las Escuelas de Enfermería de nuestra nación, como también del extranjero, solicito a usted y al H. Consejo Universitario que preside que el mencionado Consejo dicte una resolución en este sentido para qué en la brevedad posible las clases de la Cátedra mencionada prosigan en la forma indicada anteriormente." *Correspondencia de la Facultad de Ciencias Médicas.* Univeridad Mayor, Real, y Pontificia de San Francisco Xavier de Chuquisaca. Sucre, Bolivia. 18 May, 1967. CBDH.

[313] Elva Oliveira, *Interview with Author.* La Paz, Bolivia. 21 May 2012.

[314] Patient records from the public maternity in Miraflores indicate a shift in childbirth assistance in that year. Whereas in 1955 the midwife on duty (matrona de turno) attended all normal births in the maternity, during the following year, students (both male and female) attended all births in the maternity. Instituto de Maternidad "Professor Dr. Natalio A. Aramayo", March 31, 1955. ALP.

Furthermore, the rise in the number of specialists in obstetrics and gynecology in the 1970s paralleled an increase in medical specialists of many kinds in Bolivia during the same period. A history of public health in Bolivia commissioned by the World Health Organization in 1989, for example, reflected that, in the 1970s, the degree of specialization in Bolivia acquired "peculiar, and even alarming, characteristics."[315] Many doctors completed specialized training in Europe, the United States, or in South American countries like Argentina or Chile with longer and more established traditions in biomedical education and practice.[316] Others, however, pieced together "specialized training" through work in specific disciplines and received certification as medical specialists from ad-hoc tribunals that, in effect, expedited medical modernization in Bolivia. Even Bolivian satirists honed in on changes in medical practice in the 1970s. In his book, *Subdesarrollo y Felicidad: Estampas humorísticas de Tarija,* Bolivian humorist William Bluske Castellanos japed that "medical terminology is something that advances with the rhythm of medicine, like an urgent need to baptize the illnesses that it goes about creating,… it is so vast, so unintelligible, and so specialized, that sometimes one simply dies of the shock of hearing the diagnosis they don't understand."[317]

Although Bolivia followed international recommendations regarding the expansion of nursing in the 1970s, the increased specialization of medicine in Bolivia ran counter to WHO

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[315]Sociedad Boliviana de Salud Pública, *Historia y perspectivas de la salud pública en Bolivia.* (Bolivia: Producciones CIMA, 1989), 94.

[316] See Agnes W. Chagas, "Modern Nursing in Latin America," *The American Journal of Nursing.* 3, no 1 (January 1953): 33-34. All of the doctors interviewed for this project had completed specialized training, commonly in Spain or in Chile.

[317] William Bluske Castellanos, *Subdesarrollo y Feclidiad: Estampas humorísticas de Tarija*. 2nd ed. (La Paz, Bolivia: Biblioteca Popular Boliviana de Ultima Hora, 1976), 71. Orginal quote: "la terminología médica es algo que avanza al ritmo de la medicina, como una necesidad urgente para bautizar a las enfermedades que se van creando… es tan vasta tan inintelegible y tan especializada, que a veces uno se muere de susto de solo escuchar el diagnóstico que no entiende."

recommendations. An expert committee of the World Health and Panamanian Health Organizations, convened in Washington, DC in June 1971, discussed medical education in obstetrics and gynecology in Latin America and recommended that medical education become more general rather than more specialized. That recommendation held both for the teaching of gynecology and obstetrics, which the committee advised be taught together rather than separately, and for medical education as a whole. The committee argued that medical education should maintain a "social focus" in order to serve communities. Although the committee counseled each medical school to mold curricula to meet the "conditions and needs of the country" as well as the "characteristics and aspirations of the medical students," it nonetheless insisted that "the objectives [of medical education] should be oriented toward the formation of a general medical practitioner."[318]

Those students studying midwifery and nursing in 1971, when the Banzer government abruptly converted their course of study, struggled both to complete their intended degrees and to ensure that future nursing students would enter a career that held value and prestige. "They offered to just give us the nursing title," recalled Juana Gómez about the closure of the universities in 1971. "Many of the students were from the interior of the country, from Potosí, La Paz, Cochabamba and Santa Cruz, and they had come to Sucre to study nursing *and* midwifery. They had come with the purpose of studying both professions and they wanted to graduate with both degrees," she continued.[319] University administrators conceded to the students' demands, but subsequent cohorts no longer had the option of training as midwives. Students also advocated

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[318] World Health Organziation, Comité de Expertos de la OPS/OMS, "Primer informe sobre la enseñanza de la obstetricia y ginecología en las escuelas de medicina de la América Latina," Serie de desarrollo de recursos humanos. No. 16. (Washington, DC: OPS/OMS, 1971), 2, 5.

[319] Juana Gómez, *Interview with Author.* Sucre, Bolivia 1 May, 2012.

the creation of nursing programs at the level of *"licenciatura,"* a change that extended the program of study to five years and required the completion of a thesis in addition to comprehensive theoretical exams.

In spite of the efforts of nurses to shape the profession in ways that would provide Bolivian women with valuable careers, many graduates judged that the transition from midwifery to nursing both reduced the value of women's options for careers in medicine and negatively affected childbirth assistance in hospitals and clinics. Before the change, Gómez recalled, "we were the ones who attended the births, but now, that is part of the training of the residents who are studying gynecology and obstetrics. There were the first residents and then, little by little the residents started taking charge of childbirth assistance. I think it was until 1979, when I left my position at [the Women's Hospital in Sucre], after that, matronas no longer attended births there." Gómez, like other graduates of the midwifery programs saw the shift to nursing as a demotion for women in medical professions. "It is really a shame, and it is really ironic. We fought hard so that nursing would continue having a status…All of the nurses at the Women's Hospital now are specialists in obstetrics or in neonatal care. I would say 98% of them. But unfortunately, those who have the specialization in obstetrics don't even attend births. They're not even present during delivery."[320]

Even for matronas who continued working in public maternities into the 1980s, the elimination of midwifery as a university-accredited profession, and the concomitant increase in the number of obstetricians, fundamentally changed their job duties. Ruth Clavijo, who worked at the Caja Nacional de Salud in La Paz and at the maternity of the Miraflores General Hospital from the 1980s until the early-2000s, recalled that she was only allowed to conduct pre-delivery

[320] Juana Gómez. *Interview with Author.* Sucre, Bolivia. 1 May 2012.

exams and to prepare the mother for the birth. The doctor on duty took over for the birth itself. "From what I hear, there isn't even a single nurse working at the hospital of the Caja Nacional." "There are only medical students and doctors," she added. As a result of doctor-assisted births in public maternities, very few births in public maternities today occur naturally, according to Clavijo. "Here in La Paz," she said, "everyone's labor is accelerated (*conducido*). It's practically a rule… Attending birth is synonymous with patience for me. And, well, I don't think our doctors have patience."[321]

Conclusion

Two contradictory trends in obstetric care shaped the midwifery profession in Bolivia between the 1950s and '70s. While many Bolivian physicians agreed with World Health Organization committees that an expanded midwifery profession could improve both maternal and general medical care for rural, mining, and peri-urban communities, the nascent obstetric profession sought to increase technical interventions, even in 'normal' deliveries, and to restrict the application of such interventions to physicians.

The creation of joint the midwifery-nursing program in the 1960s was part of the first trend. Nurse-midwives, who graduated from the nursing-midwifery programs in Sucre and Tarija, found immediate work in mining areas and department-level public health programs aimed at expanding public health services. Particularly in mining areas, matronas acted as "agents of change" by increasing indigenous women's trust of western medical personnel, and, in some measure, ameliorating the relationship between miners and the state.

[321] Ruth Clavijo, *Interview with Author.* La Paz, Bolivia. 23 May 2012.

Also in the 1960s, a second trend in obstetric modernization spurred the elimination of the midwifery schools in Bolivia: physicians, who met at international conferences to discuss the latest research in the fields of obstetrics and gynecology, advocated increased technological and pharmaceutical interventions by physicians in 'normal births.' As a result, by the 1970s, joint nurse-midwifery degrees had lost medical currency in favor of a hierarchy that made specialized obstetricians the unquestioned authorities in pregnancy and childbirth.

The shift from midwifery to nursing succeeded in consolidating the authority of obstetric physicians over childbirth, at least within hospital and clinics, as nurse-midwives like Juana Gómez and Ruth Clavijo were quick to point out. Yet, the shift in university education left unresolved the weaknesses of the public health system and the western medical profession in general. As I discuss in the next chapter, in the 1970s and 1980s, the Ministry of Health adopted a new approach to winning over the indigenous populations in El Alto and remote areas of the country. Instead of attempting to eliminate indigenous midwives, new maternal-infant care programs aimed to foster collaboration with them.

CHAPTER FOUR

Inclusion and Control:
USAID, Hugo Banzer, and the Promotion of Parteras and Primary Care

In 1982, nearly seventy parteras participated in a training program at the *Hospital Municipal Holandés-Boliviano* in the greater metropolitan area of La Paz. For two months, the trainees learned basic biomedical methods in childbirth assistance from doctors and worked alongside them in the hospital delivery room. This type of collaboration between parteras and western medical practitioners —known as "*parto limpio,*" or "clean birth" programs—marked a stark change from the policies that medical doctors and Ministry of Health officials had promoted in previous decades. Gone were the days when physicians and public health officials could hope to render indigenous parteras obsolete with the help of university-trained midwives or nurses. By 1982, new maternal-infant care programs that relied on collaboration between traditional, indigenous practitioners and doctors and nurses, formed the cornerstone of the Ministry of Health's new prevention-centered public healthcare plan.

During the first decades after its creation in 1948, WHO's methods for solving the world's health programs reflected assembly-members' confidence in medical science; comprised almost entirely of doctors during this period, the organization dedicated itself to training more physicians, providing medical technologies to "developing countries," and eradicating vector-borne diseases, such as malaria.[322] In 1973, however, the newly appointed General Director, a radical Danish doctor named Halfdan Mahler, and delegates from China, the organization's newest member, championed new approaches to global public health care. Under their influence,

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[322] Sung Lee, "The WHO and the Developing World: The Context for Ideology," in *Western Medicine as Contested Knowledge,* ed. A. Cunningham and B. Andrews (Manchester: Manchester University Press, 1997): 24-45.

new perspectives on improving world health gained greater acceptance within the organization.[323] The new approach to public health care was enshrined in the 1978 Alma-Ata Declaration, which called on member states to provide "primary health care" for their citizens and defined health as "a state of complete mental, physical and social wellbeing, and not merely the absence of disease or infirmity."[324] Rather than relying on doctors and the latest medical technologies to solve health problems, the declaration called for member countries to prioritize preventive, rather than curative care, and to incorporate traditional healers and community members as full participants and decision-makers in national health programs. Bolivian officials participated in the conference, and throughout the 1980s, explicitly linked parto limpio programs to the goals endorsed in the declaration.[325]

Public health plans, assessments, and training manuals published by the Ministry of Health through the 1980s and 1990s explicitly tied their prescriptions and proposals to the Alma-Ata Declaration, giving their readers the impression that, in promoting collaboration between western medical practitioners and indigenous midwives, the Bolivian Ministry of Health was following the WHO's lead. [326] The Alma-Ata Declaration symbolized an international

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[323] Sung Lee, "The WHO and the Developing World: The Context for Ideology," in *Western Medicine as Contested Knowledge,* ed. A. Cunningham and B. Andrews (Machester: Manchester University Press, 1997): 24-45. Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health.* 94, no. 11. (November 2004): 1864-1874.

[324] World Health Organization, *Primary Health Care. Report of the International Congress on Primary Health Care. Alma Ata, USSR, 6-12 September, 1978* (Geneva: WHO, 1978), 2.

[325] Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health.* 94, no. 11. (November 2004): 1864-1874.

[326] Ministerio de Previsión Social y Salud Pública. Division Nacional Materno Infantil. *Normas nacionales para la atención materno infantil según niveles. Nivel II (Puesto Sanitario).* (La Paz, Bolivia: OMS/OPS, 1982). Aillon T., Eduardo and Sheila Wharton. *Atención PriMaría de la Salud Materno-Infantil* (La Paz, Bolivia: Misión Alianza Noruega, 1986). In their book *Vocabulario aymara del parto y de la vida reproductive de la mujer,* Denise Arnold and Juan de Dios Yapita take as one of their primary objectives the facilitation of the recommendation made by the Alma Ata accords that member state and organizations promote dialogue between biomedical personnel and practitioners of traditional medicine (La Paz, Bolivia: ILCA, 1999).

recognition that the persistence of poverty and illness in a great number of countries required a new strategy for improving global health. Although many Bolivian physicians and health officials did indeed foster collaboration with practitioners of traditional medicine, in the spirit of Alma-Ata, this chapter reveals that Bolivian doctors' unprecedented affiliation with parteras during the 1970s and '80s has a darker history.

I argue that although the new relationships between parteras and western medical practitioners, exemplified in parto limpio programs, fulfilled some of the WHO's recommendations, they were hardly a product of the global paradigm change. Rather, reports from the Ministry of Health and USAID, as well as oral histories parteras and nurses, who participated in maternal-infant care programs during the 1970s and '80s, demonstrate that dual goals defined the new phase of Bolivia's obstetric movement: First, maternal-infant care programs signaled a recognition on the part of many physicians and the Ministry of Health that parteras and other indigenous healers possessed authority within their communities. If Bolivia's public health system were ever to reach firmly into indigenous cities like El Alto and the still-remote rural areas, physicians would need parteras on their side. Second, new maternal-infant care programs also formed part of a top-down solution devised by U.S. agencies and Bolivian military governments to pacify and reform the country's rebellious and politically-organized indigenous population. Within the logic of the Cold War, Bolivian and U.S. officials identified the indigenous population as the root of Bolivia's political instability and economic backwardness and set out to the cure them of the "syndrome of poverty" from which they supposedly suffered and create a "New Bolivian Man."

The "Syndrome of Poverty" and Indigenous Resistance

Starting in the 1960s, U.S. aid for health programs served the geopolitical goals of creating political stability and increasing economic activity across Latin America. U.S. foreign policies of the 1960s aimed to head off the spread of communism in the region, while bolstering the U.S. economic and political power. The Alliance for Progress, launched by President John F. Kennedy in 1961, was the first and most ambitious attempt to use economic aid to secure U.S. influence in Latin America, but as the program sputtered and died in late 1960s and early 1970s, USAID continued offering grants and loans in order to further the program's mission. Under the Alliance for Progress, the U.S. granted money for the construction of ports, roads, power plants, hospitals, and schools. In principle, the programs were intended to promote moderate social and economic reform and to democratize political systems. In practice, however, U.S. Cold-War policies strengthened authoritarianism across the region.[327] In Bolivia, the Alliance for Progress targeted miners and indigenous campesinos specifically, but not because those sectors of the population were the poorest and most vulnerable. Instead, as Thomas C. Field, Jr. argues, development aid in Bolivia was intended to strengthen Víctor Paz Estensorro's and later military presidents' control over the most rebellious sectors of the population. As his illustrated,

[327] The Alliance for Progress was inspired by Walt Rostow and other scholars at Massachusetts Institute of Technology's Center for International Studies, who argued that all societies traveled down a linear path of development, from tradition to modernity. They defined industrialized, capitalist democracies as the most advanced societies along the trajectory and placed the United States at the pinnacle of progress and modernity. In the context of the Cold War, these academics were convinced that the underdeveloped or "traditional" societies across Latin America were at risk of falling to communist advances and must be helped along the path of modernization by the United States. To that end President Kennedy proposed the Alliance for Progress as a ten-year, $20-billion program that would fund economic development projects in exchange for political reform on the part of Latin American governments. In spite of these lofty ideals, Alliance for Progress officials did not base grant decisions on economic need alone, but instead used funds as the proverbial "carrot" of foreign policy. Jeffrey F. Taffet, *Foreign Aid as Foreign Policy: The Alliance for Progress in Latin America* (New York and London: Routledge, 2007). Michael E. Latham, "Modernization as Ideology: Approaching the Problem," in his *Modernization as Ideology: American Social Science and "Nation Building" in the Kennedy Era* (Chapel Hill and London: University of North Carolina Press, 2000).

development-minded Bolivian leaders teamed with U.S. modernization theorists to develop policies that strengthened authoritarianism in the service of liberal economic development.[328]

In the 1970s, USAID implemented its "New Directions" approach to economic development funding that was increasingly focused on eradicating the persistent poverty, rather than promoting democratic reform. The existence of a global "poor majority,"[329] the agency contended, resulted from a combination of weak governments and non-government organizations, lack of education, and in countries with large indigenous populations, with the "stubbornness" and "backwardness" of "traditional cultures."[330] To raise the poor majority out of poverty, the agency began directing aid toward programs in three interrelated areas—food and nutrition, population and health, and education and human resources development. The key to the new development approach was community participation in conjunction with expert assistance and economic aid.

The New Directions programs targeted for reform what USAID officials called "the family," a social unit they implicitly defined as a male-headed household with children. "[W]ithout a doubt," one report concluded, "the most serious population problem in Bolivia occurs at the level of the family; it is here where the syndrome of poverty is rooted and has its greatest effect." Although some officials recognized that the problem of rural poverty lay at least partly in the country's economic structures, the agency's main policies treated indigenous culture as the primary root of poverty. Officials reported that the rural indigenous population risked the

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[328] Thomas C. Field, Jr., *From Development to Dictatorship: Bolivia and the Alliance for Progress in the Kennedy Era* (Ithaca and London: Cornell University Press, 2014).
[329] USAID, "Implementation of "New Directions" in Development Assistance." *Report to the Committee on International Relations on Implementation of Legislation Reforms on the Foreign Assistance Act of 1973*. July 22, 1975 (Washington, DC: US Government Printing Office, 1975), 5.

[330] Nicholas Copeland, "Greening the Counterinsurgency: The Deceptive Effects of Guatemala's Rural Development Plan of 1970," *Development and Change* 43, no. 4 (2012): 975-997.

lives of their children with their irrational agricultural practices and passivity. "The majority of them live a marginal and precarious existence being that the majority are subsistence agriculturalist…A loss of a harvest of the breakup of a cooperative could mean the death of a child," agency analysts noted. "The habits of the campesino and their traditional culture," analysts continued, "reflect and satisfy their needs. It will change only when they are shown a pragmatic example in the sense that the desired change will improve the effectiveness of his life and that of his family…"[331]

This attitude toward indigenous people was common throughout Latin America. The agency applied a similar logic in Guatemala during the same period. Analysts located the poverty (and therefore presumed susceptibility to communist influence) of highland Indians in their reliance on subsistence agriculture. In both cases, policymakers argued that economic progress and inoculation against communist influence lay in production for market; rural indigenous populations required only education and assistance from technical experts in order to adapt to modern, market-based agricultural production.[332] To that end, USAID funded rural colonization and agriculture programs in both Bolivia and Guatemala.

General Hugo Banzer, who took power via military coup in 1971, shared USAID's conviction that Bolivia's indigenous people were to blame for the country's economic and social woes. In addition to the country's low literacy rates, which hovered between sixty and seventy percent, Banzer government officials believed that the cultural idiosyncrasies of rural Bolivians stymied the country's development. Among the factors contributing to the "inadequacies of the population," policymakers wrote, was the "impermeability and resistance to assimilation and/or

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[331] USAID, *Evaluación Integral del Sector de Salud* (USAID/Bolivia: La Paz, Bolivia, 1978), 61.

[332] Nicholas Copeland, "Greening the Counterinsurgency: The Deceptive Effects of Guatemala's Rural Development Plan of 1970." *Development and Change.* 43, no. 4 (2012): 975-997.

adoption of technological innovations[,] little or no interest in the reception of culture [, and] rigidity in the conservation of certain prejudices—many times ancestral—that impede the adoption of rational methods of production."[333]

As a remedy to these supposed problems, General Banzer sought to create a "New Bolivian Man," who would form the base of a new Bolivian nation. The New Bolivian Man was Catholic, a soldier, a patriarch, a fervent anti-communist, and a dutiful, obedient worker, utterly unlike the Bolivian campesino, whom reformers in the Banzer government deemed incapable of adopting behaviors that would bring about development. The New Bolivian Man's implicit counterpart, the "New Bolivian Woman," was an self-abnegating mother and wife who dedicated herself to domestic life and raising healthy children to serve the nation. Following the model of "Republican Motherhood," the woman's most important role in the creation of a new society was as a mother of a new generation of patriotic male citizens.[334]

Not only government officials and USAID officials blamed the country's woes on campesinos. Upper-class Bolivians mixed together stereotypes of race, class, and culture as they debated the role of the indigenous population in the country's underdevelopment. Articles in *El Diario* in 1975 frequently addressed sad new statistics from UNICEF on nutrition and hunger in

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[333] República de Bolivia, Junta Nacional de Acción Social, "Segunda Conferencia Nacional" (La Paz, Bolivia, 1975), 61. "Esa inadecuación del pueblo, para asumir la responsabilidad de un rápido acceso a la utilización eficiente de los medios que impone el desarrollo, puede reflejarse en este diagnóstico: Elevado índice de analfabetismo (entre 60 y 70%. Impermeabilidad y resistencia a la asimilación y/o adopción de innovaciones tecnológicas. Poco o ningún interes [sic] en la recepción de cultura. Rigidez en la conservación de determinados prejuicios—muchas veces ancestrales—que impiden la adopción de métodos racionales de producción."

[334] On Republican Motherhood in the United States, see Linda Kerber, *Women of the Republic: Ideology and Intellect in Revolutionary America* (Chapel Hill: University of North Carolina Press, 1980) and Rosemarie Zagarri, *Revolutionary Backlash: Women and Politics in the Early American Republic* (Philadelphia: University of Pennsylvania Press, 2007). This same role for women was also celebrated by leaders of the Cuban revolutionary movement. Johanna Moya Fábregas, "The Cuban Woman's Revolutionary Experience: Patriarchal Culture and the State's Gender Ideology, 1950–1976," *Journal of Women's History* 22, no. 1 (Spring 2010): 61-84. Che Guevarra, "Socialism and Man in Cuba," in *Selected Works of Ernesto Guevara,* Rolando E. Bonachea and Nelson P. Valdes, eds. (Cambridge, MA: The MIT Press, 1969).

