NUMBERS THAT MATTER: RIGHT TO HEALTH AND PERUVIAN MATERNAL STRATEGIES

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Abstract

The rights to health and to culturally respectful care are inextricably linked in the documents supporting Peruvian Maternal Health Policy. Strategies of Intercultural Birthing and Maternal Waiting Houses were purported to reduce maternal deaths, while extending the right to health to marginalized indigenous women. Based on seventeen months of field research in Peru, I argue that the narrow focus on achieving "good numbers" creates and sustains coercive modes of strategy applications. As a result, the on-the-ground implementation of these innovative strategies made them incompatible with right to health and culturally respectful care approaches.

Los derechos a la salud y al cuidado culturalmente adecuado están íntimamente vinculados en los documentos de políticas de Salud Materna Peruanos. Las estrategias de Parto Intercultural y Casas de Espera Maternas proponían contribuir a reducir la mortalidad materna y, además, extender el derecho a la salud a mujeres indígenas excluidas. En este artículo, basado en diecisiete meses de trabajo de campo propongo que la estrechez del enfoque en obtener "buenos números" lleva a la creación y mantenimiento de modos coercitivos de aplicar las estrategias. El modo de implementación de estas estrategias innovadoras las hace incompatibles con los enfoques de derecho a la salud y derecho al cuidado culturalmente respetuoso.

Keywords: Peru, Birth Care, Intercultural Health, Maternal Health

Running title: Numbers that Matter

Media Teaser: Why does a rights-based health strategy become coercive? In Peru's maternal health strategies, it was unequal healthcare structures and a narrow pursuit of "good numbers."

Bionote**:**

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"Interculturality or no interculturality, in the end it is the numbers that matter." This hurried phrase from an exasperated top Peruvian Sexual and Reproductive Health official still resonates with me. It was December 23, 2010, and after a couple of months of e-mails, a formal request letter, and follow-up calls, I had finally been granted 30 minutes to discuss the Intercultural Birthing Policy (IBP) with the highest relevant official, just before the Ministry of Health (MoH) holiday party. I had spent the previous year tracing policy creation and researching two implementation sites in the Andes. The IBP purported to provide culturally responsive clinic birth care to indigenous women most at risk for death. On paper it was a marvelous proposal, providing traditional Andean home birth like care by allowing women to birth in street clothes, consume hot beverages, have family in attendance, receive placenta for ritual disposal, and allowing for vertical birthing positions, all new additions to the clinic birth protocol.

The overall approach was to make clinic birthing more appealing, to encourage women to deliver in clinics, so to reduce traditional home births and the emergencies and deaths associated with these. Yet on-the-ground implementation could be extremely coercive. I observed women being shouted at and forced into acquiescing to clinic terms by suspending food aid and by threats of losing conditional cash transfer money. I saw midwives ensuring clinic birth by enforcing Maternal Waiting House (Mama Wasi) stays and punishing home birthers by delaying live birth certificates or requiring cumbersome certifications. I felt deeply unsettled by this. How was it possible that well-meaning health providers could talk eloquently about the right to culturally appropriate birthing, the need to respect cultural preferences, and the importance of ensuring a right to health; while at the same time accepting or engaging in coercive activities that directly contested that viewpoint?

As I sat down to this final and important interview, I wanted to know how this top-level official assessed implementation; and how she would respond to the nagging issue of coercive strategies. After some general questions I briefly explained that my observations and community interviews had uncovered coercive strategies commonly used to pressure women into clinic birthing. How did these fit into maternal health policies under the human and cultural rights framework that the ministry espoused? The answer was dismissive, and questioned my sources: "Those are people who bear grudges against the health care center and like to be interviewed." I pressed the issues and received pro forma responses in line with existing policy discourse on the importance of human rights and interculturality for ensuring reproductive health. As I finished up and turned off my recorder, I asked again about the importance of interculturality within the overall reproductive health strategy. The answer: "Interculturality or no interculturality, in the end it is the numbers that matter. The numbers [of maternal deaths] have to be good [low]." I left soon after, this last statement ringing in my head. Perhaps this was the explanation to my ongoing question, "the numbers that matter."

In this article, I show how the focus of maternal health strategies in Peru on a narrow numeric outcome, the structure of Peruvian maternal health surveillance systems, and the unequal structure of the public health system coalesced to create an environment that challenged the right to health discourse at the local level. This resulted in clinic midwives espousing a human and cultural rights discourse, while at the same time coercing women to give birth at clinics.

Anthropologists have criticized the impacts of metrics at the national and global scale, and have argued that in this new era of neoliberal efficacy-driven global health, programs and policies have elevated metrics as the only acceptable form of evidence (Adams 2016; Fan and

Uretsky 2017; Lambert 2006). The importance of registering results through measurement, epitomized in the move to evidence-based medicine, and its close cognate evidence-based policy, relies on central beliefs that deploying enumeration techniques is possible, and that they constitute a synthesized, objective, representation of reality. Such metrics represent not only numbers but also lives and futures lost. However, the way in which measurements are constructed rely on preconceived notions, estimations, and approximations (Biruk 2012; Oni-Orisan 2016; Wendland 2016)

For example, despite their origin and mode of creation, measurements created through these enumeration techniques are imbued with social and political significance (Adams 2016; Sangaramoorthy and Benton 2012; Storeng and Béhague 2017). Numbers of maternal deaths and infant deaths, for example, are leveraged as symbolic demonstrations of legitimacy or lack of legitimacy of political regimes, development programs, and institutions (Adams 2013; Erikson 2012; Oni-Orisan 2016; Storeng and Béhague 2017). These numbers impact future funding, political prospects, and the very existence of certain organizations.

