CHAPTER 5

Censusing the Quechua

Peruvian *Obstetras* in Light of Historic Sterilizations, Contemporary Accusations, and Biopolitical Statecraft Obligations

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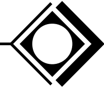

Introduction: The Demonization of Peruvian *Obstetras*

Despite evidence that a Malthusian government health policy was to blame, individual healthcare providers, and particularly obstetricians, are increasingly being demonized in the ongoing case of Peru's more than 300,000 enforced sterilizations of the 1990s. Even before this blame, obstetricians were already in positions of precarity; the profession is highly gendered, and female *obstetras* (obstetricians) find themselves subjugated to the authority of majority-male gynecologists and surgeons. These *obstetras* are currently fighting a legal battle to maintain their status as fully State-endorsed professionals, and their profession is further under fire for concerns over obstetric violence toward the poorer and Indigenous patients served by the national health service. Literature often suggests that obstetric violence occurs in Peru due to the differential races and classes of university-trained biomedical professionals and their impoverished patients (Guerra-Reyes 2019), but in this chapter, I will refute such generalizations and take a more nuanced approach to the complexities of obstetric violence and the *obstetras* who are accused of perpetuating it.

I will argue that while *obstetras* certainly played significant roles in the condemnable historical sterilizations, even today, the underlying push for "quota-filling" as a condition of employment may encourage similar coercive behaviors that seek to limit poor and Indigenous re-

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production via contraception and other methods of family planning. Furthermore, over time *obstetras*' tasks have become increasingly administrative, leading to the suggestion that the role may be a "bullshit job" (Graeber 2018)—one that should be meaningful but is rendered "bullshit" by required state "box-ticking" and "form-filling." I will suggest that a key role of Peruvian *obstetras* is to census and discipline the population as a form of stratified biopolitical statecraft (Bridges 2011a) via administrative tasks and meeting quotas, resulting in dissatisfaction among *obstetras*, patient neglect, and accusations of obstetric violence. Only by exploring this situation from the perspective of the *obstetras* themselves will it be possible to effectively understand how and why structural violence is perpetuated at a local level by those who, under other circumstances, might be victims of structural violence themselves.

Obstetrics in rural Peru is an increasingly precarious position. As a largely female workforce in environments where resources may be scarce and healthcare practitioners often need to live away from their families due to rural health center and hospital isolation, Peruvian *obstetras* face multiple problems. It is not only their working conditions that create tensions, but also the historical context of forced sterilizations within which *obstetras*, gynecologists, and primary care doctors are contemporarily instigated and blamed. In the 1990s, it is estimated that more than 300,000 mostly rural, Indigenous women were sterilized as part of the Fujimori government's national family planning program (*Programa Nacional de Salud Reproductiva y Planificación Familiar*) (PNSRPF). These sterilizations were implemented by State employees such as *obstetras* and doctors working for the Ministry of Health (MINSA), though the details and motivations surrounding these scenarios remain murky. Not all sterilizations were forced, but evidence has emerged that many women were coerced and tricked into accepting the removal of their reproductive capabilities (Rousseau 2009; Ewig 2010). Though there has been an increasing amount of scholarship on the women and communities affected by this important and tragic topic, this chapter will examine the perspective from the opposite side: that of the *obstetras* who participated in the sterilizing and/or who continue to work in the shadow of these memories. I will argue that it is only through careful examination of the realities and precarities of *obstetras* that issues surrounding accusations of obstetric violence in Peru can begin to be addressed, as, again, this group is also implicated and coerced into biopolitical statecraft, which for them is difficult to avoid.

A key issue when addressing biomedical practitioners in rural Peruvian communities is that they are portrayed as "racist" and "region-

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alist," with the assumption being that their vastly differential status from their patients incites bad behavior such as forced sterilizations, but also general obstetric violence. For example, studying the intercultural birthing policy in the Peruvian highlands and commenting on the inability of MINSA workers to sympathize with the beliefs of the Indigenous Quechua (ethnomedical and otherwise), Lucia Guerra-Reyes (2013:157) concluded: "Health personnel, who are mostly urban professionals, identify as 'white' or 'mestizo' and middle class, and assume that their view of the world is normal, desirable, and correct. This persistent ethnocentric attitude, which is shared by many Peruvians, is replicated at all levels of policy and direct-care in health." This view is also shared by Christina Ewig (2010:6), who describes a Quechua woman's experiences at a health center as she imagines they proceeded:

> At the health center, she would face a white or mestizo doctor born and educated on the urban coast who would not comprehend her language or customs. He would likely call her *mamacita* (little mama) rather than by her name. Indigenous health concepts like *pacha* (sickness from the earth) would bewilder him, which in turn would frustrate her.