Bolivia and the possible consequences of child malnutrition for Bolivia as a whole. José Carrasco Jimenez, son of *El Diario*'s founder and director and columnist for the paper, undoubtedly reflected the view of many upper-class Bolivians and health officials, when he blamed the childhood malnutrition on the ignorance of "campesinos" and people living in urban "*zonas marginales,*" and, most especially, on incompetent mothers. "It is necessary to recognize," he wrote, "that one of the fundamental causes of such a bitter situation [malnutrition and high rates of nutrition-related child mortality] lies in the lack of education and culture of our people. At this point, when science and technology develop rapidly throughout the world, dedicated to protecting human life, there are still cases in our country, as in many others, of mothers that do not know scientific maternal-infant care."[335] According to Carrasco, campesinos were malnourished because they illogically chose to "sell [the nutritious fruits of their labor] on the market or exchange them for others that only damage their existence." The consumption of high-protein foods like milk, eggs, and meat, was also lowest among campesinos, noted Carrasco, "even though those sectors are producers of those goods."[336]

Acute resentment of indigenous people also permeated the military, one of the institutions General Banzer entrusted with protecting the nation. Once in power, Banzer justified his coup as an act of national salvation and laid out his fascist-inspired vision for creating a new nation through economic development, discipline, order, and tranquility. He envisioned a government organized around an alliance between the military and the Catholic Church, the only

[335] José Carrasco, "Desnutrición infantíl" *El Diario,* La Paz, Bolivia, August 2, 1974. "Preciso es reconocer que una de las causas fundamentales de tan amarga situación radica en la falta de educación y de cultura de nuestro pueblo. A estas Alturas, cuando la ciencia y la técnica se dessarrollan [sic] con mayor rapidez en todo el mundo, dedicadas a precautelar la vida humana, aun se da el caso en nuestro país, como en tantos otros, de madres que no conocen la atención materno-infantil científica.

[336] José Carrasco, "Desnutrición infantíl," *El Diario,* La Paz, Bolivia, August 2, 1974. Original: "…lejos de aprovechar esos productos para su alimentación y la de sus hijos, prefiere venderlos en los mercados o cambiarlos por otros que solo deterioran su existencia." Original: "El consume de carne, de huevos y de leche en esos sectores es poco menos que nulo, no obstante ser esos sectores productores de esos alimentos."

two institutions he believed that had operated consistently as the "refuge of nationalism and the nucleus of defense of national values."[337] If the military nurtured and protected nationalism, it also formed a key institution through which Bolivian men learned to hate Indians. As Lesley Gill argued in her study of the U.S.-funded School of the Americas, U.S. military aid to Latin America during the Cold War supported the production and reproduction of discourses that defined indigenous people as inferior, backward, and savage. In countries like Bolivia and Guatemala, Indians were identified as enemies of progress on an equal level with communists. National military schools ingrained racism against the Indian in cadets, and U.S. military officials reinforced those beliefs. Banzer himself attended the School of the Americas in the Panama Canal Zone and later received additional training at Fort Hood in Texas.[338]

Shortly after taking power, Banzer attempted to appease miners and campesinos with patronizing rhetoric. In 1972, the general published a series of essays in which he addressed his thoughts directly at "workers" and campesinos: "To take interest in the workers is to fulfill the task of governing, because to govern is to dialogue, not to impose. To govern is to approach the workers and the campesinos in order to listen to the simple, noble voice that renews the faith and confidence in the future of the fatherland."[339] But even in his rhetorical attempt to win the trust

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[337] Hugo Banzer Suárez, *El pensamiento del presidente Hugo Banzer Suárez.* (La Paz, Bolivia: 1972), 7. "… que en medio de la crisis estructural que se planteó hasta Agosto, sólo quedaron en pie dos instituciones cuya organización y fidelidad a sus principios, contrastaban con la atonía general: La Iglesia y las Fuerzas Armadas. Al margen del carácter supranacional de la doctrina cristiana, las Fuerzas Armadas han constituido siempre el refugio institucional del nacionalismo y el núcleo de defensa de los valores nacionales." On the fascist-roots of Banzer's political philosophy, see Dunkerley, *Rebellion in the Veins,* 203.

[338] Lesley Gill, *The School of the America: Military Training and Political Violence in the Americas* (Durham and London: Duke University Press, 2004). For testimonial accounts of racist-fueled violence suffered by young soldiers from the mining areas during their military service, see Domitila Barrios de Chungara, *Let Me Speak,* 190-194 and June Nash, *I Spent My Life in the Mines,* 346-350, 358-361.

[339] Hugo Banzer Suárez, *El pensamiento del presidente Hugo Banzer Suárez.* (La Paz, Bolivia: 1972), 99. Original: "Acercarse a los trabajadores es cumplir con la tarea de gobierno, porque gobernar es dialogar, no imponer. Gobernar es acercarse a los trabajadores y a los campesinos para escuchar la voz sencilla y noble que hacer renacer la fe y la confianza en el porvenir de la patria."

and cooperation of workers, his words did not reflect the reality of workers' and campesinos' active collective struggle for better working conditions and compensation, but rather a colonial fantasy in which the indigenous lower classes would passively and respectfully submit their requests to the patriarch-president. In a subsequent paragraph, Banzer continued his political pandering, simultaneously patronizing the intelligence of indigenous people and suggesting that he saw no place for indigenous languages in political life: "To explain everything to you, it is not always necessary to know Quechua or Aymara. The best language for speaking to the Bolivian people is the language of truth and not of lies, not demagoguery. This simple language does not seek applause or support, it seeks only to speak to you from the heart."[340]

At the same time that Bolivian government officials and USAID analysts labeled indigenous people passive and resistant to economic common sense, miners and campesinos alike mobilized through the nationwide workers union, Central Obrera Boliviana, to demand political and economic change. In the face of persistent and highly-organized indigenous Bolivians, Banzer's initial commitment to "dialogue" instead of "impose" quickly fell by the wayside. In 1973 and '74, housewives, factory workers in La Paz, and both urban and rural workers in Cochabamba all protested the elimination of government subsidies, which raised the price of basic goods, such as cooking oil, eggs, rice, pasta, and meat, by 219%.[341] In Cochabamba, campesinos from the region joined striking shoe shop workers and the protest quickly escalated. Participants in the mobilization attempted to blow up three bridges, and

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[340] Hugo Banzer Suárez, *El pensamiento del presidente Hugo Banzer Suárez* (La Paz, Bolivia: 1972), 99. Original: "Para explicarles todo a ustedes, no siempre se necesita conocer el quechua o el aimara. El mejor idioma para hablar a los bolivianos es el idioma de la verdad y no la mentira, no la demagogia. Ese idioma sencillo no busca el aplauso ni apoyo, busca solamente hablarles con el corazón en la mano."

[341] James Dunkerley, *Rebellion in the Veins: Political Struggle in Bolivia, 1952-1982* (London: Verso, 1984), 211.

blocked the only road between Cochabamba and Santa Cruz. In response, Banzer flatly refused to reinstate subsidies or to negotiate any of the other demands of the insistent mass of indigenous Cochabambinos. Instead, on the evening of January 29, 1974, the crowd blocking the Santa Cruz road was met with tanks and aircraft that opened fire, killing between 80 and 200 people.[342] The aggressive persistence of indigenous Bolivians in Cochabamba was exactly the kind of behavior the Banzer regime sought to stifle, and it did so directly through violence and the threat of force, but also in an indirect manner, through health and development campaigns.

Miners also faced severe repression under the regimes of colonels Barrientos (1964-69) and Banzer (1971-78). While Barrientos' government perpetrated two of the worst mass murder of miners since the Catavi massacre in 1942, Banzer's stance toward miners' demands included other standard methods of repression; as the famous activist Domitila Barrios de Chungara reported in her testimonial, after outlawing all unions in 1974, Banzer arrested leaders, tried to quell protests of miners' wives with tear gas, destroyed the independent radio stations in Siglo XX, Catavi and Llallagua, and attempted to starve out striking miners in Siglo XX.[343]

Maternal-Infant Care Programs and the Creation of the "New Bolivian Man"

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[342] James Dunkerley, *Rebellion in the Veins: Political Struggle in Bolivia, 1952-1982,* 201-248. The massacre not only ended the formal agreement between the military and peasants known as the *Pacto Militar-Campesino,* it also animated indigenous *katarista* movements. Under the agreement, which was consolidated under the Barrientos regime, the government had pledged its commitment to uphold the key benefits of the revolution to the 'popular masses' (education, land reform, and union rights) in exchange for campesinos' loyalty and defense of the military regime. On Katarismo see Xavier Albó, "From MNRistas to Kataristas to Katari," in Steve J. Stern, ed., *Resistance, Rebellion and Consciousness in the Andean Peasant World, 18th to 20th centuries* (Madison, WI: University of Wisconsin Press, 1987), 379-419. Andrew Canessa, "Contesting Hybridity: Evangelistas and Kataristas in Highland Bolivia" *Journal of Latin American Studies*, 32, No. 1, Andean Issue (Feb., 2000): 115-144.

[343] Domitila Barrios de Chungara with Moema Viezzer, *Let Me Speak! Testimony of Domitila, a Woman of the Bolivian Mines* (New York: Monthly Review Press, 1978): 171-190. For historical analysis of the COB from 1952 to 1987, see Antonio Peredo Leigue, *La COB: El poder obrera en Bolivia* (La Paz, Bolivia: CEDOIN, 1995).

In tandem with Banzer's violent repression of indigenous resistance, during the 1970s, Banzer's regime worked with USAID to eliminate the "syndrome of poverty" within the family and create the New Bolivian Man. Nurses, midwives, and mothers constituted both targets and key functionaries within a variety of maternal-infant care programs that went hand-in-hand with more aggressive economic and political changes, such as agricultural programs and the suppression of labor activities. Such programs formed part of a long-term approach to inculcating cultural change in indigenous campesinos and miners. Bolivian policymakers held especially high hopes for the potential effectiveness of maternal-infant care programs, because they overlapped with other preventive care programs, including vaccination and sanitation projects. They hoped both that sanitation and immunity to diseases would improve the health of mothers and infants, and also that contact with mothers during prenatal care and delivery would establish relationships between health workers and families. Once those relationships were established, health workers could promote vaccination, proper nutrition and hygiene.[344]

USAID's Family Wellbeing Program

The Alliance for Progress and USAID began funding "Family-Wellbeing" programs in Bolivia in the late 1960s. Over the next six years, they poured USD $1.3 million into projects that intervened in the reproductive lives of women and monitored the health of their children (see

[344] Oficina Sectorial de Planificación de Salud. *Informe de la comisión de salud materno infantil.* La Paz, Bolivia, 1975, 25.

Figure 5).[345] Family-Wellbeing funds supported the creation of the Center for Nationality and Family (CENAFA), a semi-autonomous entity within the Ministry of Health charged with coordinating programs "related to the themes of family and the Bolivian population."[346] CENAFA also provided "technical assistance" for the country's three university-level preventive medicine departments and carried out studies on abortion and birth control in La Paz, Cochabamba, and Santa Cruz. Between 1971 and 1973, it also held nine sex education courses throughout the country.[347]

A major component of USAID's Family-Wellbeing program in Bolivia was dedicated to increasing the use of contraception among indigenous women. Throughout the 1960s and '70s, USAID partnered with a number of Latin American governments to create "responsible parenthood" programs, but in each case, local political and cultural sensitivities to birth control shaped the programs.[348] In general, such programs were comprised of both sexual education and clinical services related to reproductive health and birth control. The use of the ambiguous term "responsible parenthood" ("*paternidad responsable*") instead of "family planning"

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[345] USAID paid a total of $1,367,000 USD during those six years. The Bolivian government provided $117,000 for the programs during the same period. USAID, "Evaluación Integral del Sector de Salud," (USAID/Bolivia: La Paz, Bolivia, 1978), 461.

[346] USAID, Evaluación Integral del Sector de Salud," (USAID/B: La Paz, Bolivia, 1978), 460.

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[348] In Peru, for example, Raúl Necochea López shows that some Catholic priests agreed that permitting couples to limit the size of their families would allow them to be better parents and lead more comfortable lives. The Catholic Church, therefore, provided birth control pills as part of responsible parenthood programs, which received some funding from USAID. See, Necochea López, "Priests and Pills: Catholic Family Planning in Peru, 1967-1976," *Latin American Research Review* 43, no. 2 (2008): 34-56. In Mexico, the Echeverría administration partnered with USAID in the early 1970s to create a massive media campaign—including a telenovela—to encourage Mexicans to have fewer children. See, Gabriela Soto Laveaga, ""Let's Become Fewer": Soap Operas, Contraception, and Nationalizing the Mexican Family in an Overpopulated World," *Sexuality Research & Social Policy* 4, no. 3 (September 2007): 19-33.

(*"planificación familiar"*) was one way USAID and its Bolivian supporters avoided rousing local opposition.[349] (Table 1)

Table 1. Total USAID Expenditures on "Family Wellbeing" Projects, 1968-1974

Activity	**Amount Dispersed**
On-going programs	
CENAFA	$447,000.00
Maternal-Infant Care Division of Ministry of Health	$285,000.00
Department of Preventive Medicine at Universities	$335,000.00
Ayo-Ayo Maternal-Infant Care Center	$108,000.00
"ABES" Bolivian Association of Sexual Education	$40,000.00
Single Donations	
Boat Hospital on Lake Titicaca	$42,000.00
National Census (equipment, etc.)	$50,000.00
University Health Center	$60,000.00
Total Expenditures for Family Wellbeing Projects	$1,367,000.00

(Source: USAID/Bolivia, "Evaluación Integral del Sector de Salud." (La Paz, Bolivia: USAID/Bolivia, 1978), 462)

In Bolivia, the subject of providing birth control for indigenous women touched a deep node of political and personal nerves and forced USAID to negotiate carefully; birth control raised issues of power between spouses, indigenous resistance to state-sponsored medical

[349] Oficina Sectorial de Planificación de Salud. *Informe de la comisión de salud materno infantil.* La Paz, Bolivia, 1975, 22-24

colonization, and Bolivian and US disagreements about the political and economic value of "family planning." According to Bolivian officials, various studies in the 1970s had shown that the majority of both urban and rural women wished to limit the size of their families, but the studies had never been published because of the sensitive nature of the topic.[350] Sterilization was an especially explosive issue. In 1971, the government of Juan José Torres ended the U.S. Peace Corps mission to the country following rumors that volunteers had sterilized indigenous women. Although the rumors were never substantiated, and indeed, the Peace Corps denied them, the 1970 film *Yawar Mallku* by Bolivian director Jorge Sanjinés, in which foreign health workers were depicted sterilizing indigenous women without their consent, amplified public concern.[351] As a result, USAID officials and Bolivian birth control advocates had to negotiate the creation and operationalization of family-planning programs with caution and discretion. USAID officials hinted, for example, that some of their Bolivian counterparts had resisted the "responsible parenthood programs" because of their concerns about birth control. Only after USAID officials convinced the director of the Maternal-Infant Health Division that clinics associated with the program would not provide abortions, or carry out forced sterilizations or contraception, did the Ministry fully support the program.[352]

Ultimately, Bolivian health experts and U.S. representatives found common ground in the birth control debate that reconciled the New Bolivian Woman with an international development discourse that identified high birth rates as a threat to economic and political stability. As Erica

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[350] Oficina Sectorial de Planificación de Salud. *Informe de la comisión de salud materno infantil.* La Paz, Bolivia, 1975, 22-24.

[351] Molly Geidel, ""Sowing Death in Our Women's Wombs": Modernization and Indigenous Nationalism in the 1960s Peace Corps and Jorge Sanjinés' Yawar Mallku," *American Quarterly,* 62, no. 3 (September 2010): 763-786. James F. Siekmeier, "A Sacrificial Llama? The Expulsion of the Peace Corps from Bolivia in 1971," *Pacific Historical Review* 69, no. 1 (2000): 65-87.

[352] USAID, Evaluación Integral del Sector de Salud," (USAID/Bolivia: La Paz, Bolivia, 1978), 464.

M. Nelson revealed, in the 1970s and '80s, Bolivian researchers at CENAFA and other organizations that received funding from U.S. institutions, produced a body of studies on the reproductive knowledge of Bolivian women. Through those studies, she argues, Bolivian researchers created a "shared lexicon" that positioned Bolivian women along adeterminist line from tradition to modernity. Based on their knowledge of contraceptives and their willingness to use them, Bolivian researchers defined rural, indigenous women of the Andean highlands and valleys as tradition-bound and in need of education and reform. In contrast, they held up the country's more educated, mestiza women of the Santa Cruz region as representatives of modernization and progress.[353] This equation of modern reproductive behavior with mestiza women brings into focus the racial and cultural contours of the implicit Bolivian woman; in order to fulfill her role as wife and mother, the New Bolivian Woman understood the biological science of reproduction and used modern contraceptives to limit the number of children she had.

A pilot project in Ayo-Ayo, a "rural campesino community" of 35,000 residents in the Department of La Paz was one component of the USAID-funded Family Wellbeing program that targeted indigenous women of the Andean highlands. The project consisted of a maternal-infant health center that provided medical services and responsible parenthood classes. To reach residents from outside of Ayo-Ayo, USAID granted the center a mobile clinic to make weekly trips to markets and "ferias" that served "a large number of campesinos from other locales." The mobile clinic contained a refrigerator, electricity, potable water, audio-visual equipment, a dental chair, a table for gynecological and obstetric exams, and lab equipment.[354]

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[353] Erica Nelson, "Birth Rights: Bolivia's Politics of Race, Region, and Motherhood, 1964-2005." (Doctoral Dissertation, University of Wisconsin-Madison, 2009). See her second chapter, "Mapping Mothers: Demography, Development, and the Regionalization of Reproduction," 64-109.

[354] USAID, Evaluación Integral del Sector de Salud," (USAID/B: La Paz, Bolivia, 1978), 466.

Rural Colonization and Mothers' Centers: Creating the New Man and New Woman

The Banzer government held that a healthy population constituted a key component to economic development, but health programs reflected as much concern about reforming the rebellious nature of the indigenous population as they did about ensuring their physical wellbeing. Two years after taking power, Banzer announced the creation of the *Junta Nacional de Acción Social* (The National Council for Social Action), a new bureaucracy charged with promoting "the ideological conditions and structures that will initiate the formation of 'The New Bolivian Man'."[355] Creating the New Bolivian Man, naturally required the participation of both men and women, and government officials designed programs along gender lines so that indigenous men and women played complementary roles as they toiled for the benefit of the nation.

To shape indigenous men into new patriotic male citizens, the National Council for Social Action and related ministries relied on military service and lowland colonization programs.[356] Rural colonization programs encouraged indigenous men from the Andean highlands to migrate to the fertile lowlands of Beni and Santa Cruz, where they would live in "villages in urban style [that were] planned according to modern techniques in their physical construction as much as in their functional distribution of community services." Once the men had firmly established themselves in the new villages, they sent for their wives, and, at least in the imaginations of policymakers, set up nuclear, patriarchal families. Through these programs,

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[355] It was initially called the *Junta Nacional de Desarrollo Social* but was later renamed. República de Bolivia, Junta Nacional de Acción Social, "Segunda Conferencia Nacional". La Paz, Bolivia, 1975, 47.

[356] Lesley Gill, "Creating Citizens, Making Men: The Military and Masculinity in Bolivia. *Cultural Anthropology.* 12, no. 4 (November 1997): 527-550. D. A. Eastwood and H. J. Polard, "The Development of Colonization in Lowland Bolivia: Objectives and Evaluation" *Boletín de Estudios Latinoamericanos y del Caribe*, no. 38 (1985): 61-82.

in 1975, the Junta claimed it had not only decreased migration to urban shantytowns and improved migrants' standard of living, but had also "populated our frontiers with settlements that are gradually being imbued with national ideals." Most importantly, the colonization program purportedly "forg[ed] the New Bolivian Man, [by] educating him under absolutely optimal modalities and conditions."[357]

Other programs Banzer's regime established targeted indigenous women for cultural reform. Reaching out to women through their "natural" roles as mothers, the regime created and promoted the establishment of mothers' centers and began holding biomedical crash courses for parteras. The centers relied on university-educated nurses and nurse-midwives to provide both prenatal checkups and, at least ideally, to offer courses "in sewing, weaving, cooking, childcare, home economics, nutrition, health, and first aid" so that they could "better carry out their roles in the family."[358] A report from the Second National Conference of the National Council for Social Action also points to the underlying political goals of teaching indigenous women how to be

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[357] ("Granjas Militares de escala industrial") ("Se trataba de la incorporación de áreas nuevas, en base a la organización de Granjas Militares de escala industrial, y que posteriormente daban lugar a la creación de aldeas modelo urbanizadas y planificadas con arreglo a técnicos modernas, tanto en sus edificaciones físicas, como en la distribución funcional de los servicios comunitarios previstos." República de Bolivia, Junta Nacional de Acción Social, "Segunda Conferencia Nacional" (La Paz, Bolivia, 1975), 48. Brazilian governments also experimented with colonization programs to promote economic growth and relieve social and economic tensions. In 1966, the military president Castelo Branco established an institute to oversee development of the Amazon. Initially, development projects focused on constructing roads and dams in the region, but by 1970, drought in the northeast prompted government officials to begin promoting large-scale colonization of the area, with a goal of settling 500,000 people in the areas along major highways by 1975. When officials recognized the plan would not meet its goals, another initiative called *Polamazônia* was created that aimed at colonizing specific sites for cattle-raising, agriculture, and mineral extraction. Janet D. Henshall, "Agricultural Colonization in Rendônia, Brazil," *Luso-Brazilian Review* 19, no. 2 (1982), 169-185. In Guatemala in the 1980s, the military forcibly resettled Mayans into "model villages." Often constructed by future residents in exchange for food, the villages allowed the military to monitor and control the population in areas where rebels were most active. In some cases, model villages, or develop poles (*polos de desarrollo*), were also sites for economic development programs. Carol Smith, "The Militarization of Civil Society in Guatemala: Economic Reorganization as a Continuation of War," *Latin American Perspectives* 17, no. 4 (1990), 8-41.