The Millennium Development Goals (MDGs), discussed in several of the studies cited above, clearly illustrate the move to accountability – and countability – in global health (Fan and Uretsky 2017), and in turn, illustrate the symbolic power of metrics. While United Nations conferences produced action plans and calls for policy change, none had a built-in accountability design. The MDGs changed that, by creating eight goals measured through 21 specific targets and 60 indicators. Progress on indicators were tracked, graphed and publicly available for scrutiny. The goals were not legally binding but constituted moral commitments (Sachs 2012). Countries could uphold their "on track" status as a badge of honor, or could be derided for their lack of progress. The MDGs were a key focus of policy when I conducted this study in Peru, and

thus they are central to understanding health provider attitudes during this time. The Sustainable Development Goals (SDGs) 2015-2030 succeeded the MDGs, and follow a similar model, with 17 goals, 169 targets and 232 indicators that are publicly tracked and generate annual reports. SDG Goal 3.1 calls for achieving a global maternal mortality rate (MMR) of 70 x 1000,000 live births or less by 2030, and uses the same indicators as MDG Goal 5 (United Nations 2018).

METHODS

I draw from data collected over 17 months of ethnographic research conducted in Peru in 2007 and 2010. I followed a multi-level approach to understanding intercultural birthing (IB) and its implementation. I interviewed policy makers at national and regional ministries of health facilities, midwives charged with policy implementation at rural clinics, and local women and men. The cases presented in this article originate from interviews and observations with midwives at Kantu, a rural clinic in a province of Cusco, and from interviews with health policy officials. I spent four months in Kantu, conducting semi-structured and unstructured interviews with midwives, other health providers and community men and women, and observing family planning appointments, prenatal visits, and births. All interviewees verbally consented to the interviews; observations had verbal consent of clinic patients. Interviews with health providers were conducted in Spanish. I have a moderate knowledge of Quechua and could understand all exchanges during observations; however, I worked with a Quechua-speaking assistant for community interviewsNames have been changed to protect the identity of those involved.

The Kantu health center was a level 2 primary care facility with three general medical doctors, four midwives and three nurses in addition to two nurse's aides and support staff. All but one of the midwives were employed on short term contracts with little to no benefits. The clinic was equipped for normal birth and minor interventions, but was not certified to perform C-

sections or other major surgeries. The health center catchment area comprised a rural town, Uraymarca, and the approximately 13 indigenous communities in its municipal jurisdiction. In all, the clinic served a population of around 14,000 people. Uraymarca is in Quispicanchi, a province of Cusco, which is home to the highest proportion of monolingual Quechua speakers in the region. Cusco has a history of elevated maternal mortality rates (MMR); in 1998 the MMR was 453 per 100,000 live births (89 deaths); in 2007 it hovered around 105 (24 deaths), three of those deaths occurred in Quispicanchi. At the end of 2017 the reported MMR for Cusco was also 105; of the 25 deaths reported for that year only one occurred in Quispicanchi, the province where Kantu is located (Diresa-Cusco, 2018).

Kantu was deemed a successful implementation of Maternal Waiting House (Mama Wasi) and IB strategies for indigenous Quechua communities. They were credited with having increased clinic birthing to approximately 93% in 2010, from around 60% in 2000; and decreased maternal deaths from 3-4 a year to 0 in that same period (MoH-Peru 2010). Because of this achievement, Kantu was officially recognized as a training center for IB by regional health authorities. In that capacity, it received both national and international visitors seeking to replicate their approach.

THE RIGHT TO CULTURALLY APPROPRIATE HEALTH SERVICES IN PERU

Peruvian health policy from 2000-2015 focused on achieving MDG indicators (ONU-Peru 2013). With this in mind, between 2001 and 2006, Peru underwent a broad project of health and educational reforms. Undertaken in the wake of the tumultuous end of the Fujimori years,[1] the reforms coincided with the election of Alejandro Toledo, the first self-described indigenous descendant president. Toledo promised to address the marginalization of indigenous communities, counteracting Fujimori-era neoliberal policies that increased disenfranchisement

and discrimination (Ewig 2010). These included widespread human rights violations including mass forced sterilization of poor and indigenous women through a family planning program (Ballón 2014). New policies were designed to tackle the unequal access of indigenous peoples to adequate and respectful health care and education (Frisancho 2013).