The fact that most healthcare practitioners lack Quechua language skills was also suggested as a means through which they coerced women into sterilizations during the family planning program (PNSRPF), as they were unable or unwilling to sufficiently explain the procedure or its consequences (Rousseau 2009; Ewig 2010). Therefore, in the literature on healthcare practitioners in Peru, one is faced with what appears to be a definitive racist and classist distinction between *obstetras* and patients. This distinction simplifies the understandings of coercion—*of course* white and mestizo doctors would treat Indigenous patients badly if they have been educated by, and live in, a country with a "persistent ethnocentric attitude" (Guerra-Reyes 2013:157). However, I argue that this view lacks both nuance and sufficient ethnographic data on lived realities and falls into simplistic race/class dichotomies.

Methods

I carried out the research on which this chapter is based around the MINSA healthcare network in the rural Ayacucho province of Vilcashuaman, where the majority of *obstetras* and other healthcare providers

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not only spoke Quechua but also were Quechua. Having grown up in the surrounding areas, they knew a great deal about ethnomedical health concepts and local customs. During 2018, I lived for a year in the province capital of Vilcashuaman as well as in a smaller village conducting ethnographic fieldwork through participant observation and interviews with Quechua women and healthcare practitioners. I conducted this research as part of my doctoral dissertation project, and sought to investigate the contemporary implementation of the State family planning program in an area previously ravaged by both internal conflict due to Shining Path,[1] as well as the historical sterilization abuses.

Discriminatory Behaviors

With the above-mentioned nuances in mind, the fact that coercive and discriminatory activities still continue may actually seem more significant in the absence of simple binaries with which to analyze those behaviors. Instead, when healthcare practitioners and patients are more similar than the literature would have one believe, a deeper analysis is required to understand discriminatory behaviors, which this chapter addresses. And those behaviors *do* occur.

Khiara Bridges (2011b:38) suggested that such biomedical animosity toward patients of similar backgrounds may be due to practitioners' desires to distance themselves from those patients, as "the staff's animosity . . . is intensified by a recognition of [their] own similarity to the patient's profile and [their] desire to disavow the discursively disparaged patient as an abject version of [themselves]", and that "at least some portion of the hostility . . . demonstrated toward . . . patients can be explained as an attempt to create distance between [themselves and their patients] such that they could not, or no longer, be considered abject forms of [themselves—the practitioners]" (2011b:39). Indeed, in Peru, healthcare workers and other state employees, by virtue of their studies and their differential status, may place themselves "above" those with whom they grew up. Looking at intercultural education, Maria Elena Garcia (2005:118) commented that "even if teachers were from highland towns, their profession placed them in a higher social stratum than the Quechua farmers and herders." Thus, practitioner behaviors may be classist if not racist, or both. These attitudes reflect a common phenomenon in Peru called *choleandao*: when one group of Peruvians looks down on another, who looks down upon another. Walter Pariona Cabrera (2017:41) asserted that in Ayacucho, *choleando* is quite preva-

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lent, and that the healthcare practitioners' attitudes of looking down on their Indigenous patients (who may be similar to them in many ways) is *choleando.* Other Peruvians may look down on those same healthcare workers, and so on.

There are also other factors at work in the ways in which *obstetras* treat patients. Life as an *obstetra* is highly precarious, as the following paragraphs will discuss, and it is important to recognize this precarity when approaching negative behaviors. For example, a change of law was proposed in 2018 that would demote *obstetras* to the category of "non-medical" personnel—a position akin to a "technical" career (e.g., a nurse), that would remove a degree of respect and authority over patients from their jobs. There have been numerous manifestations and marches in protest of this change. However, this situation further underscores both the precariousness in which *obstetras* operate and the belittlement that they receive from the Peruvian government and from other workers within their own healthcare networks.

It is necessary to note here how and why such a legal suggestion could be made, and why Peruvian obstetrics is potentially ambiguous. *Obstetras* are demonstrably *not* the same as midwives in Peru, who are considered "traditional" (there is no official category of "midwife" in the healthcare services), and who themselves have been pushed to the margins due to the increasing biomedicalization of birth in the country. Nor are *obstetras* the same as a North American ob/gyn in terms of their job roles and capabilities. To mark the nuances, I refer to these Peruvian obstetricians using the Spanish term *obstetras*. In Peru, *obstetras* handle all reproductive health issues, including family planning, pregnancy and labor, and cervical cancer screening and consultation, but, unlike obstetricians in other countries, they do not operate. Instead, cesareans and other gynecological surgeries are performed by (mostly male) gynecologists, thereby diminishing the role of the *obstetra*. If the career of the *obstetra* were to be demoted to "non-medical," little would change in terms of their tasks, but they would lose some power of decision-making and respect within the biomedical hierarchy. Therefore, they have been struggling to hold onto their professional categorization.