[358] República de Bolivia, Junta Nacional de Acción Social, "Segunda Conferencia Nacional" (La Paz, Bolivia, 1975) 23.

good mothers. Ignoring the historical reality that indigenous women of various ethnic and class backgrounds had occupied very active, public positions in political and economic life in Bolivia, the authors of the report related that one goal of mothers' centers was "to remove [the indigenous woman] from the situation of isolation and passivity that she currently occupies."[359] Such selective memory on the part of Bolivian officials suggests that many were unwilling even to acknowledge forms of women's political mobilization that diverged so sharply both from the type of woman they thought they could reform, and from the type of woman they hoped to create.

In spite of those efforts to reach families in rural areas and in poor urban neighborhoods, two main problems vexed health planners and, ultimately, spurred their search for new solutions to the country's development problems. The first was that health services were still located overwhelmingly in urban areas, and even those areas lacked sufficient facilities and personnel. Bolivian officials estimated in 1978 that still only three percent of the population (about 53,000 women) participated in mothers' centers and that, despite the government's hope to reach rural women, the vast majority of centers were located in urban areas. The city of Sucre had twenty-one mothers' centers in 1975, for example, even though the rest of the Department of Chuquisaca—an area totaling nearly 99 percent of the territory of the department and containing

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[359] "Se pretendía, ante todo, sacarla de su situación de aislamiento y pasividad en que actualmente se desenvuelve, para estimularla a que participe con todo el bagaje de las potencialidades de que es portadora." República de Bolivia, Junta Nacional de Acción Social, "Segunda Conferencia Nacional" (La Paz, Bolivia, 1975), 46. One of the most well-known female figures in Bolivian history is the Aymara "general," Bartolina Sisa, who, along with her husband Tupak Katari, held a 184-day siege of La Paz in 1781. After her husband was brutally executed, she continued leading the resistance until her own capture and execution. See Marina Ari, *Bartolina Sisa—la generala aymara y la equidad de género*. (La Paz: Editorial Amuyañataki, 2003). On the historical commemoration and political symbolism of Cochabamba market women who fought royal forces during the wars of independence, see Laura Gotkowitz, "Commemorating the Heroínas: Gender, and Civic Ritual in Early-Twentieth-Century Bolivia," in *Hidden Histories of Gender and the State in Latin America,* Elizabeth Dore and Maxine Molyneux, eds. (Durham and London: Duke University Press, 2000), 194-215; By the 1930s, women workers, especially artisans, cooks, and florists had established a nationwide union called the *Federación Obrera Femenina* (FOF). Ineke Dibbits, *Federación Obrera Femenina, 1927-1964* (La Paz: TAHIPAMU, 1986).

nearly 90 percent of the department's population—had only six centers.[360] In 1977, only 13.5 percent of all medical personnel worked in rural areas, but the personnel problem was not simply one of shortage. The Ministry of Health judged that it lacked the capacity to coordinate the training—at the university-level—of the appropriate number of nurses and auxiliary nurses. Meanwhile, the public health sector absorbed a mere 19 percent of country's medical school graduates.[361] The unequal distribution and inadequacy of medical facilities mirrored the personnel challenges. The estimated 42 percent of the population that lived in communities of 200 people or less had little or no access to any kind of medical services, while in urban areas with 20,000 to 100,000 inhabitants, the public health system offered only 4.69 hospital beds per 1,000 people.[362] Even where facilities did exist, lack of funding, personnel, and the transportation difficulties often left them in states of complete disrepair. The Ministry of Health planned to repair only 193 of the 243 dilapidated and abandoned health posts between 1977 and 1980, and its budget for vehicles illustrated poignantly the challenges posed by geography, a miniscule budget, and shoddy transportation infrastructure. The Ministry planned to purchase 90 Jeeps for larger health centers and hospitals, 110 motorcycles for smaller medical posts (*puestos médicos*), 29 boats (*unidades fluviales*) for transportation in the northeastern lowlands, and 190 bicycles and 214 mules for personnel at sanitation posts (*puestos sanitarios*).[363]

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[360] Departamento Materno-Infantil y bienestar familiar- regional Sucre. *Diagnóstico de la situación de salud en Chuquisaca. Área materno infantil.* (Sucre, Bolivia. November 1973), 23. Figures on territory and population density from 1972. Area: City of Sucre (square kilometers)- 8, State of Chuquisaca (square kilometers)- 51,524. Population: City of Sucre- 51,979. State of Chuquisaca- 485,786.

[361] República de Bolivia, *Plan Nacional de Salud, 1977-1980* (La Paz, Bolivia, 1977), 6.

[362] República de Bolivia, *Plan Nacional de Salud, 1977-1980* (La Paz, Bolivia, 1977), 7.

[363] Ibid., 18.

The second problem was that, even where services existed, indigenous families often used them selectively or not at all. Cost was one reason families "under-utilized" services. In 1978, the estimated 63 percent of the population employed in agricultural work earned only USD $84 per year, meaning that the cost of a basic medical consultation could consume twelve percent of their annual income.[364] But another reason for the lack of demand, according to both Bolivian and USAID officials, was patients' apparent culturally-based discomfort with biomedical care. "In the case of the rural population with few services and the under-utilization thereof," reported the Ministry of Health "a lot has to do with the beliefs, customs, habits, and practices of the community."[365] In 1975, the health planners estimated that only fifty percent of urban women and a mere five percent of rural women had prenatal care or gave birth in a hospital. Rates of hospital deliveries varied considerably across the country, with relatively high rates (over 50%) in rural Tarija, which had a strong network of maternal-infant care services, and a full 65% in mining areas where many women were insured through COMIBOL and university-educated midwives and doctors ran community outreach programs (see Chapter Three). In many rural areas, however, Bolivian health planners judged that "because of their low culture, the *campesinas* prefer to have their babies at home. They only seek medical attention when the delivery is difficult or in the case of miscarriages and induced abortions that continue bleeding…"[366]

How could Bolivian health workers overcome both economic and cultural aversion? USAID officials warned that unless a bridge could be established between the biomedical system

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[364] USAID, *Evaluación Integral del Sector de* Salud (USAID/Bolivia: La Paz, Bolivia, 1978), 511.

[365] República de Bolivia, *Plan Nacional de Salud, 1977-1980* (La Paz, Bolivia, 1977), 4.

[366] Oficina Sectorial de Planificación de Salud. *Informe de la comisión de salud materno infantil* (La Paz, Bolivia, 1975), 13-14.

and Quechua and Aymara conceptions of health, the effectiveness of health programs would remain limited. In the early 1970s, the Bolivian Ministry of Health attempted to establish just such a bridge. By providing parteras with basic instruction in biomedical concepts and birthing techniques, the Ministry hoped to build trust among rural indigenous communities and ensure that more Bolivians were receiving effective, affordable care.

Training Parteras

Training programs for parteras constituted another main strategy that the National Council for Social Action and the Ministry of Health used to extend the power of the state and western medicine into the private family lives of rural Bolivians. Beginning in 1973, the Ministry of Health began holding short courses for indigenous midwives in El Alto, a sprawling city formed by waves of Aymara migrants that spills over the canyon rim into La Paz.[367] The following year, the Ministry of Health trained another nine parteras in a sixty-six hour course at the *Centro de Salud La Paz.* The Ministry held similar sessions during the same year in Trinidad and Riberalta (both in the hot, humid lowlands of the Department of Beni), and officials planned to hold another round of trainings in El Alto later that year. The training courses, which became known as "parto limpio" or "clean birth" programs because they taught traditionally-trained indigenous midwives to use basic obstetric tools, including medical gloves and alcohol for sterilization, also took place in rural health centers. In urban areas, doctors sometimes facilitated the trainings, but in most cases, including in rural areas, university-trained nurses, and nurse-midwives ran the sessions. In 1973, Dr. Rubén González gave a training session to six parteras in Sacaba, a city in the Chapare province of Cochabamba. In the same year, a group of parteras

[367] "Entregarán ambulancias a 3 centros de salud," *El Diario,* La Paz, Bolivia. July 29, 1974.

from Chapare participated in a training session at the Universidad Mayor de San Simón in Cochabamba.[368]

Whatever the underlying assumptions of well-to-do Bolivians and some health officials about indigenous Bolivians, training programs for parteras were carried out with the benevolent purpose of using biomedical practices to improve the lives of Bolivia's poorest, most isolated citizens. The authors of a report by the Sectoral Office for Health Planning wrote simply that the purpose of the programs was to "reduce infant mortality… and reduce the risks of motherhood."[369] The report noted that the partera training programs seemed to have positive outcomes. By continuing education and supervision of the parteras, health officials hoped to improve the level of maternal-infant health in rural areas. They also suggested modifications to medical school curricula so that doctors would be better trained to deal with the unique challenges of health care in rural areas."[370] Mery Gallo de Machicado, who worked for two years in the mid-1970s as a supervisor of maternal-infant health programs for the Unidad Sanitaria in the Department of Potosí, said that through the programs, she and her colleagues intended to transmit knowledge to parteras so that they could become leaders in their communities. Medical training for parteras, therefore, went beyond instruction on making deliveries safer; they also taught parteras basic preventive care measures. "We usually went for a week at a time to the campo," she recalled.

We would select a community from a place where a woman had had bad assistance

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[368] Oficina Sectorial de Planificación de Salud. *Informe de la comisión de salud materno infantil* (La Paz, Bolivia, 1975), 5, 25.

[369] Oficina Sectorial de Planificación de Salud. *Informe de la comisión de salud materno infantil.* La Paz, Bolivia, 1975, 4.

[370] Ibid., 25.

(*había sido mal atendida*) and had been taken to the hospital. Hemorrhaging, for example. We would prioritize that community. We would find ten parteras from ten communities. Then we would pick a central community and bring them all to that community. We would pay their travel, etc. and we'd train them. Sometimes the director of the maternal-infant health program came along, or a doctor accompanied us. Sometimes if the rural public health doctor ("*médico del área rural"*) came—the doctor who traveled all over Potosí to all the communities—then the nutritionist and a social worker came with us as well. We brought a dentist with us if possible. If a dentist didn't come, we taught the oral hygiene section ourselves.[371]

Gallo de Machicado felt that the programs achieved some success as long as public health personnel continued visiting the communities, but such programs were difficult to maintain in the long run because funding was "scarce and improvised"[372] and because working in such remote areas was physically exhausting for her and her colleagues. Leaving her young children at home with a nanny since her husband, a public health doctor, also worked, Gallo de Machicado recalled that the team would sometimes exhaust their water supply while conducting trainings in remote villages and would be forced to drink from whatever water they could find. As a result, she often came home from a week of travel with severe diarrhea.

The Montero Pilot Project: A Prototype for Primary Health Care

As the Family Wellbeing Program came to an end, USAID and the Ministry of Health turned their focus to a project that combined a variety of strategies used in disparate programs over the previous decade. Initiated as a pilot project in the Montero region of the Santa Cruz Department, the Montero Rural Health Project aimed to employ local community participation, including the active involvement of women, to provide health and hygiene education, as well as

[371] Mery Gallo de Machicado, *Interview with Author.* Potosí, Bolivia. 12 April 2012.

[372] Oficina Sectorial de Planificación de Salud. *Informe de la comisión de salud materno infantil.* La Paz, Bolivia, 1975, 25.

low-cost curative and preventive care. Architects of the project also hoped to integrate health and nutritional education services with rural agricultural development projects and general education in order to "diminish the incidence and prevalence of the main illnesses that affect the productivity and quality of life of poor campesinos."[373] In later years, the Health Ministry and USAID hoped to use the same model in the departments of Potosí and La Paz.

Proposed before the World Health Organization's historic commitment to primary care, the new health system shifted the focus of public health services from curative to preventive care through the system's central figure, "the community health promoter." A "Community Health Care Committee" would choose the community health promoter. "Community Health Committee," comprised of local community members. With organizational assistance from the Health Committee, the health promoter ideally provided preventive health services and education in five main program areas: maternal-infant health, nutrition, infectious disease control, environmental sanitation, and "medical attention programs."[374] The promoter would receive a salary, determined by the Health Committee, and would be in charge of accepting payment for services and submitting all revenue to the Ministry of Health, where projects could then be planned and budgeted in centralized fashion.

The community health promoters at local levels were linked to a hierarchy of medical professionals within the Ministry of Public Health. USAID officials frequently stressed the importance of maintaining the hierarchy, through in-hospital training, strict job descriptions, and regular supervisory visits from the nurses and auxiliary nurses who occupied higher positions within the hierarchy. "Through their training and manuals," wrote the authors of a plan to expand

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[373] USAID/Bolivia. *Sistema de prestación de servicios de salud al area rural. Proyecto 511-0483. Borrador final.* (August 1978), 1.

[374] Ibid., 15.

the Montero model to other departments, "it is hoped that the promoter will know their limits and recognize a problem that is beyond their limits in order to refer [the patient] to a level that can treat the problem."[375] In spite of the limits officials eagerly placed on community health promoters, once properly trained, USAID officials noted that the promoters would play a crucial role in public health, sometimes acting as "the only contact between the government and the campesino."[376]

The Montero-based system also employed some of the same programs used to promote family wellbeing in earlier years, namely, mothers' centers and parto limpio training programs for parteras. The assumptions of at least one author of a 1978 USAID evaluation, however, differed in important ways from that of some Bolivian Health officials. Unlike the authors of the 1975 Banzer-government National Council for Social Action plan, which depicted indigenous women as passive and isolated, USAID workers described indigenous women in much more nuanced terms:

> "The cholas are businesswomen, aggressive and sure of themselves, they possess a formidable shrewdness for business. Currently they are forming unions and are insistent in their demands for education for their children. The role of rural women, on the other hand, is clearly subordinate to the man. Nonetheless, the woman paradoxically dominates within the home. The grandmother is frequently the most prominent figure in the home, in terms of care for health, and it is generally she who most resists the adoption of modern techniques."[377]

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[375] USAID/Bolivia. *Sistema de prestación de servicios de salud al área rural. Proyecto 511-0483. Borrador final.* (August 1978), 23. Original: "Más aun, a través de su entrenamiento y de manuales se espera que el Promotor conocerá sus límites y reconocerá un problema más allá de estos límites para su referencia a un nivel que pueda tratar este problema."

[376] USAID/Bolivia. *Sistema de prestación de servicios de salud al área rural. Proyecto 511-0483. Borrador final.* (August 1978), 9.

[377] USAID, Evaluación Integral del Sector de Salud," (USAID/B: La Paz, Bolivia, 1978), 57.

In spite of those differences, USAID and the Ministry of Health agreed that good health and economic development in Bolivia rested on the abilities of mothers, and they placed responsibility for properly instructing mothers on nurses and parteras.

Bolivia and the Alma-Ata Declaration

In 1978, three years into the Montero Pilot Project (and just two months after Hugo Banzer was overthrown by Juan Pereda Asbún), the new head of state signed a presidential decree authorizing Dr. Oscar Román Vaca to travel to Alma-Ata, Kazakhstan, then part of the Soviet Union. The doctor attended an international conference on the topic of "Primary Health Care" (Atención Primaria de la Salud"), convened by the World Health Organization.[378] Three thousand delegates, representing 134 governments and 67 international organizations attended the conference. Of the seventy participants from Latin American countries, 97 percent represented official public health institutions.[379] The declaration that emerged from the meeting committed member states to an approach to health care that would make "essential health care universally accessible to individuals and families in the community in an affordable way and with their full participation."[380] Although Alma-Ata participants noted that each country and each community would have different needs, at a minimum, they believed that primary health care should include adequate nutrition and access to safe water, basic sanitation, maternal and infant care (including access to family planning education and methods), immunizations,

[378] Rolando Costa Ardúz, *Historia del Ministerio de Salud y Previsión Social* (La Paz, Bolivia: Organización Mundial de Salud, Organización Panamericana de Salud, 2000), 165.

[379] Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care." *American Journal of Public Health.* 94, no. 11. (November 2004): 1864-1874.

[380] World Health Organization. *Primary Health Care. Report of the International Conference on Primary Health Care.* (Alma-Ata, USSR, 6-12 September, 1978), 38.

prevention of local endemic diseases, community education about common health problems, and treatment for common diseases and injuries.[381]

In light of the maternal-infant care programs—including Family-Wellbeing activities, mothers' centers, and trainings for parteras—the Alma-Ata declaration signaled to Dr. Román Vaca and his colleagues at the Ministry of Health that Bolivia's approach to public health care was the right one. For public health systems organized around disease eradication and hospital care, the primary health care approach would necessarily restructure entire health systems, so that health ministry efforts could focus on providing those "essential," preventive services rather than on curing diseases. Instead of training more doctors, Alma-Ata advocated a reliance on "community health promoters," auxiliary nurses, who received basic medical training in brief courses, and practitioners of traditional medicine, including "traditional birth attendants."[382] The medical auxiliaries at the base of the medical hierarchy would provide primary health care services and education, thereby improving overall health and wellbeing at the community level at a minimal cost. All of these measures had already been implemented with the assistance of USAID in Santa Cruz, and at the time of the conference, USAID officials planned to expand the program.

Below this apparent harmony between the Alma-Ata Declaration and the approach taken by USAID and the Ministry of Health, however, lay ideological debates about the power and the place of medical doctors and "traditional healers" (including midwives) in public health systems. Questions about the role of traditional healers in public health had implications beyond strictly medical ones; they went to the heart of debates about the place of indigenous people and cultural

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[381] World Health Organization. *Primary Health Care. Report of the International Conference on Primary Health Care.* (Alma-Ata, USSR, 6-12 September, 1978), 53.

[382] World Health Organization. *Primary Health Care. Report of the International Conference on Primary Health Care* (Alma-Ata, USSR, 6-12 September, 1978).

practices within modern nations. The health system that USAID and Banzer envisioned promoted economic development with the purpose of preventing the spread of communism and maintaining Banzer's political power. They saw an important role in preventive care for community health promoters and traditional healers, but designed the Montero project so that medical power remained firmly in the hands of medical doctors at the Ministry of Health. Participants in the Alma-Ata meeting also held conflicting ideas about the social and economic goals of the new health care paradigm. Indeed, ideological divides that roughly followed Cold War lines pervaded the Alma-Ata conference and influenced debates about the relationships between doctors and indigenous medical practitioners.

The WHO's initial vision of primary care reflected the views of the organization's general director. Dr. Halfdan T. Mahler had pushed for a new approach to health care since he took position of general director in 1973 (he served until 1988). A new wave of political and academic opinions on medicine and health care that emerged in the 1960s, as well as Dr. Mahler's own professional experiences as an officer for a number of anti-tuberculosis campaigns in the 1950s and 1960s, inspired his approach. Mahler and others argued that the vertically-organized, disease eradication approach advocated by the World Health Organization after World War II had failed; as evidence, they cited the organization's inability to eradicate the most common causes of death in poor countries. Major support for a world conference on primary health care took shape in 1975, when a joint WHO-UNICEF publication underscored the need for community-level health projects to solve the basic health problems of the world's poor. At

the twenty-eighth World Health Assembly, participants reiterated the need for "alternative approaches" to disease eradication.[383]

The horizontally-organized structure of primary care practices Dr. Mahler advocated was also intended to empower indigenous healers and midwives and make physicians, and medical specialists, in particular, far less important within health care systems. Indeed, Mahler intended primary care as an antidote to the all-too-common elitism of physicians. In a speech in 1980, he chastised the "pompous grandeur" of "medical emperors" who disagreed with the principles of primary care.[384] Like-minded physicians supported Mahler's goal of empowering traditional healers and fostering their collaboration with doctors. In December 1977, less than a year before the Alma-Ata meeting, the Working Group on Traditional Medicine, headed by Dr. Ch'en Wen-chieh, met in Geneva to discuss the role of traditional medicine in community health and to develop recommendations for integrating traditional practitioners into biomedical-based public health systems. The group agreed that traditional healers of various kinds must be involved in national-level efforts to expand primary health care because traditional practitioners often held cultural currency that doctors did not, and because traditional remedies often treated mental and physical ailments in more effective ways than did western medicine. They advocated not only the evaluation and promotion of certain traditional healing techniques and the training of traditional healers in basic biomedical principles and techniques, but also the incorporation of traditional medicine into medical education in order to promote cross-cultural understanding and

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[383] Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care." *American Journal of Public Health.* 94, no. 11. (November 2004): 1864-1874.

[384] Ibid., 1872.

collaboration.[385] The group argued that "traditional midwives," who they estimated attended two-thirds of births in the world and often acted as primary authorities on matters of sexual behavior, birth control, maternal-infant care, should form part of primary health care systems. Moreover, they advocated training traditional parteras as a means of incorporating them into public health systems.

At the Alma-Ata conference, however, many participants showed far less enthusiasm for collaboration between traditional healers and western medical professionals, and, as a result, the declaration, in essence, supported national health ministries that continued to exclude traditional healers from substantive participation in the public health system. Instead of advocating the kind of mutual understanding and collaboration that the Working Groups had suggested, the report from the Alma-Ata conference noted only that "indigenous practitioners can become important allies in organizing efforts to improve the health of the community."[386] The declaration recommended only that primary care systems rely on referrals from traditional practitioners, "when needed," suggesting that practitioners with some level of biomedical training should act as the primary links between patients and medical specialists.[387] These debates were important for Bolivian physicians, who had, since the early twentieth century, fought to create and maintain a clear hierarchy between themselves and all other medical practitioners, including matronas, parteras, and curanderos.

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[385] Organización Mundial de Salud, *Promoción y desarrollo de la medicina tradicional. Informe de una reunión de la OMS.* Serie de Informes Técnicos. Ginebra, 1978.