At the Ministry of Health, a large banner proclaiming *Calidad con calidez* ("quality with warmth") advertised the new era of people-centered health care (Ramos Padilla 2006). In 2006 the MoH added an Intercultural Health framework to the Gender Equity and Human Rights approaches adopted in the Fujimori years, establishing these as the main tenets for Peruvian health policies. The MoH created the Technical Unit for Human Rights, Gender Equity, and Intercultural Health to supervise the incorporation of these approaches in future policies and programs (MoH-Peru 2006a). However, this office did not seem to monitor deployment of any of these approaches, it produced no further public reports, and seems to have disbanded it in a 2016 reorganization.[2]

Documents produced by this office recognized not only the existence but also the validity of traditional Andean and Amazonian health practices, recognizing that discrimination, persecution, and mistreatment of indigenous practitioners were a result of the unequal relationship between indigenous and official (biomedical) systems of care. The MoH documents proposed that incorporating an Intercultural Health framework into health policy would address these issues by creating programs and policies promoting cultural respect and appreciation of traditional medicine; ensuring interactions among different types of medical practitioners to promote complementarity; and identifying protective cultural factors to improve health conditions for specific ethnic groups (MoH-Peru 2006a). Finally, according to the same documents, an intercultural approach to health should not mean creating new forms of inequity or stigma. Intercultural Health was supposed to

lead to a reduction of existing inequalities *without eliminating or dismissing the differences* (MoH-Peru 2006c). Through this new framework, the Ministry of Health also commited to ensuring indigenous communities' access to health and fulfilling their pledge to expand the "right to health" in Peru. The three main guidelines were created as part of this new policy framework: the Guide for Maternal Waiting Houses (MoH-Peru 2006b); Guidelines for Sexual and Reproductive Health Counseling (MoH-Peru 2008), and the IBP (MoH-Peru 2005). All of these guidelines refer to reproduction and sexuality, marking this area of health policy as particularly culturally complex from the Ministry's perspective. Government officials have often seen indigenous women as more resistant to modernizing change, less knowledgeable about urban life and or "more Indian" (De la Cadena 1991:19). For example, the slow contraceptive uptake and limited engagement with clinics by indigenous women were attributed by the MoH to "cultural barriers," and may have led officials to specifically target sexual and reproductive care for an intercultural approach.

INTERCULTURAL BIRTHING AND MATERNAL WAITING HOUSES: THE CHANGING ROLE OF MIDWIVES

The degree to which women birthed in health clinics versus their own homes was already considered an issue for rural public health personnel before the MDGs. Following the multiple economic and political crises of the 1980s and early 1990s, in the mid-1990s there was a period of neoliberal reconstruction, (Ewig 2010). During this time the government expanded health care capacity by increasing clinics and staffing. Health personnel in newly created facilities expected increased service demands, yet many did not experience it. One of the areas where clinic demand lagged most throughout the country was maternal health, including contraception, prenatal care, and birthing (Benavides 2002). Between 1995 and 2000 many rural midwives relied on extended

networks of trained traditional birth attendants (TBAs), also called *parteras,* to reach rural women. Parteras trained by midwives participated in established referral systems. As part of this system they identified pregnant women, visited and evaluated their health and pregnancy, promoted clinical prenatal care, assessed each woman repeatedly for signs of danger, and referred those with possible complications to midwives (Guerra-Reyes 2001). Women who presented with a normal pregnancy and no signs of danger could go to the health center for birth if they desired, although most still preferred to stay under the care of the partera. Community women visited the clinic for prenatal care, eager to establish themselves as clients in case they needed to be helped in an emergency. Yet very few of them planned clinic births, they did not want to be exposed to the air, legs open on stirrups, with people watching them and putting their fingers in their vaginas for dilation checks. Furthermore clinic birthing was expensive, and tales of mistreatments abounded (Guerra-Reyes 2001). The majority chose to labor and birth at home with a trained partera, surrounded by family. Similar dynamics in other areas of the rural Andes, including Cusco, are corroborated in national statistics. In 2000 72% of all rural women who had live births had received clinic based prenatal care, but only 23.8% of them had clinic births. That same year, Cusco (rural and urban) boasted prenatal care upwards of 93% of all live births in the prior five years, yet only around 22% of all births were at clinics (INEI 2001).

The MoH and its aid partners assessed that economic, geographic and cultural barriers (Cotlear 2000) limited clinic birth care in rural populations. The ministry implemented a series of health care reforms designed to address these barriers, These reforms included: making all birth care free in public clinics; creating official maternal transportation committees; increasing collaboration with parteras; and shifting the role of midwives to be more actively involved in

engaging communities outside of the clinic (Camacho et al. 2006; MoH-Peru and UNICEF 1994; UNICEF 2004).

The Maternal Waiting House and IB strategies were created precisely in the convergence of MDG goals and the ongoing preoccupation with cultural and geographic barriers to clinic birth. Deployment of these strategies to increase clinic births in Peru were also undertaken elsewhere in Latin America including Mexico, Guatemala, and Nicaragua (Cosminsky 2016; El Kotni 2016; Penn-Kekana et al. 2017). Although these strategies discouraged home birthing, it is not illegal in Peru. Midwives, medically trained professionals from 5 year university programs, working in rural and remote clinics, were charged with implementing these strategies as a way to reduce the maternal mortality ratio by 75% (MDG-5A) by increasing the proportion of clinic births under the care of skilled attendants (MDG-5A indicator). This meant that rural midwives shouldered much of the work and the responsibility to achieve Goal 5 to reduce Peru's Maternal Mortality Rate (MMR) from 265 per100,000 live births in 1990-1996 to 66 by 2015 (INEI 2014). The enhanced responsibility also led to increased surveillance and scrutiny of their work.