In addition to these stresses, *obstetras* are constantly aiming to fulfill targets, or *metas* (goals), set forth by their employers—an activity that results in stressful working situations, which, at the same time, may incite coercive behaviors by the *obstetras*, for which they are later personally blamed. Thus, I argue that it is not possible to understand the treatment of Quechua women in Peruvian healthcare networks without also addressing the situation of the *obstetras* who serve them.

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Contemporary Quota-Filling and Historical Sterilization Accusations

> "We belong to a network that give us *metas* [goals] to reach every year. Like, we must cover 200 couples each per year [with family planning]. But you can't obligate—no, no, no."
> —*Obstetra*, Vilcashuaman

Obstetras and gynecologists are being blamed for the forced sterilizations, and furthermore, these accusations are increasingly gunning for individual blood rather than collective punishment. In Vilcashuaman, specific names of those who performed the sterilizations have been identified by patients, and therefore this mounting tension may directly affect those *obstetras* in Vilcashuaman who were working at the time. Importantly, *obstetras* are not actually licensed to perform tubal ligation sterilizations. However, they have been directly mentioned in sterilization testimonies given to me, and *obstetras* whom I interviewed also spoke about "sterilizing" women. This may mean that they either illegally performed the sterilizations themselves, or accompanied and assisted the doctors and/or gynecologists who were qualified to do so. Either event would render them culpable, although to varying degrees of legality and intent. Therefore, when the literature speaks of "doctors" sterilizing women in regard to *obstetras*, they were arguably either acting in the role of doctor or directly supporting a doctor by rounding up and coercing patients and/or assisting the actual surgery. As *obstetras* admit to having quotas, it can be concluded that, at the very least, they acted as the initial vehicle through which women were brought into the clinics for sterilization. Although there are those who argue that the Fujimori government is the culpable party because it obligated gynecologists to sterilize certain numbers of people through enforced quotas, or *metas* (Ewig 2010; Rousseau 2007), the condemnation of individual *obstetras* and gynecologists as acting alone operates as a counter to this idea.

Gonzalo Gianella (2014) claimed that, owing to the mounting evidence released against the *Colegio Medico de Peru* (Peruvian Medical College), its members felt obliged to create their "own version of the story" (2014:80). This story, Gianella suggested, sought to portray biomedical staff as victims of a perverse system, just as were the women whom they were sterilizing (2014:81), and blamed the structure of the Peruvian healthcare system, as opposed to individual will, to sterilize without consent. However, Gianella (2014:84) concluded that if this were really the case, MINSA would be apologizing for the past, when it has not. He went on to note that, as a doctor himself, he has never known a surgeon

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who did not enjoy his own authority (2014:88). Gianella also noted that if there had been a lack of medical will to do so, then thousands of sterilizations would not have occurred, and that no one resisted (2014:89)—an observation that Jorge A. Villegas (2017:109) also made—and that Peruvian doctors have blamed other actors in society (e.g., MINSA or the government) for their own actions (2014:86–87). Finally, Gianella (2014:89) stated that "the Peruvian doctors who sterilized thousands of women . . . did it convinced that they were doing what was medically correct."

As previously noted, healthcare practitioners, and particularly female *obstetras*, are already in precarious situations in Vilcashuaman, and were somewhat disempowered during the family planning program (PNSRPF; *Programa Nacional de Salud Reproductiva y Planificación Familiar*) regarding autonomy in the clinic. They argued that they were responding to the demands of the job to save their own livelihoods. This argument is not necessarily enough to exonerate these *obstetras* from perpetrating serious obstetric violence, if that is indeed the case, but it is also necessary to hear their voices to better understand their motivations for doing so.

Perhaps understandably, *obstetras* shied away from being interviewed about the PNSRPF. It is not necessarily that these *obstetras* feel guilty or deny that the sterilizations happened. Many practitioners maintain that women were not *forced* but *convinced*, and that *they were obliged* to reach certain goals as biomedical professionals, or they might lose their jobs. One *obstetra* put a figure to this situation: "They told us that we had to convince five women a month to have the *ligadura*." Another elaborated further on her experiences of working during this period:

> Women who had up to three children were ok [to sterilize], but less than that, one or two, no. In the rural places it was more—those who worked in that time had a kind of contract where *sí o sí* (yes or yes)—you had to capture (*captar*) people. If you didn't capture enough women, then you would lose your contract, so the staff, for fear of losing their jobs, had to complete their contracts however they could, even using force (*a la fuerza*). I didn't see any violence—the idea was to convince (*convencer*) the patients, although the reality I saw might have been different from what others saw—I have colleagues that *sí o sí* had to take people with violence . . . We had to work 12 hours a day, so we had to do more extra-curricular activities . . . go to the communities . . . it was like that.