[386] World Health Organization, *Primary Health Care. Report of the International Conference on Primary Health Care* (Alma-Ata, USSR, 6-12 September, 1978), 63.

[387] WHO, Alma Ata Declaration, 1978.

In Dr. Mahler's eyes, and in those who agreed with his approach, the demotion of doctors would go hand-in-hand with major political changes necessary for implementing a primary care approach. Indeed, the principal models for advocates of primary care were Mao's barefoot doctors in China and Dr. Carroll Behrhorst's program in Chimaltenango, Guatemala. After leaving his medical practice in Kansas and setting up a hospital in a Kaqchikel-speaking community in Guatemala, in 1962, Behrhorst began training members of the community to cure basic diseases and provide education on disease prevention and work as community health promoters. Behrhorst found that the health promoter approach was both cheaper and more effective, because promoters were able to gain the trust of community members and bridge the cultural divide. The complete eradication of disease among the rural poor, he believed, required the resolution of a series of problems that he ranked in order of importance and priority: social and economic injustice, unequal land tenure, low agricultural production and marketing, little population control, malnutrition, poor health training, and finally, lack of curative medicine. In the context of the Cold War and the counterinsurgency campaign of the Guatemalan military, Behrhorst's first two priorities were not only closed to debate, but also were dangerous political propositions. Sadly, community health workers of the Chimaltenango health program became targets of the Guatemalan military. The military murdered or disappeared more than two-thirds of the health promoters that Behrhorst trained. Behrhorst himself was forced to flee the country.[388]

The Alma-Ata Declaration did not include such direct calls for revolutionary political and economic reform, but in his speech at the opening ceremony, Dr. Mahler probed participants

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[388] Joseph W. Bastien, *Drum and Stethoscope: Integrating Ethnomedicine and Biomedicine in Bolivia* (Salt Lake City, UT: University of Utah Press, 1992), 106. Aldea, "Our History," http://aldeaguatemala.org/who-we-are/history/.

with a series of politically-driven questions. "Are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to universal introduction of [primary health care]?" he asked.[389] The official report from the conference, however, forwarded a much more moderate push for political change, noting only that, "[t]he conference believed that, in adopting the Declaration of Alma-Ata, governments have made a historic collective expression of political will in the spirit of social equity aimed at improving health for all their peoples. Each nation should now make a strong and continuing commitment to primary health care at all levels of government and society."[390]

The Alma-Ata declaration also attached the goal of health to development, but it left the definition of development open for interpretation. In contrast to the discourse of development that emanated from U.S. modernization theorists and the Alliance for Progress and USAID, the idea of development put forward in the Alma-Ata conference report did not rest on a belief that all nations should move toward a state of economic and political "modernization." It did not presume that development required increasing levels of capitalist production and consumption, nor did it prescribe economic development as an antidote to communism. Rather, the Alma-Ata report stated that "the purpose of development is to permit people to lead economically productive and socially satisfying lives. Social satisfaction and economic productivity will be interpreted in widely different ways according to the social and cultural values prevailed in each society."[391]

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[389] Quoted in Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health* 94, no. 11. (November 2004): 1867.

[390] World Health Organization. *Primary Health Care. Report of the International Conference on Primary Health Care* (Alma-Ata, USSR, 6-12 September, 1978), 20.

[391] Ibid., 44.

The Ata Ata declaration came under immediate attack from organizations and individuals who believed it too broad, too unrealistic, and too radical. Especially troublesome for some was that many who had shaped the declaration, such as Dr. Mahler, presented primary health care as a component of social revolution. In response to those concerns, the Rockefeller Foundation hosted a conference on "Selective Primary Care" the year after the conference in Alma-Ata to discuss (far less radical) "low-cost technical interventions" to prevent common diseases among the world's poor. Conference attendees eventually settled on four interventions, three of which specifically targeted mothers and infants: growth and monitoring of infants and the promotion of proper nutrition, oral rehydration to prevent death from diarrhea, promotion of breastfeeding, and immunizations.[392]

*"*Primary-Care" and Maternal Infant Health after Alma-Ata

In Bolivia, the Alma-Ata declaration served as a symbolized the of international validation for the type of health programs the Banzer government and USAID initiated. When Bolivia's delegate flew to Kazakhstan in 1978, the primary health care approach advocated by the WHO was already in operation through the USAID-funded Montero Project and through other projects that attempted to expand preventive services by training indigenous parteras, auxiliary nurses and lesser-trained medical professionals, such as nurse-midwives. As a result, the declaration did not spur Bolivia to revamp its health system, but instead provided international ideological and financial support to continue with existing programs, especially those focused on maternal and infant health. A theoretical victory of the Montero model, however, did not translate to a victory in practice. USAID ended the project in 1980 without

[392] Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health* 94, no. 11. (November 2004): 1864-1874.

expanding it into other areas of the country. Thereafter, maternal and infant care programs were the only remaining primary care projects in Bolivia. The agency conceded that, in spite of its initial optimism about the Montero model, the pilot project had proved expensive and ineffective. USAID's stipulation that all equipment and medicines for the project had to be purchased directly from the United States created unnecessary expenses, but the roots of the program's ineffectiveness were much more complicated.

The ineffectiveness of the Montero system resulted, in large part, from local people's rejection of the program's particular political and medical hierarchies. The anthropologist Libbet Crandon-Malamud, who spent two years researching "medical pluralism" in the Altiplano and also worked as a consultant for USAID in 1977, wrote a critique of the project six years after its demise. She suggested that the health care order imposed by biomedical health planners clashed with existing community divisions and local politics. The use of health promoters at the local level, whose primary roles were to educate people about hygiene, proper nutrition and so on, left community members with the acute sense that the government was chastising them for their health problems, rather than carrying out infrastructural works to improve their living conditions. Furthermore, indigenous healers were only incorporated into the public health system at the local level, as health promoters, and were systematically excluded from decision-making about public health projects.[393]

The training programs for indigenous midwives after Alma-Ata were similarly designed to place traditional medicine and indigenous parteras at the service of biomedicine and doctors. The bureaucratic hierarchy through which training programs were designed and implemented

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[393] Libbet Crandon, "Grass roots, Herbs, Promotors and Preventions: A Re-Evaluation of Contemporary International Health Care Planning. The Bolivian Case." *Social Science Medicine* 17, no. 17. (1983): 1281-1289. Libbet Crandon-Malamud, *Social Change, Political Process, and Medical Pluralism in Bolivia* (Berkeley, CA: University of California Press, 1991).

also mirrored the gendered division of labor and power found in the medical profession. Male medical doctors occupied top positions within the Ministry both at national and departmental levels, while female nurses and nurse-midwives labored under their command, implementing programs and working as intermediaries between the community health promoters and parteras, at the bottom of the hierarchy, and the doctors, at the top.

In the midst of Banzer's authoritarian push for political and social change, these programs produced unexpected spaces of empowerment for the very people targeted for reform; parto limpio programs allowed nurses and nurse-midwives to occupy key positions of power within the public health system.[394] These positions of power were not at the top of the Ministry of Health, but in the middle of an elaborate medical-bureaucratic hierarchy. At the national level, within the Ministry of Health, the nurse in charge of maternal-infant health programs had the considerable task of designing programs, training nurses to carry out those programs, and coordinating directors in the country's nine departments. Norma Quispe Portacarrero was not the first nurse to occupy the position of coordinator for maternal-infant health programs within the Ministry of Health, when she accepted the position in 1985. Her predecessor had already worked both to identify indigenous parteras throughout the country and to elaborate training programs that would teach parteras to recognize high-risk pregnancies and to create the most sterile conditions possible during delivery. Although she was solely responsible for reviewing and revising the programs that her predecessor designed, she ultimately submitted her own plans,

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[394] Similarly, Jadwiga E. Pieper Mooney illustrates that, in spite of the Pinochet dictatorship's conservative attitude toward women and affinity for pronatalist policies, the regime's desire to appear modern opened a space for Chilean health activists to carry out public sex education courses and promote and provide family planning services. See her "Regulating Reproduction and Sexuality to Cast a Modern Nation: 'Motherhood for the Fatherland' as a Legacy of the Chilean Dictatorship," *Transnational Subjects: History, Society and Culture* 2, no. 2 (2012): 209-236. On the adoption of progressive women's rights legislation under dictatorships in Latin America, see Mala Htun, *Sex and the State: Abortion, Divorce, and the Family under Latin American Dictatorships and Democracies* (Cambridge and New York: Cambridge University Press, 2003).

which the physician-director in charge of maternal-infant care at the national level reviewed and approved. At the department level, nurses also occupied key mid-level positions. Before accepting the national-level position, Quispe had done much the same work for the Department of Potosí, a position that nurse-midwife Mery Gallo de Machicado later occupied. The mission of the nurse-coordinator at the department level was to facilitate the implementation of programs designed at the national level. Quispe explained:

> So the nurse-coordinator would say, "There are funds. We're going to start training parteras. We have to start identifying and selecting them." Then she would travel, select the parteras or the rural areas, identify the doctor that was there, the medical director, visit all the communities… and then advise the national level. Then the trainings would start, according to the methodology that the nurses had been taught.[395]

In spite of their mid-level position within the bureaucratic medical hierarchy, their education and work experiences uniquely equipped nurses and nurse-midwives to take on leading roles in public health care. When Norma Quispe Portacarrero began her studies in Sucre in 1975, the programs had already made the switch from the joint midwifery-nursing programs to nursing, but the course requirements still emphasized childbirth assistance. Like midwifery students before her, Quispe worked in the maternity under the supervision of Emma Rivera and Manuela Pérez. Although she had chosen to specialize in instrumentalization, she and her classmates were still required to attend eighty births in the maternity in order to meet course requirements. She completed her rural service in San Lucas, Chuquisaca, a two day journey by car from the city of Santa Cruz, where she worked under a doctor, with the assistance of three auxiliary nurses. In addition to attending "many births" and making house calls with the three auxiliary nurses under her command, Quispe directed all of the other major public health programs, including malaria and chagas prevention and vaccination campaigns. She also

[395] Norma Quispe Portacarrero, *Interview with Author.* La Paz, Bolivia. 31 May, 2012.

designed maternal-infant care programs, including training programs for indigenous parteras, a project for which her skills as a Quechua-speaker were crucial. After spending three years in San Lucas, she accepted a position at a mining maternity in Potosí, but stayed for only eight month. In 1985, the Ministry of Health recruited her for the position coordinating national-level maternal-infant health programs. "I was participating in a workshop on maternal-infant health in Potosi and I guess I stood out," she recalled about how she was offered the position.

Quispe's new position gave her both the power and the challenge of designing curricula for indigenous midwives and learning to communicate effectively over cultural and linguistic divides. She consulted her former classmates after accepting the position in order to establish a basic curriculum for the training programs, but she also had to contend with the challenge of engaging indigenous midwives in conversation about the process of childbirth assistance. During her first year, she recalled, she and her assistants worked into the night to come up with strategies for effectively communicating with the parteras who participated in the trainings.

The nurses who worked with parteras were often reminded during the training sessions that many parteras' expertise surpassed that of obstetricians. Even trained matronas, suggested Quispe, would not have taught parteras anything about childbirth that they did not already know. "…We didn't have to teach the parteras anything," she stressed. "We only had to teach her to keep the area clean, because uuuuuuuiii, the parteras assisted better than the doctors! [A partera] would say, this baby is going to be born at two in the morning, and it would be born at two in the morning. She'd say, 'It's going to be male.' And it would be a boy."[396]

Although the parto limpio programs were designed to reinforce the hierarchical relationship between biomedicine and traditional medicine, they were also a symbol of the

[396] Norma Quispe Portacarrero, *Interview with Author.* La Paz, Bolivia. 31 May, 2012.

Ministry's recognition of the authority of indigenous midwives and traditional medicine. As the case of the 1982 programs in El Alto shows, however, Ministry officials often resisted incorporating parteras into the public health system, even when parteras were eager to work with doctors. Based out of the Hospital Municipal Boliviano-Holandés, the El Alto program was a unique effort to break the gender and ethnic hierarchy and strengthen collaboration between medical doctors and parteras in an urban setting. Parteras completed in-hospital training in El Alto, followed by practical training both in the maternity in the Dutch-Bolivian hospital and at the maternity at the Miraflores General Hospital in La Paz. Following the course, the participants received a certification intended to allow them to continue working with doctors at the health centers in their "district," the smallest bureaucratic division within the public health system. The short courses held in health centers in El Alto in the early 1970s had laid the ground work for this more extensive effort to integrate parteras into broader public health efforts, but in the long run, support within the Ministry of Health and from international health organizations were not enough to institutionalize a closer, more universal relationship between doctors and parteras.[397]

Although parteras incorporated biomedical knowledge and techniques into their professional practices, the transfer of knowledge was unidirectional and inconsistent. If some doctors did incorporate traditional birthing techniques into their practices, they did so informally and as an individual professional decision, rather than by formally institutionalizing hybrid (multicultural) medical care practices through reforms to medical education or the implementation of new public health policies. The programs ultimately did change the practices of participants. Parteras indicated that they were more knowledgeable about potential risks

[397]Yola Chambi de Orellana, *Interview with Author.* La Paz, Bolivia. 18 March 2012; Ana Choque de López, *Interview with Author.* La Paz, Bolivia. 18 March 2012.

during pregnancy and delivery and more willing to refer high-risk patients to hospitals than before the training. Thirty years after the training, they still used biomedical concepts like pre-eclampsia, edema, placental retention, and placenta previa, when they described the process of childbirth and their methods of assistance. Partera Ana Choque de López credited a Bolivian doctor at the Bolivian-Dutch hospital in El Alto for greatly improving her skill at manually extracting a placenta. Her mother, who was also a midwife from El Alto, also manually extracted the placenta, but the doctor showed Ana how to do it with even more care to ensure than no piece of the placenta was left in the womb. She also shortened the amount of time she waited before extracting the placenta, according to biomedical procedures, from two to three hours, as her mother advised, to thirty minutes.[398]

Partera Yola Chambi de Orellana's practices also reflected her experiences with biomedical practitioners, not just from the 1982 training, but over decades. She only attended "echadita" (in the reclined position), as required by medical doctors and many university-trained midwives. She also insisted that giving parturient mothers herbal teas (*mates*) during labor was dangerous, both for the mother and the baby. She had been warned against using *mates* by Señora Carmen, "the only matrona en El Alto" during the 1960s.[399] A native Bolivian, Carmen had her own practice in El Alto and lived in the apartment above her private clinic until, as Yola recounted, her estranged husband, who worked for the city of El Alto, had her poisoned.[400]

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[398] Ana Choque de López, *Interview with Author.* La Paz, Bolivia. 18 March 2012.

[399] Yola Chambi, *Interview with Author.* La Paz, Bolivia. 18 March 2012.

[400] One matrona listed in the Ministry of Health's 1946 professional registry, Carmen Fernandez y G., graduated from UMSA in 1936 and listed her address as "Yucama no. 60," a street now called "Rio Yacuma" in El Alto. If this is the same Carmen who worked in El Alto in the 1960s, she would likely have been in her forties at the time of her death. Ministerio de Trabajo, Salubridad y Previsión Social, *Guia de professionales en medicina y ramas anexas,* (December, 1946), 100-101.

Partera Ricardina Suntura Cusmi, another participant in the 1982 program, said, on the contrary, that she had completely given up midwifery because she feared making a mistake or being unable to help during a difficult delivery. Her rejection of midwifery certainly reflected the influence of urban life and contact with doctors. As a child in a rural Pacajes Province of La Paz, Ricardina was one of several parteras—including her brother, a partero—in her family. In rural areas far from hospitals, expectant mothers sought out parteras with demonstrated skill in helping women deliver. For these chosen ones, rejecting the profession would have been difficult. In an urban setting like the La Paz-El Alto metropolis, however, reluctant parteras like Ricardina could easily refer a pregnant woman to another midwife or to one of numerous local health centers or hospitals.[401]

Conclusion

In spite of the willingness of some parteras to collaborate with physicians and nurses, and, perhaps more importantly, of some physicians' and nurses' to work together with parteras, support for parto limpio programs was not universal within the medical community, nor was the political will to push the programs forward constant within the Ministry of Health in subsequent years. Nonetheless, the efforts initiated by the Banzer government and USAID, and spurred on by the Alma-Ata Declaration of 1978, laid the groundwork for a new era that changed the relationship between western medicine and the state.

The reports of USAID officers, officials within Hugo Banzer's government, and the general himself show that both Banzer's government and USAID believed that the cultural backwardness of the indigenous population obstructed the country's path toward economic

[401] Ricardina Suntura Cusmi, *Interview with Author.* La Paz, Bolivia. 18 March 2012.

development. In spite of that conviction, they also held hope that health programs directed at indigenous mothers and infants would succeed in reshaping the family in order to turn Indians into productive, obedient citizens. Within the male-head nuclear family promoted by the Banzer regime and USAID, the New Bolivian Man and his implicit partner, the New Bolivian Woman, would form a new cultural foundation for the nation.

Yet, instead of attempting to repress indigenous cultural practices by training more nurses and to replace parteras, as physicians and health officials had advocated in the past, public health programs funded by the Ministry of Health and USAID in the 1970s and '80s empowered indigenous midwives to take part in, and shape, maternal-infant care programs. Although mothers' centers and parto limpio programs were part of a larger project designed to engender the New Bolivian Woman, indigenous mothers and parteras participated on their own terms. Many parteras altered their practices after training with doctors and remained eager to formalize their positions within the public health system, but there is little indication that parteras or their clients were more willing to set aside cultural practices or political activism. Furthermore, instead of reinforcing women's position within the home, health programs like mobile health units, mothers' centers, and parto limpio programs allowed nurses and midwives access to important mid-level positions within the public health system.

The participation of Bolivian health minister in the Alma-Ata conference illustrates the ways in which local- and national-level plans can affect international agreements, and, in turn, how those agreements can be used at national and local levels for competing and even contradictory ends. By looking to traditional medical practitioners and medical auxiliaries to solve the country's development problems, Banzer's Ministry of Health opened a door for indigenous midwives to carry out their profession openly and in an official capacity. Although

shifting priorities in public health in subsequent years attempted to close that door again, parteras continued to demand official recognition of their work. Maternal-infant care programs initiated by USAID and the Banzer government and continued after the World Health Organization conference in Alma-Ata ushered in lasting changes in Bolivia's politics of health.

EPILOGUE AND CONCLUSION:
The Obstetric Movement from Eugenics to Interculturality

On a bright, late-summer day in March 2012, I made my way to the Ministry of Health building at the foot of El Prado in La Paz's city center to meet a group of parteras. They had traveled to La Paz for the day from El Alto and neighboring rural provinces of the department to attend a certification ceremony hosted by the departmental branch of the Vice Ministry of Traditional Medicine and Interculturality. María Rasguido Coca, a partera and then the general director of the Vice Ministry, delivered the welcoming address in Aymara and Spanish to some 200 attendees. After the ceremony, in which curanderos, herbalists, and parteras received state accreditation for their professional practices, the crowd of women dressed in pollera skirts, bowler hats and braids, and men in a mix of western-style sweaters or panchos filed out of the packed conference hall. Crossing a tangle of traffic outside the Ministry, attendees reconvened in the Plaza Antonio José de Sucre to eat, talk, and, since it was also National Coca Chewing Day, to share and chew coca. It was there that I first met several parteras from El Alto, including Ana Choque de López, whose story I included at the beginning of this study.[402]

The participation of parteras in state-sponsored certification ceremonies across the country is perhaps the most obvious sign of change in Bolivia's obstetric movement. The Vice Ministry of Traditional Medicine and Interculturality was created in 2006 at the start of Evo Morales' second presidential term. With its goal of regulating and certifying indigenous healers and integrating traditional and western medicine, the Vice Ministry advanced the ambitious and polemical mission of the *Movimiento al Socialismo* (MAS) party. Ideologues of the powerful

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[402] The following year, the departmental level of the Vice Ministry in Santa Cruz held a similar ceremony, certifying 291 parteras and other traditional medical practitioners. *El Dia,* "médicos tradicionales" and parteras. "Acreditan a 291 parteras y médicos traditionales," (22 mayo 2013), accessed November 14, 2014, http://www.eldia.com.bo/index.php?cat=362&pla=3&id_articulo=117847.

indigenous rights party behind Morales' presidency declared it their mission to "decolonize" society and reorganize it around a philosophy they call "Living Well" ("*Vivir Bien"),* a motto translated from the Aymara term *Suma Qamaña*. Weaving a legal framework from the UN Declaration on the Rights of Indigenous Peoples, the International Labor Organization's Convention 169, and Bolivia's 2009 Constitution, "Living Well" endorses consensus, community over individual rights, non-discrimination, diversity, and moderation in consumption. MAS ideologues argue that creating a society based on such a radical new principle requires the elimination of the economic, political, and cultural subordination of the country's indigenous majority to "white" national elites and their foreign allies.[403]

The prominence of the Vice Ministry of Health in the 2012 ceremony in La Paz showcases the uniquely native politics of the MAS party, but the roots of Bolivia's new politics of childbirth, like the indigenous rights movement itself, are equally rooted in international

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[403] To define and implement the concept of decolonization, the government created the Vice Ministry of Decolonization in 2009 under the directorship of Félix Cárdenas, an Aymara intellectual and former militant peasant organizer who was imprisoned both during the military governments and following the 1982 return to democratic politics. Cárdenas explained in a 2011 interview that his mission was not to "return society to a romantic past" but to rid the state of colonial influences so that it constituted a "genuine expression of our identity and traditions." Mauricio Becerra, "Félix Cárdenas, viceministro de Descolonización de Bolivia," *El Ciudadano* (2011), accessed November 14, 2014, http://old.kaosenlared.net/noticia/felix-cardenas-vice-ministro-descolonizacion-bolivia-todos-estados-est). See also, Linda C. Farthing and Benjamin H. Kohl, *Evo's Bolivia: Continuity and Change* (Austin, TX: University of Texas Press, 2014), 58-59. Brian Johnson, "Decolonization and Its Paradoxes: The (Re)envisioning of Health Policy in Bolivia," *Latin American Perspectives* 37, no. 3 (2010): 140-156. Opposition to Morales' presidency has been particularly strong in the department of Santa Cruz and in other parts of the "*media luna*" region, where people fear Morales's leftist and pro-indigenous agenda. Opposition against Morales and MAS supporters gained racist momentum in 2007 and 2008, as several violent confrontations broke out between conservative whites and mestizos and indigenous MAS supporters. More violence erupted in 2008 during local-level public negotiations over the 2009 constitution, with leftist and indigenous groups pushing for a more radical document, and right-wing Bolivians attempting to block the entire reform process. In more recent years, however, opposition to Morales's government has been less clear cut. In 2010, Morales faced major protests from his constituents around the country when he eliminated gasoline subsidies. In 2011, middle and upper-class paceños supported indigenous residents of the Isiboro Sécure National Park and Indigenous Territory (TIPNIS) in their protests against the governments' plan to lay a paved highway through the territory. Marching some 375 miles from the lowland forests of Cochabamba and Beni, the group of approximately 800 indigenous protesters demonstrated that not all indigenous people accept MAS as the party that represents and protects their interests. See Farthing and Kohl, "Capturing Power or Captured by Power?" in their *Evo's Bolivia,* 35-56.

human rights discourses.[404] Growing attention to maternal mortality in the last decade has generated a new discourse of maternal care that informs programs in Bolivia and around the world. In 2010, the UN Office of the High Commissioner for Human Rights published a report on the prevention of maternal mortality and morbidity that obligated states to prevent maternal mortality in order to protect the universal human rights of women.[405] Subsequently, an alliance of individual consultants, non-profits, and international and governmental agencies, including the WHO and USAID, expanded on the Human Rights Council's report to propose "universal rights of childbearing women." Based on a 2010 study by researchers from the Harvard School of Public Health on the disrespect and abuse of pregnant women in hospital and clinics, the report calls for the protection of a woman's right to dignity and respect for her choices of companionship during pregnancy, delivery, and the postpartum period.[406] The rights themselves are grounded in the language of the UN Declaration of Human Rights, the 2011 Report of the Office of the UN High Commissioner for Human Rights on preventable maternal mortality and morbidity, as well as other international conventions.[407]

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[404] On the international roots of international human rights movements, see Alison Brysk, "Turning Weakness into Strength: The Internationalization of Indian Rights," *Latin American Perspectives* 23, no. 2 (Spring 1996): 38-57; Rachel Sieder, "Recognising Indigenous Law and the Politics of State Formation in Mesoamerica," in *Multiculturalism in Latin America: Indigenous Rights, Diversity and Democracy*, ed. Rachel Sieder (New York: Palgrave Macmillan, 2002).