MATERNAL STRATEGIES IN PRACTICE: KANTU

In Kantu, the implementation of MDG-oriented strategies was achieved by setting up a Mama Wasi in the old health center and leveraging municipal funds to pay for a live-in supervising nurse's aide. She took care of women and provided basic weight and blood pressure measurements to midwives. The implementation of the IB program involved changes in the physical birth space to provide home-like conditions: a low wooden bed, short stool, multi-colored bedsheets, a heater, and local textiles for decoration. The IB also involved sweeping changes in the official birth care protocol, which now focused on providing a culturally appropriate birth experience, including: recognition of the need to maintain a hot environment to

prevent humoral imbalance and possible illness; allowing company during labor and birth; allowing the use of traditional herbal drinks; allowing birthing in street clothes; allowing women to birth in vertical or squatting position; and allowing the family to take the placenta home to give it a customary ritual burial[3] (MoH-Peru 2005; Nureña 2009). When talking about their service offerings, policy officials, rural clinic administrators and clinic midwives in Kantu explicitly linked the Mama Wasi and IB to the Ministry of Health's commitment, and their own dedication, to promoting health in underserved communities. "Everybody has the right to adequate care," "We birth you like in your home" were the main refrains, repeated in interviews and posters throughout health offices.

In practice, the maternal waiting house and IB strategies were often applied coercively, especially in cases where women were resistant to clinic birthing. Clinic observations in Kantu provided evidence of repeated patterns of incentives (carrots) and punishment (sticks). Communicated and discussed openly by midwives among themselves and with other clinic personnel, they seemed to be accepted procedure in this clinic.

Jacinta's Case

Jacinta's case demonstrates how the maternal health strategies described above, IB and Mama Wasi, were employed coercively. Jacinta, 28, hailed from a community four hours from the center, and she arrived to see Gloria, a clinic midwife for prenatal care, just four weeks prior to her due date. When reviewing her chart Gloria noticed that Jacinta had had a home birth previously, and began to question her:

Gloria: So what happened here?

Jacinta: The pains took me by surprise and my labor was so fast. There was no chance of coming to the health center. You can never know when the pains are going to come.

Gloria: Look here, *mamita*, I am sure that you know that women from [your remote community] MUST come to the Mama [maternal waiting house]. We tell this to all women from your community and to your community leader. I am sure I told you to come to the Mama Wasi for that pregnancy and you did not. In my book that means you escaped the Mama Wasi, so now we have a problem, don't we?

Jacinta tried to explain that it was the middle of the night, assuring her that they had called the health center the very next day, and that nobody had said anything at the time. Gloria gave her a skeptical frown, and with pursed lips, indicated to Jacinta to move to the examination table. After the physical examination Jacinta sat in the patient chair, and Gloria returned to the issue:

Gloria: Look. Here is your birth plan that you signed, right? Read what it says here [she shows Jacinta the birth plan for her current pregnancy]. It says "place where you desire to birth." And the answer is "in the health center." And here is your name. So this is what you already agreed to do, and to do it you have to stay at Mama Wasi because your community is so far away. [Emphatically] You *did* sign this.

Jacinta interjects: I have never had any complications with my births, they are fast and with no problems. I was with my husband, and my mother-in-law, and they took good care of me.

Gloria: That doesn't matter because emergencies occur unexpectedly and if you die, then what happens? What does your husband know? Is he a doctor? Birthing in the health center is compulsory, and it's not just me who says so. Your mayor and your community president both have signed documents. Look there it is. And you know that you will lose your

JUNTOS [Peruvian Conditional Cash Transfer Program] for two cycles. Nobody can care for you at your house and here in the Mama we have a room, and you get food, and some wood to cook.

At that moment, Claudia, another midwife, came into the room. Gloria brought her into the conversation. She told her that Jacinta was resisting coming to the Mama Wasi. Claudia, repeated the information about the illegality of birthing at home, told Jacinta again that it was compulsory for women of her community to come to the Mama Wasi, and suggested that Jacinta should stay in the Mama that same day. Jacinta protested. She was not prepared, hadn't brought anything, and her husband didn't know. Gloria told her to "work it out with the Mama [Wasi] supervisor" and sent her with Claudia to be checked into the Mama Wasi.[4] Jacinta seemed surprised and repeated her entreaties: she would come for sure on another day, she must arrange for her children. Gloria told her to go with Claudia, and on her way, told her she may be able to work something out with the Mama Wasi caretaker to come back tomorrow. But that she expected to see her there on Tuesday [three days later] or she would come to get her from her house.