The "capture" of patients refers to the targets given to practitioners. Stéphanie Rousseau (2007:108) wrote that "the government's prioriti-

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zation of tubal ligation was . . . reflected in target quotas and incentives offered to medical personnel . . . quotas were pursued, notably, by holding 'tubal ligation and vasectomy festivals' organized by MINSA staff in various poor regions of Peru." Ewig (2010:152) also concurred with the notion that "If quotas for sterilizations were not met, then within this labor structure, professionals risked losing their jobs." However, because of these pressures, it was claimed that the workers "overstepped the norms in order to fulfil a quota and touched people who should not have been touched" (2010:152).

Although practitioners in Vilcashuaman continue to express innocence and to claim that they were "only following orders" when sterilizing, it is worth mentioning that the files containing medical information about the known sterilization victims had "gone missing" from the health posts when I tried to locate them. It should also be noted that this was a fact that not one healthcare worker tried to conceal from me, so the absent files do not necessarily express guilt, but may highlight the unease produced in *obstetras* when they are singled out for "justice." It is also worth reiterating that in Vilcashuaman, it is known who specifically participated in the sterilizations. Rural healthcare networks are small, and, again, *obstetras* and other healthcare practitioners are recognizable. Therefore, the threat of denunciation constantly lingers over those who performed the sterilizations. Indeed, *obstetras* are fearful of being denounced by patients, not only for past sterilizations, but also for contemporary maltreatment. For example, one *obstetra* told me that it was always important to ensure that the forms (described below) were filled out correctly, and that the patient had given their fingerprints as consent; otherwise, the patients would *denunciar* (denounce) them.

Although I never actually heard of a case where a patient had successfully taken any healthcare provider to court or "denounced" them, the increasing focus on individualized guilt for their sterilizations may heighten *obstetras'* awareness of this possibility. *Obstetras* often fretted over this. For example, when one *obstetra* was discussing the day-to-day realities of her work, she said:

> *Obstetra*: In reality it's difficult . . . it becomes difficult because of legal things (*se hace difícil por las cosas legales*).
>
> *Rebecca*: What do you mean by *cosas legales*?
>
> *Obstetra*: The patients can denounce you for everything, they want to denounce you (*te quieren denunciar*). It's not easy working here for sure because of this.

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She was not alone in her concern about being denounced. Another *obstetra* said that her work was difficult because her patients would often neglect their contraceptive method, or the method would inexplicably fail, and she would be blamed for their unwanted pregnancy: “If she becomes pregnant, it’s you who she will denounce, and why? Because now she has four children, and who is at fault? Because sometimes we say that a method is *seguro* (safe), but instead we should say that it is ‘highly effective.’”

The fact that *obstetras* showed concern over a patient taking legal action underscores one important thing—that those patients are not entirely without agency in their interactions with healthcare workers. Although it may prove legally complicated and expensive should a patient wish to officially report malpractice on the part of an *obstetra*, the fact that the threat of this possibility is felt in the health posts suggests that Quechua patients may have a degree of agency and power within this situation, perhaps more than they are aware of. However, Quechua women are also wary of being denounced by official workers in turn. As one woman suggested to me, people in her village were previously asked to sign paperwork that was used “to denounce us” (though it was unclear what for); hence she no longer wanted to sign anything official nor to respond to questions.

Denouncement can be a weapon of agency on both sides; thus both sides are suspicious of it, perhaps underscoring the shared cultural approach to certain State mechanisms by Indigenous *obstetras* and their patients. Yet despite these concerns over potential legal problems with patients, *obstetras* did not necessarily cease certain behaviors. In all this, of vital importance and contemporary concern is the subject of quotas, or *metas* (goals). This subsection of this chapter opens with a quote from the head *obstetra* at the healthcare center in the village. She admits that goals are given by “the network”—the MINSA network—which decides how many people healthcare workers need to “capture,” similarly to the Fujimori quotas. But this is not a quote from 20 years ago, as may be inferred; instead, it is happening right now.

Obstetras face mounting blame for the sterilizations they performed, or helped to perform, whereas they claim that they were responding to government-set quotas. However, *obstetras* must fulfill *metas* or risk loss of work. Sterilization as a specific target has long been off the table, an *obstetra* argued—yet in a bid to fulfill their mandated goals, coercion may still occur in regard to other contraceptive methods (although she insisted that they could not obligate people). In fact, *obstetras* are somewhat hushed about these contemporary targets, as they are aware of the implications. One *obstetra* directly (and misleadingly) told me, “We

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don't have targets because then we'd have to obligate, like in the time of Fujimori." Her superiors said otherwise. Furthermore, the achievement of *metas* is also still implicated in *obstetras*' job security, as evidenced by the frequent evaluations.