[405] Judith Bueno de Mesquita and Eszter Kismödi, "Maternal Mortality and human rights: landmark decision by United Nations human rights body," *Bulletin of the World Health Organization* 90, no. 2 (February 1, 2012): 79-79A.

[406] Diana Bowser and Kathleen Hill, "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth. Report of a Landscape Analysis," Harvard School of Public Health, September 20, 2010, *www.mhtf.org/wp.../Respectful_Care_at_Birth_9-20-101_Final.pdf.*

[407] See the "Respectful Maternity Care: The Universal Rights of Childbearing Women." It is on the WHO and USAID websites. Accessed November 14, 2014, http://www.who.int/woman_child_accountability/ierg/reports/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf.

The emphasis on safe maternity as a universal human right marks an important change from previous debates about maternal health and life. A 1960 study by public health physician Hernán del Carpio Vásquez exemplifies the social significance the Bolivian medical community placed on mothers' lives for more than half of the twentieth century. Using maternal mortality statistics compiled by the Ministry of Health in 1951 and 1956, Dr. del Carpio Vásquez showed that Bolivia's maternal mortality rates soared above those of its Chilean and Peruvian neighbors. Such loss of life, the doctor lamented, "allows us to glimpse the magnitude of the problem of abandonment of Bolivian children, especially when we compare [Bolivian infant mortality rates] with other international rates."[408] Framing the problem of maternal mortality in terms of the lives of surviving children certainly demonstrated the doctor's concern for the wellbeing of families, but it also tied the value of a woman's life to her role as a mother and to her value within the nation.

One new midwifery program in Bolivia explicitly takes up the mission of protecting women's universal human rights by putting a new twist on the old midwifery-nursing programs of the 1960s.[409] In 2009, the universities in Sucre, Tarija, and Llallagua (in the department of Potosí) began offering a new five-year nursing-midwifery degree.[410] Conceived by nurses connected to the *Colegio de Enfermeras de Bolivia,* the country's primary nursing association, and planned in conjunction with the Vice Ministry of Traditional Medicine, the United Nations Population Fund (UNFPA), and the World Health Organization, the program sought to attract

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[408] Hernán del Carpio Vasquez, "Protección Materno Infantil en Bolivia," *Boletín Médico* no. 29 (April1960), 25. "la mortalidad materna boliviana nos permite vislumbrar la magnitud del problema de abandono del niño boliviano, sobre todo cuando comparamos con otras cifras internacionales."

[409] Carrera de Enfermería, "Diseño curricular de la licenciada de enfermería obstetriz", accessed at http://www.usfx.info/enfermería/.

[410] Jon Pelling, "Lessons in Respect," *Midwives Magazine* (December 2009/ January 2010): 32-33. Lilian Calderón, *Interview with Author.* La Paz, Bolivia. 26 March 2012.

young women from rural areas. The new students would be instructed according to standard biomedical birth assistance methods, but would also learn about indigenous birthing traditions.[411]

Other projects funded by foreign governments and NGOs have answered the call both to protect a woman's right to dignity and choice of companionship during pregnancy and to integrate indigenous and western medicine in a way that privileges the work of parteras. In 2006, for example, the Canadian government funded the construction of an "intercultural birth center" in a small rural town in the Department of Oruro, four hours south of the city of La Paz. The birth center, which was supported by Bolivia's Vice Ministry of Traditional Medicine, was decorated with *aguayos* and had a family room, where relatives of the laboring mother could brew tea and cook meals. Next door, a doctor stood by in case of emergency, but births were attended by a local partera. By 2007, the clinic boasted that it had succeeded in increasing the percentage of women who gave birth in the clinic from 9% to 84%.[412]

Yet, public support for human rights has not meant that the entire health community in Bolivia has embraced plans to integrate indigenous parteras into the public health system. In the years after the 1982 program to train parteras in El Alto, the Ministry of Health proved unwilling, or perhaps simply unable, to institutionalize the collaboration between parteras and physicians. In spite of their certification, years after they completed the training program, those parteras who wished to continue practicing in El Alto and collaborating with doctors often faced difficulties in doing so. After Ana Choque de López moved from the district where she lived at the time of the 1982 training, she was unable to continue working with the doctors in her new district. "The

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[411] Juana Gómez was one of the graduates of the nurse-midwifery programs of the 1960s and '70s who conceived of the programs. Juana Gómez, *Interview with Author,* Sucre, Bolivia, 1 May, 2012. On the Colegio de Enfermería de Bolivia, see http://enfermería.bvsp.org.bo/php/level.php?lang=es&component=32&item=11.

[412] Andrea Gourgy and Terry Sebastian, "Born into Bolivia," *Verge Magazine,* 16 July 2010, http://www.vergemagazine.com/galleries/born-into-bolivia.html.

doctors don't want to work with me," she said. "They don't value us.... Sometimes they kick us out." According to Choque de López, at times, when she would send a patient to the hospital with complications, the doctors would chastise the mother for having gone to a partera in the first place.[413] She felt especially frustrated by the attitude of some doctors because, from her perspective, she and other parteras were actively working to instill in parturient mothers a trust in the biomedical system.

In contrast, in 2012, Yola Chambi still worked closely with two different institutions, the Santa Rosa Hospital and the Rosas Pampa Health Center, both in El Alto. Because of her state certification as a trained partera and her relationship with doctors at the two centers, Chambi was able to work in an official capacity, registering births and signing birth certificates for the babies she delivered. In Chambi's case, referrals worked effectively in both directions. Chambi convinced her patients with high-risk pregnancies to deliver in hospital, and doctors at the two centers with which she had affiliation, referred low-risk cases to her for delivery. She explained,

> [The doctors] even say to the *señoras,* "and where do you want to have your baby? In [the Dutch-Bolivian Muncipal Hospital]? In the Rosas Pampa [Health Center]? And they say, no. I'm going with Doña Yola because she delivered my first baby who is now nine years old. Other [doctors] say, "How do you want to have your baby? With a partera? In the maternity? And they say, "with a partera." And so [the doctor says], okay, then you're going to have your baby with Doña Yola. Here is her phone number.[414]

Nonetheless, the comments of one doctor at the Women's Hospital in the Miraflores neighborhood of La Paz indicate that many western medical practitioners still refuse to accept parteras as legitimate childbirth assistants. Dr. Gustavo Mendoza, an obstetric-gynecologist who

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[413]Ana Choque de López, *Interview with Author.* La Paz, Bolivia. 18 March 2012.

[414] Yola Chambi, *Interview with Author.* La Paz, Bolivia. 18 March 2012. A recent increase in contact between doctors and indigenous women in El Alto can be attributed, in part, to the Bono Juana Azurduy. The Bono, or state-granted monetary award, gave one time cash payments to women for each prenatal check-up they had and an additional payment for delivering in with a medical professional.

graduated from the Universidad Mayor de San Andrés medical school in La Paz in 1980, criticized the training programs of the 1970s and early-1980s for their supposed ineffectiveness. He judged that part of the reason for their failure was that the parteras identified by communities and selected for training were often not parteras at all and had no real interest in practicing. Instead, he said, "many completed the training, left with the suitcase [of obstetric tools] and that was it." The solution, he insisted, was to insist that all births happen in medical institutions. His opinion was certainly not unique. At the time of the interview, doctors at the United Nations Population Fund (UNFPA) in La Paz had also changed their position on home deliveries and similarly stressed that giving birth outside of a hospital, and, in particular, without the assistance of a trained medical professional, was too risky.[415]

Although Dr. Mendoza emphasized his commitment to making childbirth safe, his perspective on how to achieve safe childbirth conflicted with the proposed universal rights of childbearing women. "People simply have to learn," he insisted, "that the only way to ensure a safe birth is to deliver in the hospital." He continued,

> I believe that, respecting cultures and everything, I believe that birth should be institutionalized. I am absolutely convinced of that. If you want, you can call me conservative (*retrógrado),* no problem. I believe that birth should be institutionalized. That's to say that [birth] should be in a health center. That is, in my conception, the only way to dramatically reduce maternal-infant mortality. There is no other way. The partera is not going to contribute anything. … the partera is never going to link up with [work with] a health center. Because she is going to attend to *her* patient in *her* house, and she [the partera] dies and then it's over... The idea was that if there was a conflict between the patient and the partera, the partera would go to the local health center to resolve it, but that didn't happen. I think that birth should be institutionalized and I don't think that we should train parteras anymore. Who knows in the inaccessible zones. But at this time, there are very few inaccessible zones.[416]

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[415] Lilian Calderón, *Interview with Author.* La Paz, Bolivia. 26 March 2012. Dr. Calderón was an obstetrician and maternal health advisor at the United Nations Population fund in La Paz. Tragically, she died in 2012 after being mugged outside the UNFPA headquarters in La Paz. Dr. Calderón was a respected member of the medical community in Bolivia.

[416] Gustavo Mendoza, *Interview with Author.* La Paz, Bolivia: 30 March 2012.

Dr. Mendoza's opinion certainly reflects that of many of his colleagues. While he acknowledged that parteras might have some public health value in rural areas, where doctors were unavailable, he firmly rejected the idea that they could work together with medical doctors. Indeed, like the majority of Bolivian doctors throughout the twentieth century, he viewed parteras as competitors who could never feasibly contribute to the public health system in urban areas. In his assessment, the goal of the programs of the 1970s and early 1980s had been to incorporate parteras into the public health system as rank-and-file members of the medical hierarchy. The programs failed, he believed, because parteras had refused to defer to the authority of doctors and had instead made off with supplies and continued treating their own patients outside of the public health system. From his perspective then, the parto limpio programs weakened the medical system and the authority of doctors, rather than strengthening them.[417]

These new debates reveal that the politics of race and gender still provide a powerful subtext that shape obstetric care programs and policies. In contrast to previous decades, however, physicians now confront a powerful indigenous rights discourse within the state itself that limits their authority. In the early twentieth century, physicians found evidence of a deplorable gap between Bolivia and the political and social modernity modeled by France in the state of the country's public maternities, and in the mothering practices of lower-class indigenous women. In order to project modernity and solve the country's "Indian Problem," physicians pushed for the construction of new public maternities, worked to consolidate a professional medical hierarchy of nurses, matronas, and physicians, and promoted eugenics- and puericulture-based public health programs.

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[417] Gustavo Mendoza, *Interview with Author.* La Paz, Bolivia: 30 March 2012.

The Villarroel government and the MNR, in contrast, saw maternal-infant care programs as a way to both create a unified, "mestizo" nation and bolster the physical health and production potential of the nation's workforce, a goal shared by the United States and facilitated by SCISP. By the 1970s, the Banzer regime's concern with maternal and infant health among lower-class rural and indigenous populations belied the regime's intention to reform and control the indigenous population, starting at the level of the family. Now, in the twenty-first century, new education programs emphasize a desire to protect the human rights of mothers and indigenous rights to self-determination. The administration of President Evo Morales has put the power of state institutions like the Vice Ministry of Traditional Medicine behind the birthing preferences of indigenous mothers and the assistance practices of parteras. As parteras push the state to make good on their promise of decolonizing the state, physicians like Dr. Mendoza resist the movement toward intercultural medicine.

Parteras, matronas, nurses, and mothers all shaped the process of nation-building and state formation. Both matronas and parteras continued to work independently through the 1950s, in spite of state-led efforts to regulate or (in the case of parteras) eliminate their practices. At the same time, in the 1940s and '50s, public health nurses trained by SCISP formed the front lines of public health campaigns designed to create national unity and forward mestizaje by bringing indigenous families into the care of the public health system. Both public health nurses trained by SCISP and graduates of the nursing and midwifery programs of the 1960s and '70s embraced active careers that empowered them as members of their families and as representatives of state health programs. Nurse-midwives, in particular, pushed the physician-defined confines of the profession in their jobs as midwives in mining towns, and as public health educators.

The choices of mothers also shaped maternal-infant care in Bolivia in important ways. Throughout the twentieth century, mothers continued to patronize parteras and matronas, regardless of the laws that limited their practice. As a result, by the 1970s, after decades of trying to eradicate parteras, physicians within the Ministry of Health, with the financial assistance of international organizations, turned to them to improve the health of rural Bolivians. Moreover, when clean birth programs lost political and medical support, former participants in those programs, like Ana Choque de López and Yola Chambi, insisted (with different degrees of success) on maintaining collaborative working relationships with hospital physicians.

Ultimately, the options for care available to a woman during childbirth and the choices she makes tell us about more than just the state of medical science in her village, city, or country of residence; they tell us about the gendered and racial contours of her nation and the structure of her state. From Señora Modesta Sanjinés' 1883 donation for a maternity ward in La Paz, to Ruth Clavijo's work in a mining town clinic and Ana Choque de López's fight for formal professional recognition, examining the social and political concerns that drove the obstetric movement reveals that childbirth assistance is first and foremost an act of power.

APPENDICES

APPENDIX A: Indigenous and Non-Indigenous Population According to 1950 Census

Race in 1950 Census	
Non-Indigenous	1,000,794.00
Indigenous	1,703,371.00
Total Indigenous Language Speakers	1,719,887.00
Quechua	987,695.00
Aymara	664,288.00
Other Indigenous Languages	67,904.00
Total Counted	2,704,165.00
Percentage Indigenous	62.99%
Percentage Non-Indigenous	37.01%

Source: República de Bolivia, *Censo de la población nacional. 1 de Septiembre 1900* (La Paz: Oficina de Inmigración, Estadística y Propaganda Geográfica, 1904), 100, 102.

APPENDIX B: Linguistic Groups According to 1976 Census

"Race" in 1976 Census	
Monolingual Spanish	1,508,365
Monolingual Quechua	568,707
Monolingual Aymara	315,228
Bilingual Quechua and Aymara	52,684
Spanish and Quechua and/or Aymara	1,647,461
Spanish and Others	49,802
Others	7,014
Total	4,149,261
Total Non-Spanish Speakers	943,633
Total Quechua and/or Aymara Speakers	2,584,080
Percentage Non-Spanish Speakers	22.74%
Percentage Quechua-Aymara Speakers	62.28%

Source: República de Bolivia, Resultados del Censo Nacional de Población y Vivienda, 1976. Volume 10. (La Paz: Instituto Nacional de Estadística, 1978), 70.

APPENDIX C: Literacy Rates by Sex from 1950 Census

Age	Men, Literate	Women, Literate	Men, Illiterate	Women, Illiterate
15-19	71,348	43,208	63,685	89,782
20-24	62,808	39,349	53,299	90,918
25-29	49,273	29,567	54,327	88,168
30-34	33,343	19,274	44,173	69,958
35-39	31,315	18,258	45,867	68,355
40-44	20,053	11,333	34,509	53,480
TOTAL	**268,140**	**160,989**	**295,860**	**460,661**
Percentage	**47.54%**	**25.90%**		

Source: República de Bolivia, Ministerio de hacienda y estadística. Dirección general de estadística y censos. *Censo Demográfico, 1950* (La Paz: Editorial "Argote," 1955), 112-113.

APPENDIX D: Women in Medical and Non-Medical Professions, 1950

Medical Professions	**Total**	**Women**	**Men**	**% Women**
Certified Midwives	87	87	0	100.00%
Dentists	314	273	316	86.94%
Certified Nurses	466	369	97	79.18%
Pharmacists	300	76	220	25.33%
Other Laboratory Technicians	88	17	71	19.32%
Other Medical Specialists	58	8	50	13.79%
Medical and Denistry Technicians	76	10	65	13.16%
Physicians and Surgeons	706	20	686	2.83%
Non-Medical Professions	**Total**	**Women**	**Men**	**% Women**
Primary School Teachers (capital)	3485	2304	1181	66.11%
Unspecified Teachers and Professors	2239	1327	912	59.27%
Primary School Teachers (rural)	2536	1064	1472	41.96%
Indigenous Education Teachers	281	98	283	34.88%
Writers	13	2	11	15.38%
Journalists and Reporters	213	16	197	7.51%
Chemists	148	10	136	6.76%
Civil Engineers	689	14	675	2.03%
Lawyers	1103	15	1088	1.36%
Judges	104	0	104	0.00%

Source: República de Bolivia, Ministerio de hacienda y estadística. Dirección general de estadística y censos, *Censo Demográfico, 1950* (La Paz: Editorial "Argote," 1955), 231-252.

APPENDIX E: SAMPLE INTERVIEWS

A few notes on the following transcriptions: Virginia Honorio Calle, a partera in her early thirties who speaks both Spanish and Aymara fluently and can both read and write Spanish, conducted three interviews in Aymara for me. I met Virginia and her mother at the certification ceremony hosted by the Vice Ministry of Traditional Medicine that I discussed in the conclusion. She accepted my offer to act as my assistant in interviewing a group of midwives whom I invited to my rented house in Sopocachi on March 18, 2012. In total, six parteras agreed to drive down from El Alto to talk to me about their experiences. Virginia and her mother, Cleta Calle, visited the day before the meeting to practice for the interview. I first interviewed Virginia according to a script, and she, in turn, interviewed her mother in Aymara. Cleta's occasional interjections appear below in the transcriptions of my interview with Virginia. Since we were practicing for the next day's interviews, and I was eager to hear Cleta's story, Virginia translated for me as the "tape rolled." In the transcription below, I occasionally deleted her translations to minimize repetition.

The next day, the midwives arrived. I talked to them about my project and explained the types of questions I would ask them. While Virginia interviewed Ricardina Suntura Cusmi and Yola Chambi, I interviewed Ana Choque de López and Lidia Flores Mamani. After we finished the formal interviews, I retired to the kitchen, leaving them to talk while I baked chicken, potatoes, and plantains. Over lunch and copious pots of tea, they talked about the similarities and differences in their birthing assistance methods and gossiped and shared stories from the trenches of midwifery. They discussed with each other their answers to some of the question I had scripted for the interviews. How had they become parteras? Did they give their patients tea? Those two particular questions raised a debate. Yola Chambi, who most closely followed the obstetric practices she learned from a matrona in the 1960s and during her training in 1982, insisted that giving parturients mates was dangerous. The other women objected. When Chambi criticized parteras who claimed they were also wisewomen (*yatiris*), who could cure and see the future, Virginia came to her mother's defense and insisted it was true. A number of the parteras told stories of assisting full-term births of fetuses that had been deformed by abortifacients. Another told of a time when she knew that the baby she helped to deliver had "come as contraband" (*vino contrabanda*), rather than from the new mother's husband.

Lic. Edgard Humerez T. completed both the transcriptions and translations that follow.[418]

[418] Humérez is the author of *Idioma Aymara. Curso Audiovisual* (La Paz, Bolivia: Artes Gráficas Bartedano, 2012).

VIRGINIA HONORIO CALLE

KG: Cómo te llamas?

V: Virginia Honorio Calle

KG: ¿Cuándo naciste?

V: 14 de mayo de 1976

KG: Dónde entonces (naciste)?

V: En Provincia Pacajes, Santiago de Callapa, mi comunidad se llama Lupacamaya

KG: Y entonces siempre has vivido ahí, en esta Provincia?

V: Sí, también en la ciudad de La Paz, en el Alto.