When they left I asked Gloria about Jacinta's case. Why did she have to stay? "It's really a precaution," Gloria told me. "We know she escaped last time, so this time we cannot take the chance that she will not come. She has three [children] already, and they are much too close in age. Since she birthed at home last time, she probably won't come, and we can't have another [perinatal] death. We need to be forceful sometimes." She is sure Jacinta will sign an agreement with the Mama Wasi supervisor: "The signature [on the birth plan agreement and the Mama Wasi agreement] is more a psychological thing, it really has no legal value."

Jacinta was pushed in various forms to acquiesce to the Mama Wasi stay and to clinic birth: by pointing to her prior commitment, by leveraging the authority of the mayor, by making her responsible for the loss of JUNTOS money, and finally by effectively checking her into the Mama Wasi.

Other Pregnancy Sticks

Patterns of forceful treatment emerged as I observed midwives' interactions with women in different stages of pregnancy. The pressure to commit to both the Mama Wasi stay and clinic birth increased as the pregnancy progressed. At each visit, in each interaction, women's attitudes and compliance were evaluated by midwives. Jacinta's case illustrates a more severe form of coercion imposed on women nearing term to prevent home births.

Community men and women wryly called the Mama Wasi "the health center's little jail," precisely because, as with Jacinta, the stay was often imposed on women, including those who had more than four prior pregnancies, anyone with a previous home birth, and those who lived in remote communities. However, increasing forms of coercion (or sticks) occurred regularly from the first visit, for example, with the creation of the birth plan, a document designed to provide women with a voice in birth care decision-making processes. As it was applied, it provided the midwives with a first indication of a woman's labor and delivery intentions by asking "Where/how do you wish to birth?" This question was inserted into the document as part of the IB strategy to provide women the space to voice their preferences. If a woman demurred, or boldly said "at home," the attending midwives deployed a prepared and forceful script. They assured the woman that, whatever she had done before or despite what others had told her, home-birth was now illegal, that she risked jail, heavy fines, and suspension from JUNTOS if she persisted.

While the illegality of home birth and possible jail time were not true, loss of JUNTOS was a real punishment. JUNTOS is a conditional cash transfer program, which seeks to disrupt intergenerational poverty and promote human development among the poorest people in vulnerable communities (Perova and Vakis 2011). The program promotes access to health and education by offering a monthly monetary stipend of 100 Nuevos Soles (approximately US $25-30) to enrolled participants in exchange for compliance with several behavioral benchmarks, including: schooling for all children, well-child visits, pre-natal and post-partum visits, and according to midwives in Kantu, birthing in the clinic. Non-compliance with benchmarks resulted in suspension from the program and loss of income for enrolled families. I could not find documentary evidence for the clinic-birthing claim, even though local JUNTOS personnel verbally confirmed it. The influence of clinic personnel on JUNTOS disbursement in Kantu was undeniable: the health portion of the family tracking form was managed at the Kantu clinic and was used to compile eligibility reports and release funds by local JUNTOS personnel. It was a powerful tool in obtaining women's acquiescence to clinic birthing during birth plan discussions.

From the midwives' perspective, obtaining a signed document which explicitly stated a preference for clinic birth was a safeguard; knowing that local men and women placed great symbolic value on a signed document, they could later hold it as a contract-like document to increase the pressure. During later prenatal visits, the stress on women to remain compliant remained. Signs of transgression, like being late (or even early) to an appointment, not bringing their prenatal card or having missed lab work, were severely chastised. Those who missed appointments were punished by delaying or suspending their nutritional aid package of shelf stable legumes, rice and cooking oil. The package was provided by National Food Aid Program (PRONAA) but was managed and distributed through the clinic to expecting women and

mothers of infants once a month. To receive packages from the clinic, women had to take a signed note from a midwife to exchange for the food; these notes were withheld as a form of discipline. By the time the pregnancy had progressed to the third trimester, midwives had already identified those they called “resistant,” as one midwife recalled:

> It’s easy to know. You can see they’re lying/. They say “yes, yes,” but we know. Then you evaluate: What pregnancy number is it? Where did she birth the other children? Does she live in town? Do we know the family? Then we make sure we do something. … In my experience the ones who have migration experience are more *entendidas* [have more knowledge], you know are more modern and live in town, they know it can be worse. They’re really good patients. They come, don’t gripe, and collaborate nicely. Some of the others are really *chúcaras* [wild]. (Yuli, Kantu)

Midwives found that working with more modern women, identified as those who knew more and had migration experience, was much easier. They were more compliant, and therefore were deemed better patients. Much ongoing discussion among midwives centered on what was needed for resistant women to become “knowing.” They agreed that the various forms of pressure exerted on women during pregnancy was part of educating women into being better patients.

Home Birthing Punishment

If being a good patient meant compliance, birthing at home was the ultimate marker of resistance, in Peru and throughout Latin America (Berry 2006; Otis and Brett 2008). As a result, it was severely penalized. For example, the woman and newborn were taken by ambulance to the health center for a puerperal check-up. Several community men and women viewed this requirement as essentially damaging for a woman’s frail recently birthed body, because it exposed her to damaging cold air that could produce humoral imbalance and harm her health

(Kuberska 2016). Additionally, families were charged for the gasoline used in this trip. Another form of penalty was delaying the certificate of live birth, which is required for official registration and can only be provided by a clinic. A registration delay of more than 30 days triggered administrative charges in the Municipal Records Office and signified added transportation costs for the family.