Evaluations, Paperwork, and Precarity

Unless an *obstetra* has earned a "named" position after years of service, she will need to undergo an evaluation at the end of every contract period. To be "named," or *nombrada*, grants a worker special privileges and permissions not available to those under contract, and is usually granted after a minimum of ten years of service within one healthcare institution (Ewig 2010:105). Without this status, whether or not an *obstetra* will have her contract extended or terminated will depend on the positivity of this evaluation.

To pass the evaluation, *obstetras* need to prove that they are reaching the *meta*s assigned to them for "capturing" women for prenatal care or contraception. This proof is shown through documentation of work completed and lists of patient records that show how many people have been attended by each practitioner. In a rural network such as Vilcashuaman with little technology, this is all done by hand, leading to an excess of paperwork and administration due to the evaluations that non-named workers (who are the majority) must undergo every three to six months, depending on their particular contract. No paper trail, no proof; no proof, no positive evaluation; no evaluation, no contract renewal.

During fieldwork one day, I found an *obstetra* in her consultation room sitting behind a stack of papers and forms when I came to interview her. Her contract was coming to an end, and with the evaluation looming, she was hurriedly trying to complete the necessary forms to prove that she had reached her *meta*s and should be kept on as an employee. Stressed by her imminent professional "Judgment Day," she was keen to offload about the evaluation and contracts:

> O*bstetra*: Look, when you have this kind of contract [short term, renewable] it's not that stable, in any moment they can tell you that you have to go and look for another job . . . if they want to put someone else . . . it's not stable. It's stressful. What papers you might have to prepare, maybe you need to study a bit more, so you are ready for the evaluation. If you don't pass it, then *hasta aquí chau* (until here, then goodbye). The modality of work is like that: they contract you, they evaluate you, then they contract you . . .

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> *Rebecca*: What are the duties that you must fulfill to pass the evaluation and be contracted again?
>
> *Obstetra*: It's according to your profile. Yes, you have to *captar* pregnant women [*gestantes*], yes, you have to *captar* women for *métodos* [contraceptive methods]. If you achieve this according to your profile, then there's no problem . . . In the case that you don't fulfill your profile, then yes, the superiors have the obligation not to contract you again.
>
> *Rebecca*: Do they give different "profiles" to different workers depending on their experience or abilities?
>
> *Obstetra*: It depends; it's personal. If you are doing well, then they will renew your contract.

If, as this *obstetra* states, she and other healthcare workers are still at risk of job loss lest they fail to fulfill certain *meta*s outlined in their contracts, then, arguably, those same incentives that resulted in past coercive sterilizations continue to exist in some healthcare networks. It is not hard to conclude that if an *obstetra* is given a goal of reaching say, 200 people per year for family planning, and her job depends on successfully fulfilling that *meta*, then she may do so by whatever means possible—including coercion.[2] However, if such activities continue to exist as they did under the Fujimori presidency, it should be questioned whether or not coercive behaviors and accusations of obstetric violence occur due to racism and discrimination, as suggested by Ewig (2010) and Guerra-Reyes (2013); or due to power-mad authority abuse and self-righteousness, as suggested by Gianella (2017:88); or if in fact they may be due to institutional and structural conditions that *obligate obstetras* to pursue certain activities and behaviors on behalf of the State in order to keep their jobs. Of course, it is tempting to suggest that they should "just say no." However, realistically, losing one's employment is unlikely to be a viable option for these *obstetras*, who also need to survive financially.

A further problem with this kind of system is that so concerned are *obstetras* to produce a positive evaluation that they necessarily concentrate a large part of their working time attending to the accompanying paperwork to prove that they have performed successfully. To complete an evaluation, *obstetras* need to not only provide evidence of patient records through the FUA and HIS (discussed below) but also to complete large quantities of other documentation to prove that they have been working hard (such as, for examples, lists of houses visited, regardless of patient attendance once there, and records of additional training and

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professional development). Though there may be some use to forms that collect patient data, as will be later argued, much of the paperwork that goes toward the evaluation cannot necessarily be considered as such. Impossible to overstate is the sheer volume of the working day, during which *obstetras* and other practitioners can be observed completing paperwork and forms at every level of the healthcare network. *Obstetras* will fill forms during lunch breaks, during consultations, and even on days off, for if the forms are incomplete, the employee faces penalties. Indeed, paperwork administration is not confined to MINSA, but is a feature of government offices across Peru. As Joaquín Yrivarren Espinoza (2011:22) suggested in his study of a Lima municipality's transition to an electronic system, for most public service workers, "paper is king" (*papelito manda*). Many sectors of the government, especially in rural areas, lack the resources to move to an electronic system, and all "paperwork" in the Vilcashuaman MINSA network is just that—written on paper.