KG: Y cuándo has… nada más has viajado mucho entre…

V: Sí… llegamos aquí también porque siempre como parteras no ve, especialmente mi hermana esta pues, nos llama allá hay pacientes que hay que atender entonces venimos de aquí allá y bueno allá igual… tenemos ganaditos también hay estamos una semana y nos volvemos también aquí otra semana estamos y después como casi cuatro horas de viaje en Provincia.

KG: Entonces, si estás aquí en La Paz o en El Alto, ¿dónde te alojas, con familia?

V: Tengo mi casita de mi mamá, no de mí, entonces ahí nos quedamos.

KG: Entonces tienen una casa en El Alto y después en la Provincia.

V: En la Provincia sí, actualmente en la Provincia tenemos todo lugar, espacio para ganado todo eso.

KG: entonces es como una finca?

V: Ahá (sí)

KG: Y qué tienen… qué tipo de… tienen animales?

V: animales sí: ovejas, llamas, vacas, eso nomás también, también tampoco es como valle solamente es altiplano, entonces produce papa, haba, después cebada… eso nomás… quinua también produce.

KG: Y alguien de la familia está ahí todo el año?

V: Sí está ahí, siempre mi mamá, está en ahí. Mi mamá y papá están los dos están en ahí; nosotros venimos, vamos a visitar, estamos… tenemos que tener algún lugar… atender los partos, ahí vamos.

KG: Entonces tu padre todavía vive?

V: Vive, sí vive.

KG: Y está ahí en la Provincia?

V: (Sí) En la Provincia.

KG: Y se queda ahí trabajando ?

V: Sí ahí trabajando, cuidando los ganados.

KG: Entonces bueno, esta es una pregunta para usted también, pero…Cuándo nacieron sus padres?

V: um… eso si ya no…(no me acuerdo) me olvidé.

KG: año más o menos?

V: Debe ser… ahorita tiene mi papá 75 años.

KG: Y él nació, y usted también [a la madre, Cleta Calle], sus padres nacieron ahí en la provincia?

V: Aquí en la provincia. ([Madre: 15 de noviembre uk kunaw (eso es…)… sí 15 de noviembre sas (diciendo)……] su fecha de nacimiento pero el año ya no me recuerdo).

KG: Pero más o menos 75 años tiene.

V: 75 años tiene.

KG: Y entonces todo… siempre ha vivido ahí en la provincia, y siempre se ha dedicado a…?

V: Al ganado, chacra, todo eso.

KG: Y tiene… tienes hermanos?

V: Sí tengo hermanos.

KG: Cuántos?
- somos hartos. Una docena de hermanos

V: Docena?

KG: ahá (sí).

V: Y cuéntame, cómo se llaman y cuántos años tienen?

KG: Mis hermanos tienen… otro mi hermano mayor tiene 50, el otro mi hermano tiene 47, el otro tiene 44, 40, 38, algunos así, …sucesivamente hay, el otro 30 y yo estoy sobre ahí, 34 …si.

KG: ¿Y la más joven?

V: Más joven es mi hermanita tengo de 24. (mamá: Ella es cholita igual también… cholita hay…)
Igual de 24 años tiene, la menor, ella es más menorcita, (mamá: joven… jovencita) es jovencita.

KG: ¿Y dónde viven entonces?

V: En el Alto viven (mamá: todito viven al Alto)

KG: ¿Y tus hermanos?

V: Si, están trabajando, otros en el Alto… mi otro hermano trabaja en el Chapare Santa Cruz.

KG: ¿Y qué hace ahí?

V: El hace… Escuela de Naval ha estudiado es suboficial, entonces en ahí trabaja, está en el cuartel.
Es un hermano que hace… Único que está así. Otros mis hermanos trabajan, otros hacen negocio, venden, compran… en el Alto.

KG: ¿Y tienes hijos?

V: Sí, yo tengo hijos, dos hijitos.

KG: ¿Y cuántos años tienen?

V: Mi otro hijito tiene 14 años, el otro tiene… el otro menorcito tiene 4 añitos.

KG: ¿14 y 4?

V: ahá…

KG: A qué bien, hay una diferencia grande. ¿Entonces están en la escuela?

V: Están en la escuela.

KG: Y viven … dónde?

V: En el Alto.

KG: ¿Viajan contigo?

V: Sí, el otro chiquitito… está todavía, no está en la escuela. Aquí reciben cuando tengan 5 añitos… reciben a la escuela, pero los otros… le dejo con su papá que trabaja aquí siempre, entonces yo vengo aquí, estoy aquí una semana, me viajo así estoy.

KG: Y qué hace tu marido? ¿En qué trabaja?

V: En carpintería, muebles hace igualitos.

KG: A qué bien. ¿Entonces él se queda en El Alto?

V: Con mi hijo.

KG: ¿Y tú?

V: Yo viajando vengo, cuando estoy aquí a veces me vendo algunas cositas… frutitas vendo a veces también cocino comidita… me vendo, otras cositas gelatina, así.

KG: ¿Y qué más?

V: Eso nomás… gelatina, refresquitos de durazno, de manzana, preparo eso.

KG: Porque de partería, de atención al parto no recibes nada de dinero, o ¿sí te pagan?

V: Sí, sí cuando claro atendemos el parto, nos pagan, nos pagan las señoras que se hacen atender, su esposo, están toda su familia… nos pagan. Siempre estamos con mi mamá así

contacto entre nosotras… mi mamá como es de edad más experiencia tiene, un poco como recién estoy aprendiendo también, ya le he visto como es, he vivido como dices la vida enseña así ¿nové?, poco a poco ya estoy aprendiendo, entonces mi mamá tiene más experiencia, entonces los dos vamos ahí a atender.

KG: ¿Juntos? ¿Juntos siempre?

V: ahá (sí)

KG: Bueno entonces ¿Cuándo empezaste a atender partos con ella?

V: Yo ahorita estoy como 8 años algo más o menos nomás. Mi mamá está como 40 años atendiendo los partos.

KG: ¿Y cómo decidiste, o por qué empezaste…?

V: Empecé realmente… mi mamá como sabía… yo le visto pues, entonces una vez aquí, estaba en aquí, una señora estaba con su barriguita y me dice, me duele tanto que esto que me cuenta pues, yo le he dicho eso es para acomodar, cuando la guagua está mal acomodado, entonces hay que acomodar, por eso vas a estar bien diciendo, ahora no conozco a nadie, entonces, yo le digo, mi mamá sabe pues, está en viaje está en provincia le digo. Entonces quién puede frotar no tengo a nadie, no le conozco, ella está creo que en Santa Cruz, creo que en Santa Cruz había vivido también, ha venido aquí, yo le dicho yo te voy a frotar, voy a ayudarle a usted a acomodarle a su bebé le dicho. Cuando yo he ido un día, pues ahí me he practicado, entonces ahí como mi mamá ha dicho así, así le he acomodado, una cremita que tenemos, con esito (eso) más. Después ya, al día siguiente me he encontrado –ya estoy bien, bien me has acomodado, estoy tranquila me siento- me dice. Está bien le digo, entonces, ahora. –Otro más me vas a hacer, un tiempito me voy a quedar, otro más para que nazca mi hijo- diciendo, ya diciendo. Una vez más he ido. De ahí en ahí…

KG: ¿Y eso era en la provincia?

V: En aquí, en aquí, todo en El Alto. Una semana más… 2 semanas más me quedé aquí, de ahí me dice, hasta que nazca mi hijo por favor me dice, porque yo no quiero el doctor, doctor seguramente me va decir cesárea me dijo pues, entonces –ya le dicho- una vez más le froté, cuando después de unos cuantos días, ya había tenido y más tranquilo, más fácil; desde ahí me dijo, usted había sabido bien frotar, me ha acomodado mi hijo bien en su lugar, facilito he tenido el parto me dice, lo había tenido más rápido. Así, así entonces cuando viajo a provincia siempre está hay. En la provincia hay señoras que están embarazadas. Otro también que he ido, a su pueblo de mi esposo es más lejitos, más otro ladito, entonces ahí he ido. Cuando en ahí también una señora, estaba así con su… esperando el bebé, igual andan pasteando oveja, y yo le digo –tanto te cansas y cómo así vas a andar- le he dicho; -sí estoy cansada, me duele tanto- me dice, ya, te frotaré, yo sé le dicho pues, ya diciendo, le frotado cuando, ella me dice –estoy bien-

diciendo, después otra vez he viajado. En su provincia he llegado igualmente, después de 2 semanas igual su hijito había nacido bien tranquilo nomás también. Y así sucesivamente. Después ya aquí igual ya. Ya me buscan ya, usted sabe hermana, ven pues, esa cremita también nosotros que hacemos de la plantita, de la medicina, entonces eso más, eso me llevo siempre para frotar como los doctores ponen una cremita para sacar ecografía ¿nové? Igualito nosotros con eso calentamos, le frotamos, le acomodamos, entonces siempre están buscando esa cremita también así.

KG: ¿La crema de qué es?

V: De, digamos, todo de natural, de romero, de coca, está preparado del este… andres huaylla (planta medicinal) que hay aquí las hierbas, (madre: es plantita) eso.

KG: ¿Es qué?

V: Andres huaylla decimos las hierbas que tienen nombre bonito ¿nové? Con eso todito, cosas que calienta al cuerpo, así preparamos.

KG: ¿Qué es la grasa que usan?

V: La grasa es vaselina sólida, en (de) la farmacia, eso compramos. Con eso hierba preparamos. Eso es más lindo, el dolor que hace calmar, todo eso.

KG: Entonces esto de frotar es… ¿cómo se hace?

V: Eso es fácil… (madre: con esto frotamos)

Madre: Esto es pues.

KG: Ah… ¿me permite oler? Ah… Huele lindo.

V: Muchas gracias (madre: Gracias) muchas gracias.

KG: Bueno, entonces, nada más empezando con una experiencia, con una hoguera en El Alto y ella dijo que tienes talento mas o menos. ¿Y de ahí siempre te han buscado?

Madre: sí, sí siempre han buscado

V: Sí me buscan siempre, yo siempre voy, me dicen estoy mal, ya entonces con eso también… frotando, también parche preparamos, parche cuando colocamos ¿nové? Entonces parche también de lagarto puede ser, hay unas hierbas que son melosos con miel de abejas preparamos parche, con eso parchamos también cuando están lastimados, otros digamos se caen, o cualquier accidente le pasa ¿nové? Entonces con esito (eso) le parchamos, con coquita más se le

parchamos, entonces eso le saca pues afuera la lastimadura nové que tiene adentro, que es moradito, así tenemos cuando chocamos por lo menos, esito le sacamos, y afuerita le sale ya.

KG: No entiendo, ¿qué es? ¿Qué hacen?

V: Un parche, al cuerpo colocamos, digamos preparamos de las hierbas pues, entonces como los doctores dan unos calmantes dicen ¿nové? –toma tu pastilla eso te va a calmar- dicen. Igualito nosotros pero, ya no pues con pastillas, solamente es con hierbas, entonces le parchamos le colocamos tal lugar, entonces te absorbe hacia afuera, ya te saca, entonces ya te sana, con esa cremita más, ya estás sanita. Adentro también esos matecitos, así, se toma andres huaylla, molle, ruda, son calientes, tomas y te limpia también pues, en vez de la pastilla todo eso, nosotros todo eso utilizamos en el campo más que todo no hay doctores, están lejanos, no hay ni posta, hay postas de salud centros de salud, pero está pues a 2 horas, 3 horas de viaje, y hasta ahí que aguante el dolor el enfermo no puede aguantar.

KG: ¿Y tiene que pagar también en los puestos médicos? ¿O no?

V: No, no, es claro… los otros pagan, pero los otros así digamos control prenatal no pagan pues, es gratuito ¿nové? Entonces ahí…

KG: Pero a veces es demasiado lejos, no?

V: Lejos es pues, no se puede alcanzar, entonces nosotros ya como sabemos, preparamos en la casa todo eso, calentamos, hay nomas le hacemos tener su bebé, eso sería. Entonces los… digamos cuando hay centro de salud que hay más cercano también a veces los partos no son pues cualquier, no es programado el día ¿nové? Siempre varía un día adelantado, otro día atrasado así siempre, entonces, hay ya, cuando así cualquier rato agarra entonces a veces hasta el día domingo, sábado entonces está cerrado el centro de salud, ya no están los doctores, a veces vienen aquí a La Paz así, entonces nosotros nomas siempre estamos ahí atendiendo los partos.

KG: ¿Y cómo calculas cuándo va a nacer el bebé?

V: Digamos, frotamos, pero así cuando ya más caliente está, está calentando la mamá, está traspirando, entonces ahí nomas nosotros calculamos, estamos atentos así, espaldita mas, entonces clarito es el bebé que está bajando así, hacia abajo, entonces…

KG: Entonces saben bueno ¿en una semana o 2 semanas o algo así?

V: No, digamos cuando falta una semana… digamos clarito es, hasta sus venas está un poquito calmadito… calculadito nomas de la vena nomas nosotros agarramos

Madre: yo también igual calculo de la vena nomas.

KG: Interesante, calmado como…

Virginia a su madre: aymaratat jum mamit parläta, jiskht'äta = tú mamita hablarás y preguntarás en aymara). Ah, (sí), así pues. (Anchhit nay invitar jup juparurak parläta = ahorita yo le invitaré tú le hablarás también) Así nomas.

V: Cuando la vena está más calmadito, entonces la carita también está pues medio morado, sus ojitos todo eso, nosotros hay nomas, entonces cuando, ya su estomaguito también... el este ya… bien delgadito es, como un nylon así se vuelve pues, entonces ya vas a tener para esta semana, o cuando, mañana pasada será, entonces ya le así calculamos más o menos entonces ya, ya dice pues, ya pasando 2 días un día ya esta pues la señora que está mal, nos dice ya estoy yo con parto, así nos hace llamar, entonces vamos, entonces le atendemos así, mas antes le frotamos un poquito, matecito le damos, matecito de romero diciendo, matecito, esito, sino manzanillita nada más eso, se toma… después, chocolate también es bueno, es caliente y calienta más rápido, hay otro también del este… del… aquí decimos zapallo no sé, aquí zapallo decimos una verdura, entonces su pepita más, esito (eso) le tostamos le molemos como un café, como un café hay que preparar.

KG: ¿Zapallo con café?

V: Como un café, eso hay que tostar su pepita nomás, hay que tostar después hay que moler y con aguita (agua) le echas calientito, después ya está, esito hay que tomar, entonces eso ya, para que tenga rapidito.
KG: ¿Entonces esto empieza… que ayuda a qué…?

V: Ayuda a la fuerza, al dolor, un poquito que… más que todo al frotar le acomodamos entonces ya no tiene mucho dolor ya, el paciente, entonces hay nosotros con esos matecitos que le damos, entonces ayuda pues, nosotros también le frotamos, le calentamos que no esté enfriándose, respirando, respirando, hay nomas nosotros le atendemos. Cuando ya tiene, entonces le damos también así un calientito chocolate, hay que dar porque también, aquí dentro ya pues, nové, sangre todo eso tiene que limpiar, hay un matecito también, en el campo hay todo eso, recogemos, con esito le damos, que limpie su estomaguito así, entonces así le cuidamos, le damos también almuercito, que almuerce, una cenita en la noche, así, eso todo que atendemos a los partos.

KG: ¿Y después del parto, qué sugieres que coma la madre, o que no coma, qué debe hacer, qué no debe hacer?

V: Después del parto, sería, nosotros en el campo que tenemos ganado y oveja, esito le cortamos pues, su sopita le damos, le sacamos su grasita, todo sopita y chuñito, nada de cebolla ni zanahoria, ni papa nada, solo que un poquito de arroz y chuñito esa carnecita nomas tiene que comer toda una semana, o dos semanas tiene que estar comiendo, sin tocar ni agua, tiene que abrigarse, ni salir al sol, si sale sobreparto le agarra dicen, es más enfermedad que, hasta le mata

a la madre nové, entonces, esos consejos le damos, te vas a cuidar entonces se tiene que cuidar del frío, del sol, no tiene que salir una semana tiene que estar en el cuarto así, cuidándose.

KG: ¿Y de bañarse, puede bañarse directamente?

V: Bañarse, después de un día, de 2 días, bañamos con un matecito calientito le bañamos.

KG: ¿De romero?

V: De romero, de romero siempre, a veces también otros con manzanilla se baña, esos son calientes, entonces con esito bañamos, al bebé igual con manzanilla le bañamos.

KG: ¿De uno o de 2 días después del parto puede bañarse y mientras tanto sólo puede comer…?

V: Sopita, y nada más.

KG: Y no debe salir al sol.

V: A sí, ni sal… tanto… sopita, ni zanahoria, zanahoria también a veces colocamos, otros se colocan, cebolla si no, no se utiliza.

KG: ¿Y cómo hace con el cordón umbilical que se amarra al dedo del pie, hacen esto?

V: No, no, no, otras parteras dice que practican así, pero nosotros no, el bebé cuando nace entonces ahicito (ahí) bajamos, le envolvemos así mismo, entonces esperamos un ratito unos diez minutos hasta que salga su placenta, hasta que salga su placenta por eso un matecito también hay que dar para que le esté limpiando, o le dé más fuerza, que empuje más rápido nové, entonces ya tiene placenta y al bebé le bajamos, la placenta también le apartamos así, otros las placentas se guardan porque eso también medicina había sido, para…

KG: ¿Y qué hacen con la placenta?

V: Le lavamos, le secamos, le secamos y eso es medicina para, que dicen otros, en el campo hay especialmente khari khari (khari khari = saca grasa del cuerpo humano) le decimos, otros dicen lik'ichiri (lik'ichiri = saca grasa del cuerpo humano) diciendo, entonces eso es cuando se enferma así una familia nové, entonces esito le hacemos tomar, le sana.

KG: Entonces, después de secarse como… ¿qué se hace para usarlo como medicina, se corta no sé?

V: Sí, se corta así chiquitito, pero hay que guardase ya en un frasquito se guarda, cuando uno está mal, entonces con eso también nos curamos.

KG: ¿Cómo, qué tipo de enfermedad es?

V: Esas enfermedades que cuando… digamos la gente se enferma como decir, kharisiri (deriva de khari khari = saca grasa del cuerpo humano) diciendo en el campo, en el aymara dicen kharisiri, cuando el (a la) gente, en el auto, en cualquier lugar que se duerme, entonces, digamos ese kharisiri que le agarra nové, la gente pues cuando esté vomitando, con diarrea, todo está entonces todo mal entonces, le hacemos tomar y le calma y le sana, un tratamiento le hacemos, un mes tiene que ser sin tomar tampoco gaseosas, coca quina, ni coca cola nada de eso, entonces así también se sana. Para eso también se guardan, esa placenta es bueno.

KG: Tengo una amiga en los Estados Unidos y sus amigos y sus amigas hicieron lo mismo con la placenta, pero no sabía por qué entonces, parece que hay muchas tradiciones que usan la placenta para algo, para curarse. Bueno, y ¿cuándo cortan el cordón, después, inmediatamente o después de que se deja de latir o…?

V: Después, cuando… ya su placenta más ya ha nacido entonces ese rato cortamos, el cordón.

KG: Entonces, ¿cuántos partos ha atendido?

V: Yo más o menos he atendido unos 6, 7 partos, algo por ahí nomás también.

K: ¿Y había problemas?
V: Especialmente que he atendido, casi no, son jovencitas, jovencitas casi un poco no, cuando uno ya tiene un poquito edad eso sí un poquito tarda en tener porque, su cuerpito su digamos el cuerpo resulta endurecido, está bien endurecido, entonces cuando son jovencitas son ágiles, todo así acomodamos, más rápido tienen pero cuando son de edad un poquito sufren en tener su bebé.

KG: Y entonces, ¿cuántos años tienen las madres, cuántos años tenían?

V: Desde que he atendido más o menos 25 años, otros que he atendido 30 años así, 26 así más o menos otro que he atendido primera vez que he experimentado en ahí, tenía 35 años la señora. Su último bebé dice que va a tener sus hijos tienen dos jovencitos, entonces ella ha tenido su último hijito, una mujercita era. Pero como ya también sabe tener entonces fácilmente… los que tienen primerito siempre hay se sufren, porque otros ya tienen 2, 3 hijos entonces tienen nomás normal aunque tengan 36, 40 años, tienen normal nomás, pero otros que no tienen, primera vez que tienen, esas sufren, cuando son más jovencitas son también rapidito, su carne su cuerpo son suavitos (suavecitos) así, siendo joven siempre todo hacemos.

KG: ¿Y cuántas de ellas están aquí en La Paz o en El Alto, cuántos están en la provincia?

V: En la provincia he atendido 4 aquí 3 nomás. Aquí en El Alto 3.

KG: ¿Entonces hay muchas mujeres en El Alto que prefieren quedarse en casa en vez de ir al…?

V: Sí, prenatal, de hacer hacen prenatal, pero cuando… al tener, otros tienen en la casa nomás, mayormente quieren en la casa, porque el doctor en allá yo he visto, una vez mi cuñada también de mi esposo su hermana, ha tenido después he visto, temblando lo tienen, entonces cuando ha tenido, ella no ha tenido normal con cesárea ha tenido, porque era mayor, con sus 38 años ha tenido su primer hijito, entonces yo le visto, al hospital he ido. Entonces siempre cuando voy al hospital así están las mujeres todo así votados, no lo atienden rápido, gritando, pero mientras en la casa nosotros rapidito lo atendemos, la atención le tomamos a ella como no hay otras pacientes, a ella tenemos que atender, porque en el hospital son vaRíos las mamás uno y otro están teniendo, entonces la atención es un poquito este… se olvidan, de eso más que todo las mamás, casi no… me da miedo, al tener así me jalan, me alzan a todo lado, ese rato me duele, entonces no quiero dicen, de eso otros quieren tener en la casa nomás , aún cuando sea a pesar que ahora el gobierno dice que, Juancito no sé qué cosa… Juana Azurduy dice que le paga a las mamás cuando tienen ahora recién nomás a salido esa ley también, ni eso no quieren porque prefieren tener en la casa nomás; por la mamá que tiene prenatal dice que va a dar 200 bolivianos, ni aún así, pero ni aún así no quieren porque es… los doctores me gritan, cuando estoy con dolor ay… ay así le estoy gritando, -aguántese pues, para qué ha dormido con marido usted- así me grita dicen, así, de eso ya no quieren las mamás, ahora ojalá dicen las parteras que atienden hospital, dice que bien sería también de una parte ¿no? Otros que quieren que le atienda la partera otros quieren el doctor, bien también sería yo digo. Así nomás atendemos nosotros.