Some extended surveillance and punishment of home birthing had with the implicit support of local authorities. Midwives had lobbied local communal leaders, and the town mayor, obtaining commitments to support their efforts to reduce maternal deaths. For example, in addition to employing the Mama Wasi supervisor, the mayor wrote a memorandum calling on local women to birth in the clinic. Upon close reading, it is an exhortation not a mandate, and it also instructs midwives to respect the community and acknowledges that women shouldn't be forced into clinic birthing. Midwives kept a copy of the memo pinned to the obstetrics consulting room board, helpfully opened to the page of the broad appeal for clinic birthing, which was highlighted and underlined. Midwives often misstated its importance and referred to it as the "document where the Mayor says it is mandatory to birth in the health center." The document was written in the florid and complicated Spanish of regional bureaucracy; thus it is unlikely that the majority of women patients, most monolingual Quechua or bilingual with limited literacy, would be able to understand the text. The memo served mostly as a prop for midwives' messages.

Other leaders were also persuaded to participate in the punishments for home birthing. Some communal or *ayllu*[5] presidents and boards (commonly formed by men elected from member households) had voted to promote clinic birthing by supporting the midwives' call for a home-birth ban for their members. These ayllus made offending families pay fines – typically counted

as free work days – to the communal board in exchange for a letter from the president certifying the provenance of the child and restitution of the families' membership rights.

Benefits of Clinic Birthing

In addition to these many "sticks" to ensure clinic birth, there were also some "carrots" or incentives. Certainly, the main incentives of both IB and Mama Wasi for local women and their families were important: the ready availability of medical care in case of emergency, reducing the risk of death; the rapid evacuation to more advanced care in the city if need be; avoiding the likely dangers of birthing outside "in the road"[6] on the way to the health clinic; and the ability to labor and birth in your desired position, accompanied by your family, and in your own clothes. While these are all positive things, which some women readily welcomed and appreciated, the benefits of both strategies were eclipsed by the forceful nature of their application: clinic birth with interculturally adapted care was not a choice, but a mandate; Mama Wasi was not a helpful service, but an enforced stay or "a little jail" in the eyes of community members.

In obligating women to stay in the Mama Wasi, and birth in the clinic, midwives were obscuring the positive aspects of both services. The matter of who gets to choose, who has the power, and who is respected as a rights bearing human was central to community reluctance to both strategies, and especially clinic birthing, despite its many positive aspects. As one older woman quipped: "In their center [clinic] they can do anything, and you can do nothing."

Kantu women and men were concerned by the restrictions on their capacity to choose, but JUNTOS beneficiaries felt compelled to comply with compulsory clinic birth. Several others shrewdly managed to resist or manage clinic pressures. For example, two women, who had a higher income through cattle farming and were not in JUNTOS, told me they basically ignored the cajoling and birthed at home. Others delayed going to the clinic until expulsion was

imminent, bypassed the Mama Wasi requirement by staying with extended family, and in some cases were covertly accompanied in birthing by a local trained *partera.* However, there was enough concern about the mistreatments I have described that the clinic administrator had been called to respond to concerns at a communal meeting. It had little impact.

NUMBERS AND SURVEILLANCE

IB and Mama Wasi were implemented to reduce home birthing, a common practice, and to increase or maintain levels of clinic births. I had heard the phrase "keeping the numbers" often in conversations with Kantu midwives, in relation to three types of numbers: number of births with a clinic midwife; numbers of maternal deaths; and numbers of perinatal[7] deaths. These numbers mattered because they were collected as part of routine maternal health surveillance figures, through the newly enhanced epidemiological surveillance system (Iguiñiz and Palomino 2012), which ultimately fed into the national MDG data collected by the National Statistics Institute.

Susana, a 25 year old midwife, mentioned it first, when I asked why she did not let a woman declare "home birth" in her birth plan:

> We can't have that on the chart. I leave it blank if I can't convince her, then I talk to her husband, her mother, father, anybody to make her change her mind. But most of the time they answer, "wherever it is best" and I fill in "clinic." Imagine if I left that [home birth] and then we had a planned home birth, NO, that would mess with our numbers.

The implication was that if she left the home birth indication in the birth plan, not only would she be derided and potentially disciplined for "endorsing" a home birth, but she would be held liable if there was a death.

The prestige and potential future job security of the midwifery group in Kantu was intimately linked to keeping clinic birth numbers high. They received little support from policy officials for

their work with intercultural birth, yet they had to keep it going. As Gloria, the senior midwife, and the only one with a permanent position, declared: "They send me people [to train in intercultural birthing], and they don't give me a single marker. All of this I do because we need to maintain our prestige, we need to do this, and on top of that keep our numbers … No maternal deaths since three years ago that is why they consider us a model clinic for intercultural birthing."