This heavy reliance on paperwork also produces another effect: it turns the practitioners into administrators. There are obvious negative effects of this transformation—more time spent filling forms and filing them away means less time with patients. It also takes a toll on the practitioners themselves. Everyone always complained about the amount of paperwork required of them, and I can attest that it is genuinely excessive.

Obstetra evaluation paperwork aside, the principal forms that must be completed for each patient are the FUA (*formato único de atención/* care records form) and the HIS (*historia/*patient history) along with other specific forms for the patient's medical concerns (e.g., family planning record, pregnancy record, etc.), as well as the medication(s) and contraceptive methods a patient has been prescribed or has discussed. These forms are then filed in a paper folder stored within the patient's corresponding healthcare center. When patients come for an appointment, they must fetch their corresponding folder from the records room, and the *obstetra* will return it once the new paperwork is filed. The following section addresses the political function of these specific forms themselves; however, for now, it is instructive to examine how the workers relate to these forms and to paperwork more generally.

It may be telling that those who are undertaking their mandatory year of rural service (SERUM), the *serumistas*, who are new to the MINSA system, make jokes about the patient forms, both verbally and in the form of shared memes. For example, one meme shows a shocked "Lisa Simpson" staring down at an FUA and reads: "My face the first time that I saw the FUA and HIS [forms]." The second shows a cross-

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armed, grumpy "Pingu the Penguin" and reads, "I want to fulfil my *meta*, but I don't like to fill out FUA or HIS." Daniel Miller and colleagues (2016:172) argue that memes are a way to reinforce norms; in this case, the begrudging acceptance of certain paperwork to reach one's goal (and the importance of fulfilling that goal) through humor: "Memes circulate as a mode of moralizing and humor; as such they are a way of reinforcing social norms . . . there seems to be a case for regarding memes more generally as a kind of 'internet police,' attempting to assert moral control through social media." Thus, the sharing of discontent with MINSA paperwork through memes may be part of the process by which *serumistas* come to understand the gap between their studies at university and their actual roles within the healthcare network—fewer patients and less hands-on health care, more forms and tedium. However, *serumistas* are new to their roles, and after years of such tasks, one's humor may change. *Obstetras* would often lament about how frustrated they felt with the situation. An *obstetra* sighed, "Look, it's all paperwork. *Todo papeleo*."

On this subject, David Graeber (2018:9–10) discusses the rise of unsatisfactory work through the "phenomenon of bullshit jobs"; work which he defines as: "a form of paid employment that is so completely pointless . . . that the employee cannot justify its existence even though, as part of the conditions of employment, the employee feels obliged to pretend that this is not the case." Neither Graeber nor I would ever suggest that the work of *obstetras* and other healthcare workers is in any way pointless (for example, Graeber [2018: xix] mentions nursing as the opposite of "bullshit"). However, the rise of the administrative sector, which results in reams and reams of paperwork destined for nowhere *is* highlighted as "bullshit" by Graeber (2018: xv).

Of course, not all forms are useless, as the following section will discuss; however, here I refer principally to those forms that justify an *obstetra*'s evaluation (as opposed to the FUA and HIS), and that must be completed over and over as every new evaluation cycle begins. As such, a job that is vital in many aspects, yet reduces itself to mindlessness through State-mandated necessity, could be seen as "partly bullshit" (Graeber 2018:24). What should be an active, engaging job such as obstetrics is arguably becoming pointless to an extent in the eyes of *obstetras* and other practitioners due to the endless march of paperwork and form-filling (and lack of patient interaction). Furthermore, the destination of these forms is likely at the bottom of a cabinet or a dank records room, alongside other forms like the contract evaluation records, which may never even be properly reviewed due to the volume and frequency with which all un-named staff submit them. The tasks of filling out

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the FUA and HIS forms are specifically what Graeber (2018:46) calls "box-ticking," which is often a form of government, and functions to "allow an organization to be able to claim it is doing something that, in fact, it is not doing" (2018:45) (e.g., to satisfy MINSA *metas*). The effect that this "box-ticking" has on a person is far more serious than idle boredom, Graeber argues, and can be "soul destroying" (2018:133). Humans, he suggests, are wired to produce a cause and an effect (2018:113), the lack of which can result in stress (2018:117) and physical illness (2018:119). Furthermore, the very act of forced pretense—of pretending that one is undertaking something meaningful while realizing that this is untrue—can be particularly damaging. *Obstetra*s do realize that the paperwork is stopping them from spending any real time with patients but are forced to do it anyway for their evaluations. Graeber (2018:113–134) muses:

> It is hard to imagine anything more soul destroying than . . . being forced to commit acts of arbitrary bureaucratic cruelty against one's will. To become the face of the machine that one despises. To become a monster. It has not escaped my notice that the most frightening monsters in popular fiction do not simply threaten to rend or torture or kill you but to turn you into a monster yourself: think here of vampires, zombies, werewolves. They terrify because they menace not just your body but also your soul.

Following on from Graeber's rather haunting premonition, if *obstetras*' jobs are becoming partly bullshit through the perpetuation of the *administerization* of biomedical care, nevertheless they must continue to do so in order to satisfy the evaluations that will ensure the continuation of their employment—the evaluations that are based upon the target-reaching that has historically led to mass sterilizations and subsequent blame. Thus, how can *obstetras* be expected to offer optimum care to their patients when they can barely find time to be with them, and the system that measures their success is geared toward reproductive coercion? When addressing obstetric violence, this situation clearly needs to be taken into consideration, and the literature has yet to do so

Although healthcare networks are set up to provide biomedical care, the aforementioned situation suggests that there may be other motives; it seems clear that paperwork and form-filling data collection are being prioritized over patient primary care. Thus, there may be an impetus and a motive for the patient forms beyond optimum care provision. It has been suggested that the very nature of paper-based forms and medical reporting may have implications for the ways in which the healthcare system and employee relations (both with patients and with each

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other) are constructed through the act of writing, which would be lost in an electronic system, thus supporting the continuation of paperwork. Marc Berg (1996) argued that the patient record itself can be taken as a "Latourian force" that transforms the social interactions around it (1996:501) and renders the patients "manageable" (1996:507)—an important point to which I return in the following section. Significantly, the use of paper administration made the previously mentioned disappearance of sterilization records possible, thereby directly mediating relationships not only of provider-patient interaction, but potentially also of justice. As Yrivarren Espinoza (2011:22) stated, "For many Peruvians, to be 'papered' (*empapelado*) means to be submitted to an unjust power." Indeed, this issue of paperwork tying one to a power system is not inconsequential; it does exactly that, through the census.

Data, Census, and Biopolitical Statecraft

As noted in the Series Overview in Volume I of this three-volume series (Davis-Floyd and Premkumar 2023a, 2023b, 2023c, 2023d), "'biopolitics' refers to a way of regulating populations through 'biopower'—the application and impacts of political power on human biology in all aspects of human life" (Davis-Floyd and Premkumar 2023b:xiv). The paperwork that *obstetras* and other healthcare workers must complete not only contributes to suboptimal patient care, but is also intimately related to the State and its power. Gathering and recording data on patients tells MINSA a great deal about the population with whom the contracted workers are dealing—information that is very important for the exercise of State biopower—though indeed it is worth noting here that this information-gathering is only useful where specific kinds of data are collected through an FUA or HIS. Taken as such, the focus and importance placed upon data-gathering and record-keeping through staff incentives (i.e., "complete the tasks or lose your job") becomes unpacked. Indeed, *meta*s may be about encouraging contraception coverage by any means to control the fertility of a population, but they also ensure that healthcare workers collect information from as many patients as they possibly can to achieve their *meta*s/work targets. Thus, in this section I argue that the FUAs and the HISs are more than just paperwork; *they are also agents of power*.

Berg (1996:513) suggested that "the medical record is one of the ways power differences are materially constituted," as "the reality of a patient's body is assessed and transformed through layers of paperwork" (1996:511). Furthermore, Berg (1996:501) wrote that the medical re-

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cord is a "force" in and of itself, "*mediating* the relations that act and work through it . . . social interaction is *transformed through* it" (italics in original). The information recorded on these seemingly innocent sheets of paper does not and cannot reflect "reality" or "the truth," as these are highly subjective. The papers thus are records made by individual actors to interact with other actors; their contents and consequential calls-to-action dictate the social interactions (perpetuated by the papers) that occur during the evaluations. In Berg's discussion, such interactions take place among those within the hospital network. Yet the relationships that are mediated by the medical forms may be much larger than that. Such relationships may occur with patients, other practitioners, the State, and on to the global health communities with a vested interest in the national government, such as USAID in the case of Peru—if we consider the destinies of health statistics and their influences on donor programs, for example—and on it goes. It thus further follows that medical records such as the FUA and the HIS should be understood as actors within a human-nonhuman relationship, and should be treated as equal agents of power.