KG: Entonces, ¿has tenido a tus 2 bebés en el hospital o en la casa?
V: Yo en la casa nomás.

KG: ¿Con tu mamá o…?

V: Con mi mamá nomás también. Todas mis hermanas han tenido con mi mamá también. Estamos bien nomás también.

KG: ¿Y sin problemas?

V: Sin problemas, sí.

KG: Y entonces ¿por qué tienes que… has tenido que ir muchas veces al hospital?

V: Si cuando… a hacer prenatal, hacer controlar.

KG: ¿Entonces vas con las madres a hacer prenatal o para tus propios mates?

V: Yo he ido prenatal, pero a las mamás siempre recomiendo también –andá hazte ver, tienes que ir siempre a prenatal, después qué te dice el doctor, entonces yo te voy a acomodar también, yo también te voy a ver cómo está- le digo pues, entonces ellas van también, porque eso también controla cuando ya ha nacido su hijito, el papel de prenatal controla también los doctores –dónde

está que has hecho el prenatal, te lo voy a registrar a tu hijo- dice, entonces para eso es importante que vayan las mamás, entonces yo de dónde vas a preguntar, ahora qué es lo que dice el doctor, a mí igualmente me decía cuando hacía el prenatal, entonces, -de tanto tiempo usted está teniendo, de 10 años mirá, cómo pues de usted va a ser cesárea- me dice pues, yo ya nomás le digo, claro yo ya sé cómo es a mi hijito le voy a hacer acomodar, ya entonces caminaré, yo mismo cuento pues, como yo sé, entonces caminando, al último me dice –está a un lado tu hijo, ahora no sé, vas a tener que caminar harto- me dice, ya le digo también; trabajaba también esas veces en una empresa en tejidos hacía pues, trabajaba entonces, yo caminaba así, entonces como mi mamá sabe también entonces me frotaba también, otra vez al último mes he ido a la posta centro de salud, entonces me dice –qué ha pasado señora, tu hijo está acomodado- me dice, sí he caminado pues doctor, le digo nomás también, entonces -cuando va a estar completo va a venir aquí va a llamar nomás a este teléfono- me dice, cuando, una mañana me ha agarrado el parto, y entonces tampoco ha tardado, rapidito también he tenido, como me ha frotado mi mamá, con esa ayuda también he tenido, no era tanto problema, siempre con experiencia, con eso le recomiendo a las mamás, le pregunto cuando está embarazada, como estás, te duele, otros cuando está un lado el bebé, nové, entonces su piecito se hincha así, otros me dicen me duele este lado, otros me duele la espalda, así me duele, entonces –te frotaré- le digo, ahora mismo ayer una señorita una hijita tiene ella igual está mal de 6 meses, entonces igual me duele, me dice, entonces en la tarde te voy a frotar porque abajo mañana voy a ir, entonces voy a venir le dicho, entonces te voy a llamar, a veces ellos llaman a veces yo también les llamo –cómo estás- diciendo les llamo entonces me dicen –estoy bien, o estoy mal- así, voy pues a visitar así, así nomás nosotros trabajamos.

KG: Y entonces ¿qué hacen las mujeres en la provincia, pueden hacer el control prenatal también o no?

V: Sí… algunos, algunos que otros van porque, como te dije que es un largo viaje, entonces tampoco ellos pues tienen sus ganaditos, tienen sus bebes también, otros que tienen así seguidito tienen nové, chiquitito otros de así tienen pues, entonces, eso no hay quien dejarles, de ese modo ya no van pues, ya se olvidan, están con su barriguita hay nomás, otras también cuando están cercanos, van también al prenatal.

KG: ¿Pero tú vas a nada más a ver cómo están y, a veces haces tú como un tipo de control para ellas…?

V: Sí, sí, sí, hago también, porque están cuantos meses están entonces, ellos saben también tantos meses, -de esto vas a estar bien, así te vas a cuidar- recomendamos pues, le hablamos, así nomás es diciendo, le hablamos entonces, según a eso también ellos se cuidan, entonces nos preguntan cómo es nosotros que hemos pasado ahora a lo menos, 3 años que estamos pasando cursos, nosotros hemos pasado también, según a eso también las hermanas sus experiencia que nos ha contado siempre un diálogo que hemos tenido, hemos pasado cursos entonces, sus experiencias que nos cuenta yo he aprendido de esos un poco más, yo les digo así nomás es, otros también me dicen así era mi abuelita, mis abuelitos así se cuidaban, así era, me dicen también las señoras,

está bien como te han dicho, cuídate así como te va resultar le digo también, entonces se cuidan por ahí nomás, al ver cuando vamos a frotar, entonces su bebé está bien nomás, más que todo de venita agarramos, su carita le miramos cómo está así, más que todo de vena se pesca bien nomás, está latiendo su bebé o no, así, cuando le preguntamos cómo está se mueve o no, otros también (dicen) ya no se mueve, entonces quiere decir que está mal su bebé, entonces le mandamos –andá hazte ver, andá hazte sacar ecografía- así.

KG: Entonces, ¿en cuáles situaciones mandas a ver al médico?

V: Cuando ellos dicen, -no, mi bebé ya no se mueve, ya no siento ya cómo se mueve, porque cuando está su bebé moviéndose a todo lado estoy bien nosotros también le tocamos, entonces está bien nomás, entonces cuando no se mueve –andá hazte sacar ecografía, hay vamos a ver qué es lo que te dice el doctor, entonces con ecografía también se ve si está bien o está mal, algunas mujercitas su bebé… cuando son mujercitas casi no se mueve mucho, si son varoncitos se mueven a todo lado, eso nomás nosotros charlamos de aymara, bien hablamos pues, así nomás nosotros practicamos.

KG: ¿No has tenido dificultades con partos, nunca has tenido que mandar alguna madre al hospital durante el parto, por ejemplo?

V: Hasta el momento no, tal vez otros, pero no, está normal nomás, tranquilo han tenido.

KG: ¿Nunca has tenido problemas con demasiada sangre o que están en una posición mala, o algo así?

V: No, porque desde 4… 5 meses hay que acomodar, ahí ya crece, a su lugar ya crece, ahora mientras cuando otros se hacen acomodar digamos últimos meses ya no se puede tampoco, pero aún así, acomodando, acomodando hacemos nacer nomás también, sí porque ahí dicen los doctores –ya cesárea nomás ya, para cesárea- rapidito levantan pues, he visto en el hospital así a veces voy también a visitar a los familiares, voy también, entonces ahí he visto también así.

KG: En la provincia, ¿Cuánto tiempo… dónde está el centro de salud si necesitas mandar a una madre al centro? ¿cuánto tiempo va a durar para que llegue…?

V: Para que llegue, 2 horas y media más o menos 3 horas porque hay 2 centros más, uno a este lado, otro a este lado, entonces el otro queda más lejos el otro un poquito más cerca, entonces 2 horas y media siempre tiene que tardar.

KG: ¿Y qué tipo de transportación hay?

V: En el campo casi no hay mucho, donde yo vivo pero hay en otros lugares que hay también otros más cercano, también cuando están los doctores en el centro de salud, hay ambulancia, con eso van, pero donde yo vivo son… más lejanito que mi pueblo, entonces no siempre … a lo

menos que mi mamá ha atendido no ha mandado a ningún centro de salud, mi mamá también tiene harta experiencia tiene, así nomás, no ha mandado, normal hasta, una señora que se ha muerto en el estómago su bebé, igualmente le hemos hecho tener. Eso es más riesgoso nové, entonces nosotros hemos atendido nomás, más que todo a nuestro señor nos oramos siempre, fe al Señor hay que tener también al curar, entonces igual nomás sabemos hacer tener porque, hasta mandar ir a Colquiri, tampoco no hay taxis nada pues en ahí en ese pueblo, entonces no pues, arriesgaremos por lo menos tenemos fe al Señor nada más orar, por favor siempre pedimos, entonces también nuestro Señor escucha también cuando tienes fe, tú tienes fe entonces te escucha también bien, a El nomas nosotros entregamos también, mediante de vos vamos a curarle, tú me vas a dar tu mano siempre yo le digo, entonces se salvan nomás también, tampoco es… estar mandando al doctor, hasta mientras por ahí le pasa algo entonces va decir también –ah ella ha mandado, ella le ha hecho matar, ella ha hecho morir, tanto así… mejor hay que evitar eso, nosotros tenemos eso, como es lejos también. Otras provincias cercanos también es pues, entonces ahí va la ambulancia pero cuando están los doctores, así nomás nosotros pasamos la experiencia en la provincia.

KG: En los hospitales, ¿Por qué las mujeres no quieren ir ahí, porque no quieren cesárea, cuáles son las razones para que no quieran ir?

V: Porque, mayormente es por la cesárea y otros dicen mucho me riñen (los doctores), me dicen tantas cosas, me da miedo dicen de eso no quieren, como decir, una señora me cuenta –para qué duermes con tu marido, aguántese pues- así como le dicen, entonces de eso tanto miedo así nos dice yo prefiero tener en la casa, otros también quieren más limpio así pues dicen, está bien así de limpio, higiene claro tienen, pero a veces cuando con el frío le hacen pasar eso, cuando tienen bebé todos sus cuerpitos sus venas están abiertos nové, entonces al tener bebé con el frío hacen pasar otra enfermedad sobre parto le agarran están enfermos las señoras cuando tienen, otras por evitar así también están en la casa nomás lo tienen, por eso mayormente dicen –prefiero tener en la casa- dicen, así nomás nos cuentan también, de esas experiencias que tenemos.

KG: Cuando vas a atender, a mujeres en 2 lugares, en el campo, en El Alto, ¿Qué llevas contigo, qué cosas?

V: Nosotros llevamos, guantes, después toallitas, toallas higiénicas, llevamos, para cortar su cordón llevamos gillette llevamos, alcoholcito (alcohol) más con eso desinfectamos, después algodón llevamos, algodón para limpiar, tapar su cordoncito, hay le envolvemos, le tapamos, así, eso llevamos, nuestro material.

KG: La primera cosa que dijiste, ¿Banda?

V: Toallas higiénicas, toallitas también para limpiarnos, guantes también para cuidarnos, para colocarnos, para manejar. Eso también después nos llevamos… barbijos también nos llevamos.

KG: ¿Y los guantes que usan son desechables?

V: Desechables son, desechables son, de la farmacia nos compramos también, así nos llevamos.

KG: ¿Y esto…?

Madre: en la farmacia hay…

V: En la farmacia hay eso para comprar, eso hacemos nosotros, para nuestro cabello tenemos, entonces eso nos ponemos también, así nomás atendemos.

KG: ¿Y los curso que has hecho?, cuéntame sobre esto.

V: Los cursos que hemos pasado, nos ha hecho practicar igualmente, cómo hacen ustedes y, cómo han atendido todo eso así, entonces nosotros una señora que está embarazada le practicamos.

KG: ¿Y fueron cursos de… con una organización o con el Ministerio de Salud?

V: Con el Ministerio de Salud, de medicina natural, de las parteras que dice.

KG: ¿Y cuándo fue esto?

V: Esto, el año pasado se ha llevado pues en junio, en abril, después en diciembre.

KG: Entonces este año…?

V: Este año después recién en abril va empezar todavía.

KG: ¿Antes de hacer estos cursos has usado también, guantes, barbijo, todo esto o es nuevo?

V: Primera vez no he usado tanto eso, pero después de eso hemos pasado curso, ya hemos usado también, sí, porque, tampoco no, nosotros casi mucha experiencia tenemos, primera vez yo, no tenía mucha experiencia, porque mi mamá antes antes que atendía yo sé ver a mi mamá, entonces de eso yo así nomás también yo he atendido, nada de usar nada. Entonces después que hemos pasado curso, hace 3 años que he pasado, estamos pasando ese curso, entonces ya tenemos todo material así completo casi; después mi mamá igualmente, porque antes así nomás se lavaba su manito con jaboncito, jabón es más desinfectante nové, entonces con eso nos lavamos, entonces ahí (así) nomás atendíamos también todo limpiecito, su camita hay que alistar bien limpiecito, pañal… así nomás atendíamos, ahora más que todo ya, después que hemos pasado esos cursos, prácticas que hemos hecho entonces, nos… hemos comprado, algunos también del Ministerio nos ha regalado algunas cositas entonces con eso ya hemos practicado, ya hemos atendido.

KG: ¿Qué usas para cortar el cordón?

V: Gillette, ese Gillette… dice eso para cortar, Gillette nové. Otros en el campo casi con vidrio cortan (Madre: con Gillette)

KG: ¿con vidrio?

Madre: con este, Gillette, con este... Gillette, Gillette utji (utji = hay) nové…

KG: Que hay uno como…

V: Del plato… cerámica…

KG: ¿O de hueso…?

V: No, del plato… del barro está hecho en el campo entonces ese plato rompen, filito sale entonces con eso, hay que desinfectar con alcohol con eso también se puede cortar. Gillette nosotros también utilizamos pero, no tanto, hay que desinfectar con alcohol con algodón se limpia así, con eso cortamos.

KG: Las mujeres de aquí en El Alto, cuando van al control, ¿van solas o vas con ellas a veces?

V: Ellas van solas, con su esposo otros acompañados con alguien… van solas, después cuando ya están en la casa me llaman, entonces yo les voy a ver, así –cómo estás- -así así me dice el doctor-, entonces está bien -cuídate nomás- le decimos también, cuando está mal -así dice que está mal acomodado mi hijo- dicen entonces, te arreglaré, te frotaré, entonces con un mantel le hacemos mover… le manteamos, un aguayo grande, un poncho le ponemos ahí, le manteamos también.

KG: ¿Y cómo a… cómo es con 2 personas en cinta…?

V: Solita nomás, le agarramos así, al otro lado le agarramos así le hacemos, ese unita nomás con un mantel se hace también, así.

CLETA CALLE CALLE

V: Mamit siw (mamita, dice…) kun satätas jumax sasaw sis jiskht'am (cómo te llamas dice que te pregunte)

C: Nayaxa Cleta Calle (yo, Cleta Calle)

V: Kunapachas nasta, kawkins nasta uka (¿cuándo has nacido, en dónde has nacido?)

V: Provincia Pacajes, Provincia Pacajesan nasta, ukat pero, janiw amtasktti kuna ficha nasiminto amtasktti (Provincia Pacajes, he nacido en la Provincia Pacajes, pero no me acuerdo en qué fecha, no me acuerdo) 26 de abril
-26 de abril, jan amtasktti, año jan amtasktti (26 de abril, no me acuerdo el año no me acuerdo)

V: Año jan amtasktati (no te acuerdas el año)
-¿Te lo traduzco?

KG: ¿En qué año?

V: El año no se recuerda, solamente la fecha de nacimiento, 26 de abril.
-Mamamax jiwatat jakaskichi

C: Jiwat mamajas jiwat tatajas jiwat kun (mi mamá y mi papá están muertos, todo están muertos).

V: Ella dice mi padre mi madre han fallecido, no tiene a los dos.
-Jilanitati kullakanitacha (¿tienes hermano o tal vez hermana?)

C: mä jilaniki mä kullakampi kimsaniki (un hermano con una hermana, sólo tres)

V: ¿Están vivos?
C: Están Vivos

V: Qawqha maranis siw (dice, ¿cuántos años tiene?)

C: Naya (yo?) Jani jilanaka kullakama
-Kullakajax niya 68, esterak tiyajan 66, ukhapuniskiw 66, Alejox qawqhachiy sullkachiy mayni peor este… ah sesentapachaw. Jichhaw wawanak apsusk siw. (mi hermana ya tiene 68, también de mi tía 66, eso siempre es 66, cuánto tendrá Alejo, es el menor, ah debe ser 60. Recién está sacando a los hijos).

V:Su hermana tiene 65, su hermano… no su hermano tiene 65, ah 66, su hermano tiene sesenta y… ay estoy mal, su hermana tiene 66, su hermano tiene 60 años, los dos nomás.

K: ¿Y sólo habían los dos?

V: Sí, hermano y hermana. Mi menor; soy mayor. Ella es más mayor, sí.

KG: ¿qué hacían sus padres, a qué se dedicaban? También ganado y ¿dónde vivían sus padres?

V: Kuns tatamax luranx siw (dice qué hacía tu papá)

C: uwij wak awatin ukiy kampun qamana (pasteaba vaca y oveja nomás pues, vivía en el campo)

V: Igualmente dice, del campo, con ganados pasteando con eso…

KG: ¿En el mismo lugar?

V: En el mismo lugar también, sí.
-Qwaqha wawanitas mamit siw (cuántos hijos tienes dice mamita)

KG: Walja wawanit tunka payan wawajax (tengo muchos hijos, son 12 mis hijos)

C: Tunka pusin paya jiwata samañ… (son 14, 2 están muertos dí pues)
-Tunka pusinipi tunka pusin paya jiwat (son 14 pues, 14, 2 están muertos)

V: Ella ha tenido 14 hijos 2 se han muerto, sí… mi hermana mayor mayor siempre Mónica se llamaba, era bien bonita, simpática, ella se ha muerto, sí.

KG: ¿Y de qué se murió?

C: Eso, como te dije el rayo ha caído sobre ella.

KG: ¿Puede contar esta historia?

V: Kuentam chä kunamas uka historia.

C: Uka historiax rayot puriraqatanaw wawajar ukat uk apt ukat resiena ninaw wal aqtix ukat aqtipan uka text'awaytx jiwjawayxipuniw ukat nayar ampar churawayxpachitux. Ukhamay. Ukax ukham ukat wawa qhipat… primer wawapinin qhipat wawanix waljanisa. Waljaniw ukat, suxta, 7… paqallqu imill wawa, pusi lluqall wawa ukhama (Esa historia, cuenta que a mi hija le ha caído el rayo, después de eso la he alzado, recién ardió el fuego, al haber ardido mucho la he dejado, y se ha muerto siempre, entonces a mí me habría dado su mano. Así fue, eso, entonces después los hijos… era la primera hija siempre, después los hijos fueron muchos. Después fueron muchos. Seis, 7… siete niñas y cuatro varones).

V: Ukat qawqhats qullañ qallttax (Después ¿desde cuándo has empezado a curar?)

C: Ukhatak qullañ qalltawayxta. Ukat ukham jaya sarnaqapt mä kimsa pusi pusi phaxsipach puyrisaki amparajax akham wawa usuntanx khitis usuntkanti jan wawa usuntkanti. (Desde ahí he empezado a curar, después hemos caminado así mucho tiempo, unos tres, cuatro meses creo, mi mano así de por sí cuando mi hijo se ha enfermado, nadie se había enfermado, no se ha enfermado el bebé).

V: Janit Gumirsinduki. (¿No era Gumercindo?)

C: Jä Gumersindukit jä ukakit yaqha Germanapachä Lidiapacha usunti ukat kunarak kamach kukitamp… ampar kattwa aka justupak sisxa. Akax chuxripach ukham sarakirisä mamajax yatipinirakiniy qullaña qullapinirakinw aka q'al qullañ. Ukhamatak katuyta. Ukhapachaw sas ukhamp kukit… ukhatak yatiqawayt ampara yas yatxakipini. Kawks yatxakipini istinakas jach'a jaqinakas auto accidentenakas ukanaks yatiqta, uks yatt qullxta. Ukat resienaw parter est tukuwayta, partera. Jaqi ukham jutir qaqit jumax qulliriw sarkmas –qullt'iritpÏ ast parter qaqut yast mayak qaqurita.Ukhama. (No era Gumercindo, no era él, creo que era otro, Germán o Lidia, cuando se ha enfermado ¿qué será? ¿cómo va a ser así? con coca he visto y me ha dicho directo, esto es lastimadura también dice, mi mamá sabía siempre curar, curaba siempre, todo curaba. Así nomás lo he hecho agarrar, eso debe diciendo, así con la coca desde entonces ha aprendido la mano, ya he aprendido. Cualquier cosa sé nomás, por ejemplo personas mayores, accidentes, esas cosas he aprendido, eso ya sé, he curado, entonces recién me he convertido en partera. La gente así saben venir diciendo frótame, dicen que tu eres curandera, sé curar pues, -partera frótame- rápidamente se frotar, así).

V: ¿Has entendido?

KG: No. No aprendo tan rápido.

V: Dice ella, cuando se ha caído el rayo sobre mi hija dice que era una tarde, y a su hija le había alzado ella, un fuego dice que ha ardido, a ella más y a su hija más, como ha ardido el fuego lo ha soltado, cuando ha soltado ya pues, mi hermana se ha muerto, ya se ha muerto, ella después de enterrarlo todo eso una semana, otro mi hermano se ha enfermado, el hermano mayor que tengo, que es policía que te dije nové, él, entonces ella había con coquita pijchándose todo le había curado un poquito, le había tocado dice, hay nomás ya ha captado qué lugar estaba lastimado, clarito dice que es lugar que está lastimado, ha captado, entonces ha curado y le ha hecho sanar, ha su hijo le ha experimentado… harta experiencia ¿no? Cuando ya, una vez otros así señores que venían dice que –sabes curar- diciendo. Esta vez ya he aprendido a curar, después de partera, de mirar de coca, algo también decía su mamá hay que mirar de coca, sí o sea que hay que curarse las guaguas, entonces eso ella ha pensado así a dicho mi mamá, yo voy a hacer igualito entonces desde ahí a empezado su experiencia. El don que le ha dado, ese rayo, el señor pude ser ¿no? Entonces desde esa vez ella sabe bien dice.