Early successes seemed to complicate matters for Kantu midwives. They had reduced their maternal deaths from three to four a year to zero, nominally through their "gold standard" implementation of IB and Mama Wasi. Now, they were bound to yearly targets for allowable negative outcomes based on this prior performance: zero maternal deaths and six perinatal deaths.

Yuli, at 23 the youngest midwife and the only one who spoke fluent Quechua, had just finished a referral to Cusco for a suspected fetal death. She was concerned because this meant Kantu was close to its allowable perinatal death count of six, and it was only August. Surpassing that number would mean negative consequences which made her extremely anxious:

> [I]f you [go over your targets], they call you in [to the Cusco Health Direction] for a special training … They send you back with an agreement of what you're going to do that has to be signed by the health center administrator and the community [that's only for perinatal deaths but] if even only one mother dies they normally throw you out, there's a report, they call you in, it's like a trial.

Thus "keeping good numbers" was not only linked to the prestige of the clinic and its midwives; it was also a requirement of staying employed. This was especially critical for Yuli, Susana and Claudia who were on temporary renewable contracts, dependent in large part on their

acquired prestige for continuing employment and professional advancement. While they collected a lot of data per patient,[8] including birthing position (vertical or horizontal), there were no surveillance system codes to record data related to implementation of culturally appropriate maternal health strategies. Registering things like Mama Wasi stay, family accompaniment during birth, use of herbal beverages, reception of placenta, and perhaps some measure of patient engagement or experience in official surveillance, would signal the importance of these strategies.

As it stood, the lack of official interest or oversight of implementation marked them as ancillary. This status was reinforced by the limited funding for implementation from regional health officials. Kantu personnel used monies from ~~IB implementation in Kantu, for example, was completed with funding from~~ AECID, the Spanish cooperation agency, to complete the IB room set-up. The subordinate nature of these strategies was obvious when health officials in Cusco could not remember where IB was implemented within their networks, speculating that perhaps clinics that registered more vertical than horizontal births had implemented the policy (Guerra-Reyes 2016).

WHEN NUMBERS FAIL: INEQUALITY IN THE PERUVIAN PUBLIC HEALTH SYSTEM

When numbers failed – that is, when the number of deaths exceeded expected allowances or when the proportion of births under midwife care were reduced – midwives at rural health clinics bore the brunt of the consequences. These could be severe, ranging from loss of reputation to dismissal from the job. During my time in Kantu, memories of a spate of punitive review panels, three years before, were still fresh. These had been triggered in a neighboring district by two deaths at patients' homes. It was rumored that the midwife in charge was not able to convince the women to come to the clinic. The reviews, conducted by the regional health directoratein the city

hospital, had resulted in one dismissal and one suspension for those involved. Proceedings had left a bitter taste among Kantu midwives. Gloria described it as a persecution:

> Let's call it what it is, a persecution of the midwives! If a mother dies the midwife loses her job, [but] patients die and the doctors don't get canned and children die and the nurses are not fired, so why the midwives? … We know maternal deaths are a mixture of several factors that influence, and they go beyond the health service. Education, transportation, economic, cultural barriers. … but yes, there was a persecution, so a mother died and the midwife was dismissed.

Midwives in rural Andean clinics, where home birth preference had historically been the norm, had a higher probability of experiencing a maternal or perinatal death, and as a result they were more likely to suffer the consequences.

Additional inequalities in the public health system compounded midwives' precarity. In the strictly hierarchical system, urban public health hospital posts were deemed positions of great prestige and were highly competitive. These positions were allocated through a ranking system that allowed those with better scored tests and dossiers to choose their location. Urban positions filled quickly, leaving rural positions to be filled by those lower on the ranking. As a result, urban professionals felt better prepared or knowledgeable than those serving in the periphery (as rural clinics were called). Furthermore, urban living afforded midwives the possibility of participating in more training, and a higher likelihood of boosting their meager public health wages with private practice. Midwives and other medical professionals in Kantu felt very much outcast and concerned at the loss of opportunities (Guerra-Reyes 2016). In addition to the rural-urban hierarchy, most rural midwives were young, recent graduates, and female, and this made them more vulnerable to mistreatment from within the public health system. In two cases I

watched as midwives, trying to arrange a referral, went back and forth over who was going to make the phone call to the city hospital. They finally called on the Kantu male doctor to talk to the attending hospital doctor as a favor. Yuli explained that they did not want to do it because they feared reprisals:

> [T]hey can be very [thinks for a moment] let's say blunt. Actually, hospital doctors are really bad tempered with us. I've been insulted more than once, as have all the colleagues here. They just question everything, our judgement, our knowledge. So, it is better for our doctor to talk to him [laughs], [between doctors] they understand each other.

Furthermore, negative attitudes against the IB strategy and the preponderance of short term contracts made the Kantu midwives increasingly concerned for their ability to remain continually employed in the Public Health system. The compounded effects of these systemic problems rendered Kantu midwives at a particular disadvantage in the case of "bad numbers." Achieving the "right numbers," for professional survival, seemed to justify coercive measures to reduce the likelihood of home births, and the possibility of maternal and fetal deaths.

CONCLUSION

The changes in pregnancy and birth care proposed by the Mama Wasi and IB strategies not only provided lifesaving birth care, but also ensured recognition of cultural difference and respectful care for indigenous women. Both strategies have been lauded as ways to make amends for years of discrimination and neglect of indigenous women's birthing beliefs and preferences (Palomino 2008). However, in application, the transformational "right to health" discourse was lost to the reality of numbers-linked evidence-based policy and to the extreme pressure placed onto rural clinic midwives to deliver "good numbers."

The success of Maternal Waiting Houses and IB in reducing maternal and perinatal deaths rested solely on the ability of midwives to reduce home birthing and increase clinic births. This led to the normalization and acceptance of coercive practices in rural clinics. While midwives and other health providers could confidently discuss the importance of human rights and cultural respect during birth, they sustained existing discriminatory behavior towards indigenous women, and generated or upheld coercive strategies that stripped away individual, social and cultural rights. Such strategies included forcing women to remain in the Mama Wasi against their will; cajoling them to commit in writing to clinic birth; chastising their questions and cultural preferences; castigating home births; and generally treating them as untrustworthy and child-like.

Defining "numbers that matter" in contraposition to the original objectives of policies is not new for the Peruvian public health system. The mass forced sterilization of indigenous women was originally proposed as a means to empower indigenous women by granting them the choice of controlling their fertility. Program leaders tied clinic employment to tubal ligation quotas, resulting in widespread violations of the human rights of indigenous and poor women (Ballon 2014). While intercultural maternal health policies emerged precisely to avoid similar results, the narrow focus on obtaining good numbers has negated their transformative potential. Through focusing on specific numbers, the maternal health strategies described here have been re-cast as a mechanism of reproductive governance, where state institutions use "legislative controls, economic inducements, moral injunctions, direct coercion and ethical incitements" to control reproductive practices (Morgan and Roberts 2012:243). In this case the state use of both policies seeks the normalization of clinic birthing through degrading traditional Andean forms of maternal care.

Maternal health focused intercultural health strategies are abundant in Latin America; programs similar to those in Peru are found in Ecuador, Guatemala, Bolivia and Mexico (Ruiz Cervantes 2013). Although they differ in scope, government support and the role they afford traditional indigenous midwives, a common critique points to difficulties in articulating with public health systems and persistent structural bias against indigenous cultures as barriers to their success (Charyet al. 2013; Ramirez Hita 2014; van Dijk et al. 2013). The Peruvian Ministry of Health recently reiterated its commitment to intercultural birthing by updating the policy through a new resolution which provides technical guidelines to provide vertical birth within the framework of human rights and intercultural relevance (MoH-Peru 2016).

The Sustainable Development Goals represent a renewed opportunity for enumeration and governance. How these will impact national level policy and the right to health remains to be seen. However, as demonstrated in the Peruvian case, and others referenced here, "what we count" matters, and many times, we do not count "what matters." In Peru midwives were evaluated solely on measures of maternal deaths, infant deaths, and clinic births. Respect for cultural differences, community connection and increasing right to health were mentioned as significant, but these were not evaluated in any way, effectively marking them as less important.

At this intersection. sustained anthropological engagement with an intercultural health framework could be fruitful. For example, designing data collection tools on the implementation of intercultural maternal health strategies could lend them legitimacy. Going further, one could imagine, for example, a collaborative definition of measures "that matter" to indigenous communities added to SDG-linked surveillance, perhaps as a local initiative engaging communities in evaluating strategies in addition to reporting for health policy goals. Direct anthropological engagement with intercultural health in medical education, and in proposals for

an equitable restructuring of current public health system, could also subvert existing paradigms. As we anticipate another decade of goal centric global health policies, the challenge of assuring the right to culturally appropriate maternal health remains.

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NOTES

1. In late 2000 then president, Alberto Fujimori, escaped Peru amid mounting evidence of multiple genocidal human rights violations, scandalous bribery videos, and rapid deterioration of his dictatorial grasp on power. Following impeachment and removal from office, congress called for a new general election in the year 2001.

2. The government has since created a Vice-Ministry of Interculturality, under the Ministry of Culture, however it doesn't have any oversight of health issues.

3. The placenta is called *madri* and is considered the mother of the fetus, it is given an honored place under the home hearth or family field so it can continue to nurture the family.

4. Checking-in to the Mama Wasi, meant registering the name and identity document number in the Mama Wasi ledger, showing the room and providing a key to the lock. The ledger served for rounds every morning and was used to keep track of resident women.

5. An Ayllu is a traditional Andean communal organization, formed by several families that administer shared land and water. A communal board regulates members' rights and responsibilities.

6. For example, the imbalance of hot/cold humors produces s*obreparto* a culturally specific ailment which can manifest as strong cramps immediately after birth which can lead to death, or to a lifelong weakness. See Larme and Leatherman (2003) and Kuberska (2016) for more information.

7. From 22 weeks gestation to seven days old.

8. Midwives spent almost 15 minutes per visit completing required paperwork.

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