C (Traducido): He nacido de pie, mi mamá solía decirme tú serás adivino (yatiri = sabio) serás tal vez curandera, has nacido también de pie, sabía decirme mi mamá, sé adivinar y ver en mis sueños, se soñarme entonces con eso me ha debido señalar Dios, por eso he aprendido a curar.

-C (Traducido): Torceduras de pie y de mano igual fácil nomás arreglo, luxados.

V: Cuando se luxan nové, luxados, también en el campo no hay doctores que… cuando una persona que se cae, algunas personas de edad se caen pues, se luxan, otros también están rajaditos, están pues, hay que masillar, en aquí el doctor masilla, pero allá no pues, mi mamá cura toda medicina natural.

-V: De una señal eres partera ¿no mamá?

C: Uhu (Si).

V: ¿De tu familiar, quién era partera dice mamá?

C (Traducido): En mi familia no había parteras, mi sabía también un poco pero no sabía muy bien, en mi familia no hay ninguno.

V: ¿De una señal ya eres partera nové?

C: Ahá (Sí) A partir de ahí sí.

V: ¿No había en tu pueblo parteras o parteros?

C: Traducido: No había, no había.

V: ¿No había ni en Romero?

C: Traducido: No, no.

V: Este… aquí dice nové hermana, donde dice parteras y parteros en la familia, ella… dice en su familia no había parteras ni parteros dice, ni en su comunidad, nada. Hasta ahí más o menos, ella era la única. Su mamá cuando… cuando ella era chiquitita más antes nové no había dice, entonces no sé yo pienso esas veces como haygan (hayan) tenido sus bebés ¿no?

KG: ¿Quién ayudo a su madre?

V: No sé quién será, una abuelita había dice pero, una ancianita. Ellos nomás antes, no había mucho.

C (Traducido): Así nomás han debido tratar, sin el menor cuidado –te arreglaré un poquito- diciendo.

V: Su suegra de mi abuelita te ayudaré un poquito, te arreglaré por si acaso diciendo, no había más antes.
- ¿Cuántos partos has atendido hasta ahora?

C (Traducido): Muchos, deben ser unos 30, en el campo se atender harto, atiendo a muchas en el campo, uno tras otro vienen, en todos lados. No me acuerdo, no puedo acordarme siempre, luego

hice nacer, después también hice nacer a 4 bebés muertos, niños muertos, son 4 los niños muertos enterrados en el campo, donde el doctor también han nacido, su hija del Lázaro pues, uno de Catalina, otro de la Carmen, otro de Lidia, son 4 siempre.
-Le habré lastimado al bebé en el vientre, habrá muerto, lo he hecho nacer muerto, tiempo estaría en su vientre muerto, lo he hecho nacer muerto, se habrá lastimado.

V: Cuando sus bebés que se han muerto en su estómago mismo, entonces ella asimismo le ha atendido normal dice, otros se lastiman al caer entonces ahí también se lastiman su bebé, a veces también sangrado líquido se vacía, un líquido a veces le tapa al bebé, ha debido morirse, asimismo yo he hecho nacer normal dice, ella, ninguna de las mamás se ha muerto dice. Eso nomás, así.
- ¿Has viajado a las provincias, a los departamentos como partera?

C (Traducido): He ido sólo a Cochabamba, a Oruro, Patacamaya, a las mismas provincias como Callapa, a las mismas provincias, hay muchas provincias, Villque, Comarapa… a varias comunidades, ahí hay que atender, yo sola nomás atiendo en el campo, me buscan, vienen también a buscarme a la casa, me llevan, a veces camino a pie, a Patacamaya voy en auto, al campo en auto también pues. Así es pues. Vienen en la noche, vienen para que atienda en sus casas.

V: Cualquier rato que vienen ellos yo tengo que estar dice, como doctor ¿no? Digamos en la noche, a media noche una de la mañana llegan cuando es el parto que tienen entonces rapidito yo tengo que atender ahí voy dice.
-¿Envías a realizar el prenatal? te dice.

C (Traducido): Antes no había el prenatal, no había el prenatal, el prenatal era sólo frotar nada más con pomada, antes había la grasa de la vaca, con eso se frotaba; recién está apareciendo la pomada.

V: ¿Haces prenatal o no?

C(Traducido): En prenatal sólo froto nada más, froto 3 veces hasta acomodar, yo no les hago hacer ni yo hice, no había eso, no había ni en la posta, cuando yo tuve hijos tampoco iba, para nada iba, después está apareciendo, yo nomás sé frotar, en el campo se frotaba nomás, eso nomás es el prenatal, he dado examen para frotar nové, tres veces se frota nada más. De tres veces se sabe si es o no, ya será el mes diciendo, ya entonces en ese mes vienen para hacer nacer. Puedo estar frotando hasta cuatro veces, otros igual cuatro veces se hacen frotar si es necesario. De donde sea vienen siempre a hacerse frotar como si fuera prenatal.

V: ¿Qué instrumentos utilizas para frotar o para hacer nacer? Te dice.

Cleta (Traducido): Para hacer nacer, antes no había nada, sé lavarme con alcohol las manos y del plato de barro se sacar para cortar el cordón umbilical, y sé amarrar con hilo, con eso nomás, no había antes, ahora más bien ya hay, desde las prácticas que he hecho nos a dado para cortar el cordón, ha aparecido el Gillette, el jabón, antes con alcohol nomás se lavaba todo, había siempre alcohol, así se recibía (al bebé) así era.

V: ¿Entonces das mate?

C (Traducido): Más bien hay mate, había siempre mate, mate de coca, mate de orégano después ya había romero todo quieren son diferentes algunos quieren de romero y otros de manzanilla ¿eso hace calentar al cuerpo nové? Si eso le hace calentar todo el cuerpo y sudar y eso es fácil por eso no sufren sobreparto si eso nomás es con ese matecito pues ¿después hay que frotar? Si luego hay que frotar.

KG: ¿La embarazada puede escoger la posición que quiera, para dar a luz?

V: Este dice mamita, ¿cómo hacen nacer a los bebés, echados, sentados, o sino de espaldas, en qué posición, cómo hacen nacer? Dice.

C (Traducido): A otras hacemos nacer sentados, les hacemos apoyar la espalda a veces les hacemos apoyar la cabeza sobre nosotras, a lo así pujan, de lo echado no pueden algunas, otras a veces de lo echado pueden pujar, la mayoría de lo sentado nomás hacen nacer, a lo sentado se apoyan a lo alto, se agarran, así.

V: Dice ella, en su posición del parto, ella siempre así es, un poquito sentado dice, medio agachadito, no echado, porque echado un poco incómodo es, entonces siempre yo tengo que agarrar de su cabecita, sus esposos les agarra o yo le ayudo dice, le froto así agarradito de algo, en posición de sentadito dice, así, en hospital claro es así… tienes que pujar, más sufres a esto, de esa parte también las mamás casi no quieren tampoco, el doctor me vota en una mesa estoy ahí pujando, no puedo dice, a lo así sentado baja más rápido pues, si estás así echado ya pues te sube arriba, nové, a este lado te sube, más que todo ahora hay sueros que te ayudan también, eso un poquito los doctores que tienen ayuda ¿no? El suero que coloca, con eso te ayudas también, nosotros no, hay nomás.

KG: ¿Y tiene que agarrar nomás la guagua o tienes que, no sé… como a veces como meter las manos así…?

V: No, no, ella dice solamente yo me frotado, froto, acomodo bien, después ellas se agarran bien de la mesa o de la cama ahicito como sentadito, sus esposos ayudan de la cabeza, no sé la cabeza le duelen siempre fuerte dicen, entonces agarran la cabeza, entonces nace la guagua tranquilo nomás, tampoco es meter la mano, jalar, nunca practicamos eso, pero otras practican dicen eso, practican, no es que no también, como dicen mañana va a haber entonces ellos van a decir sus experiencias nové, entonces nosotros especialmente en eso así nomás hemos ayudado a las mamás, ella lo que dice así.

KG: Esto es lo que quería decir con esta pregunta ¿qué hacen con sus manos, dónde se queda usted para ayudar a la madre, en qué posición puede estar la madre? cosas así.

V: ¿Cómo le haces nacer y que haces tú cuando nace el bebé?

C (Traducido): Le sé agarrar, sigue le sé agarrar, no hay que dejarle, si no le agarramos y si le dejamos sigue puede sufrir, entonces de la cabeza hay que agarrarle, aquí hay que hacerle apoyar, después la guagua nace, rápido nomás nace.

V: (Traductora) Cuando nace el bebé ¿cómo tiene que cuidarse?

C (Traducido): Tiene que cuidarse… tiene que comer chuño con arroz, con carne tiene que comer caldito, sin sal, con poca sal tiene que comer caldito, para la leche del bebé, y luego tiene que seguir cuidándose, tiene que seguir tomando mate en la tarde, manzanilla sino romero, el romero le limpia la barriga de adentro nové.

V: ¿El sanu sanu?

C: (Traducido): El sanu sanu, pero es mejor el chachacuma, eso todo le limpia, lo saca los coágulos de sangre, otros toman chocolate, la gente pide todo tipo de cosas, otros dicen eso sé tomar dicen, pero las jovencitas no saben pues, pregunta a las parteras ¿qué es bueno pues? -romero vas a tomar, tomas nomás chocolate también y te vas a cuidar- diciendo, unos 4 días hay que cuidarse, entonces ellas se lavan nomás también, otros a los tres días ya se aburren, así también es.

V: ¿El bebé , en qué momento debe mamar de su mamá o rápidamente…?

C (Traducido): Otros bebés rápido quieren mamar, otros ya a las doce ya quieren mamar nomás también, en la tarde también, cuando no quieren mamar hay que hacerlos tomar mate, mate de anís, para que no tenga dolor de barriga.

V: Ella dice, cuando ya nace es bebé a la mamá hay que decirle que se cuide como dije hace rato nové, sopita tiene que tomar de cordero, de cordero tiene que tomar más sopa, porque a veces otras mamás dice que no tienen leche, más rápido no tienen, entonces una sopita, otras guagüitas dicen que al nacer hay que dar matecito para que a su estomaguito le limpie, porque tiene flemas todo eso, al nacer mi mamá dice que flemita siempre limpia de la boquita, solo que hay que hacer tomar al bebé su matecito después lavarle y después que agarre leche, porque directamente leche dice que dolor de estómago agarran los bebés, entonces las mamás también después de tres días o de dos días se aburren también, incomoda con su sucio nové, tiene que lavarse con mate de romero, digamos sino con manzanilla, dice que le aconseja, otros también más experiencia que tienen, otros tres, cuatro hijos que tienen, entonces ellos ya tienen experiencia, entonces ellos dicen yo voy a tomar tantas cosas, si está bien dicen, mi mamá dice -ya está bien- dice, otras jovencitas recién casaditas no tiene mucha experiencia a ellas dice que le explica, así es pues esto, te vas a cuidar, esos vas a tomar con eso te va limpiar, tu estómago es nuevo, dice que le explica, le enseña.

KG: ¿Y cuál es la razón para no lavarse por 2 días o algo así?

V: A eso sí, es como decir rapidito nace tu bebé el doctor te lo lava rápido ¿no? Sí, pero en la provincia o campo que acostumbran dicen ellos sobreparto, eso afecta a lo más edad, ya tienen bebé después, como las mamás que tienen menopausia, a los 45 años dice queda menopausia esa

enfermedad de sobreparto dice que más le complica, ahí las mamás dice que fallece pues, entonces en el campo más que todo practica, de esito (eso) hay que cuidarse, cuando tu bebé que tienes todo tus raíces tus venas está abierto, entonces, con eso que te lavas se te enfría entonces ahí es donde tienes…todo el tiempo que va avanzar así, cuando con tus 45 años más la menopausia se complica entonces hasta llega a fallecer las mamás, por eso otros que se enferman con reumatismo, con sobreparto todo eso se complica, por eso en el campo mayormente las abuelitas acostumbran lavarse después de dos días, el agua enfría, entonces ahí mismo las enfermedades te entran, depende como está pues… el hospital está pues, ese ratito le lavan así temblando le están sacando de la sala entonces a la otra igual así entonces ahí es que tienen otros hartos las mamás, las señoras, los que he visto, con menopausia, con sobreparto, todo eso se han fallecido he visto sus manitos que se han vuelto medio así, así todo eso, de eso dice que es, entonces eso los del campo practican entonces hay nomás también nos llevamos.

KG: Y por eso también bañarse con agua caliente…

V: Si, con agua caliente, con matecito de romero esos calientitos limpia también, esos, por eso practicamos.
-Mamita ¿Desde cuándo ha cambiado la forma de atender el parto?

C (Traducido): Desde que ha aparecido las postas, desde ahí, desde que hay los doctores en la posta, otros no quieren hacerse curar con el doctor, entonces las enfermeras han buscado a las parteras, una vez han llamado a las parteras, yo he ido ahí en ahí he practicado, dije practicaré más, ahí he ido y me han preguntado eres partera, cuánto tiempo atiendes como partera, ese tiempo ya atiendo dije, entonces, tú necesitas los materiales te vamos a dar, entonces el doctor me dio, el doctor Mario Tintaya me ha dado, tu ya atiendes entonces, estás ciego de los ojos, te vamos a dar lentes, cuando necesites guante, no vas a manejar a las guaguas con guantes le puede entrar enfermedad dijo, después, ¿el cordón con qué cortas? Yo igual le dije con Gillette corto, eso está bien, pero el Gillette con jaboncillo tienes que lavarte, ¿con qué se lavan? Yo me lavo con alcohol, con alcohol me lavo las manos, eso está bien no infecta a los bebés sabía decirnos, ahora con esto van a lavar, nos ha dado jaboncillo, toallita, después con eso van a lavar, bien habían sabido. En la posta nos ha tomado examen, haber frótale a esta doctorcita cómo sabes frotar, y así le frotado, entonces sabes, y nos dieron el material, después de eso ya nos hemos acostumbrado a los materiales, nos dieron las toallitas y los hemos recibido.

V: ¿Desde cuándo has cambiado?

C (Traducido): Recién estoy cambiando, así nomás trabajaba, debe ser el 2005.

V: No debe ser el 2006 o 2007.

C (Traducido): En el 2006 debe ser, cuando estaba joven nové, de ahí en adelante ha manejado, más antes no manejaba, recién estoy manejando así.

V: Dice, atención del parto ha cambiando dicen desde que ha aprendido el 2006 por ahí dice, una doctorita nos ha hecho llamar, dice que en la radio había, entonces ahí ha ido para practicar, y ahí me ha preguntado todo eso, cómo has atendido, cuánto tiempo, después había dicho 30

años he atendido, entonces vos que sabes mucho, yo te voy a dar material, guantes, tijera, cortaúñas todo eso, toallas, porque para atender al parto hay que cortar su uñita de su mano todo limpio, he aprendido hasta el momento tengo el material, y ya he cambiado dice.

(KG):¿De dónde era la doctora?

C (Traducido): De mi pueblo, Callapa, organización es, en la radio he escuchado, que vengan parteras, curanderas, así ha dicho, por eso he ido.

(KG):¿Pero antes de esto, antes de 2005, 2006, de esta capacitación, usted hacía todo lo mismo, practicaba lo mismo?

C (Traducido): Sí, así mosmo.

V: Más antes dice pues ella ha atendido así nomás, nada de guantes, nada de útiles, ni barbijo, porque lente más necesita porque cuanto atiendes dice que a tu ojo hace mal dice ¿no? Entonces ella pues… después de hacer… antes así nomás hacía atendía dice, así normal, lavarse su manito todo así.

V: ¿Cuántos partos difíciles has atendido mamá? Dice.

C (Traducido): A los enfermos más difíciles? Son unos diez, o unos doce.

V: ¿Has atendido complicados, o más difíciles, o a niños muertos?

C (Traducido): A niños muertos, normales nomás pero a los más difíciles hay que llevarlos donde los doctores, sé atender, pero lo que es para llevar al doctor a veces yo lo atiendo, pueden dicen, yo miro de la coca y sabe, puedo poder sé decir, unos eran en la provincia, unos cuatro, eso yo nomás con mis manos, he ayudado de aquí, así así he ayudado por aquí.

V: ¿Entonces ya no has enviado a ninguno al hospital ni a la posta sanitaria?

C (Traducido): No ya no he enviado, miro mi suerte en la coca y, va estar naciendo se decir, ya no tengo miedo por eso. De la coca nomás miro, va estar naciendo diciendo, sino puedo mirar de la coca, puedo decir que se lo lleven nomás, no es para mí diría pues.

V: ¿Entonces esos cuatro muertos nomás has hecho nacer?

C (Traducido): Esos cuatro nomás, otro ha vivido nomás también, era de la Luisita, ha sobrevivido nové, el bebé se había ahorcado con el cordón, después ese bebé casi muerto siempre, el hermano de la Martita, después se ha muerto a la semana o dos semanas nové, de aquí se había ahorcado pues, entre tres o cuatro ha pasado algo parecido, entonces de así sé sacarlo, entonces el bebé sabe revivir gua gua diciendo… sabe llorar, pero a la semana se morían siempre, habrá sido unos cinco, no se enviarlo al doctor.

V: Ella dice, así, estos partos difíciles he atendido dice pero, esos que estaban mal cuando están muertos en sus estómagos nové, es muy difícil entonces, ella dice ninguno he mandado al hospital, porque, ella como mira de la coca, la coca dice es para mí nomás entonces he atendido todo eso, y si me decía la coca no vas a poder entonces yo iba mandar dice, como me dice la coca está bien nomás entonces, yo nomás he atendido, a ninguno les he mandado al hospital ni a la posta dice.

C (Traducido): Otros bebés están ahorcados con el cordón, a ellos los salvo nomás.

V: Otros bien amarrados con el cordón dice que nacen pues, entonces eso rapidito tengo que sacarlo, salvarle dice, porque sino va salvar pues, como no hay hospital cerca entonces no les mando dice. Así.

V: ¿No has acompañado a ninguna al hospital no vé?

C (Traducido): No, yo nomás se hacerlo, cuando quieren ellas, si quieres ir puedes ir nomás les digo.

V: Recién ahora pues, antes no pues.

C (Traducido): Sí recién.

V: ¿a cuántos enfermos lastimados has atendido?

C (Traducido): A los enfermos lastimados, unos seis deben ser los lastimados, así como con la placenta han vivido, frotando, unos cinco deben ser también.

V: ¿A todos los enfermos así, cómo nos podemos dar cuenta, a los que están con la placenta retenida?

C (Traducido): Cuando están con parto, no pueden desembarazarse, no sale rápido, entonces les frotamos, les calentamos , les hacemos traspirar, entonces con eso baja nomás, por ejemplo a una enferma misma, no podía desembarazarse, entonces con miel de abeja lo sacado así, lo he jalado, se había estado dando cuento también, entonces he esperado una media hora, luego rápido a nacido.

V: Ella dice que cuando al nacer dice que la placenta dice que se cuela a su espalda o cuando están por mucho tiempo dice que está su placenta colado, entonces yo le ayudo al calentando, o frotando un poquito más dice que eso hacen rápido, otros también tardan dice depende de la gente, sufren dice, eso pero, hasta el momento a ninguno he acompañado a la posta, ellos han ido ahora recién al Centro de Salud, están intentando algunos pero yo estoy frotando todo eso dice.

(KG):¿Entonces si la placenta no… nazca rápido… por qué es?

V: Porque está colado dice, está más colado en su espalda, cuando durante el embarazo, ellos están en el frío, en el sol, entonces en ese tiempo su placenta se cuela así.

(KG):¿Y qué hace otra vez para que salga?

V: Ella dice que con… dar matecito, entonces calentar, frotando otra vez como hemos frotado al bebé nové al nacer al bebé, otra vez, otra vez tengo que frotarle después la espalda todo eso, hay se suelta ya su placenta dice, eso es hasta ahí nomás.

V: ¿A cuáles de tus hijos has hecho nacer difícilmente en allí?

C (Traducido): El último menor la Hilda, pero normal nomás ha sido, no he sufrido siempre yo, ya he caminado pues nové, he ido a todo lados, se subir y se bajar, normal nomás, no he sufrido nada, ah cuando era del Sabino tal vez, en eso he sufrido un poco, eso nomás he sufrido, normal nomás han nacido, no sé ir al hospital, ni sé hacerme frotar ni parteras, normal yo nomás, se estar caminado, una tarde me ha agarrado, una mañana, al caminar he agarrado, fácil nomás han nacido, ni he sufrido ni con la placenta,.

V: ¿Acaso no te ha frotado Fabiana?

C (Traducido): Ah… para la Hilda me ha frotado, Fabiana, el debe saber un poquito, sabe frotar también, sabe frotar.

V: ¿A ella debíamos traerle aquí como partera?

C (Traducido): Sí, debíamos haberla traído a ella, ella sabe frotar también, ella vive cerca pues, donde ella se ir, frótame pues, así frótame se decirle, te frotaré sabía decirme también, pero sólo con ella me hecho frotar por esa vez nomás, por ninguna más.

V: ¿No ha habido otro difícil? ¿De la Rossmery?

C (Traducido): De la Rossmery tampoco, rápido nomás ha sido también nové, no me hecho frotar otra vez más, así.

V: Ella dice, ninguno de mis hijos ha nacido con problemas, tampoco he sufrido, normal he tenido los 14 hijos dice, tantos hijos ja ja ja. Solamente antes pasteando oveja, correteando a todo lado, no se sentir, ahora, más o menos creo que ya sentimos yo especialmente ya no puedo, entonces ella dice yo antes me alimentaba bien, de eso será pues que he tenido normal, al último que es mi hermanita menor, ella más bien un poquito me ha hecho sufrir, había una señora que sabía un poquito de parto dice, entonces con ella me he hecho frotar un poco dice, hasta hay después ya, bien nomás, ninguno de mis hijos me han hecho sufrir tanto hasta llegar al hospital dice, todo en la casa a tenido. Así lo que ha contado. Hasta ahí es.

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