From this perspective, we can see that the information on the MINSA forms does not just record a patient's "reality," but actively incites a transformation in that reality. Simply put, the data collected on the forms—data about children, fertility, contraceptives etc.—is fed back to the State (or at least has the *possibility* to be so), which can then take steps toward its own goals for the population based upon this information—which can be seen as biopolitics. On this subject, Michel Foucault ([1978] 1990:25) stated that governments perceive that they are "not simply dealing with subjects or even with a 'people,' but with a 'population' with its specific phenomena"—a population whose reproduction becomes a "thing one administered" ([1978] 1990:24). Ways to achieve this "administration" include "analysis, stocktaking, classification, and . . . quantitative . . . studies" ([1978] 1990:24), all of which culminate in the census—the ultimate way to analyze and take stock of a group of people (or a nation). To expand, Dianna Taylor (2011:46) writes:

> Biopower administers life rather than threatening to take it away. In order to administer life, it is important for the [national government] to obtain forecasts and statistical estimates covering such demographic factors as fertility, natality . . . for this reason, an important moment in the history of biopower is the development of the modern census.

The "administration of life" is possible through governmentality, and James Scott (1999) suggested that the State needs to collect comprehen-

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sive data on its citizens to achieve the "legibility" to govern effectively. The census—an "instrument of statecraft" (1999: 343)—is the tool used to collect this data. Scott (1999:77) outlined the aim and scope of the census thusly:

> State simplifications such as maps, censuses, cadastral [surveying] lists, and standard units of measurement represent techniques for grasping a large and complex reality; in order for officials to be able to comprehend aspects of the ensemble, that complex reality must be reduced to schematic categories.

It is important to note that in Peru, the 2017 State census re-introduced ethnic categories, including Indigenous self-identification, and that this re-introduction was analyzed as highlighting the Peruvian government's re-emerging interest in identifying these communities within the country (Chirapaq 2017). Thus, it follows that the FUA, HIS, and other forms of data collection undertaken in MINSA are also forms of census-taking that may eventually contribute to the whole State snapshot of population demographics.

In the case of the medical records, the term "census" can be applied if one considers the motivation and execution of the modern census and notes the same manner of reductionist statistical collection in the FUA and HIS. However, if the national census can identify the ethnicities of communities in the county, then the health census can identify bio-elements of the people within those ethnic categories and "report back" to the central government statistics and population demographic databases. The work of MINSA can help to flesh out the realities of the population's health to make them "legible" (Scott 1999). Yet this work is arguably not only about understanding these realities. The health data gathered can also help the State to "administer life" (Foucault [1978] 1990) for these groups. For example, *obstetras* are careful to ask questions about a patient's fertility, infant mortality, use of contraception and reasons for discontinued use, number of sexual partners, and so forth—all of which is written down in the medical record. Combined with the national census information on ethnicity, one would now be able to infer the relationship between, say, Quechua women's fertility compared to the also Indigenous Aymara of Peru, and therefore create more meticulously targeted healthcare programs based upon this new information, for better or for worse.

It is important to note that the gathering and tabulation of statistical data about a "population" is a constructive activity in and of itself. As Khiara Bridges (2011b:148) argued: "The measurement and quan-

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tification of population does not occur after the population has been constructed; rather, population is constructed simultaneously with its measurement and quantification." Ian Hacking (1990:3) calls this population construction "making up people." To count people and their characteristics, it must first be decided which categories will be presented for them to be placed into. For example, Indigenous/ethnic categories must be reduced into quantifiable categories, thereby producing those ethnic categories through the act of the national census's insistence on citizens self-selecting only one such category, when they might actually also belong to another, or to several.

In terms of the census information that the *obstetras* collect, this categorization and quantification may be even more ambiguous. For example, listing a contraceptive for the FUA may be made more difficult if the woman did not consent to past contraceptives that she has had, or if she and her sexual partner(s) use natural or traditional methods (such as the rhythm method or withdrawal) that do not feature as an acceptable biomedical census category. One risks being a non-user statistic through the necessary rigidity of quantitative State data collection. The census forces people to put a number on things that may be too complicated to quantify, thus inventing the categories "in which people could conveniently fall in order to be counted" (Hacking 1990:3). This not simply counting, either. As Hacking argued, statistical inference and the census are based upon an idea that through classification, "one can improve-control a deviant subpopulation" (1990:3) The forms of data collection that make up *obstetras*' days, then, are arguably themselves agents of State biopolitics. In light of the recent national census's focus on ethnic, particularly Indigenous, categorizations, the mass collection of family planning and contraception use data and statistics should not be brushed off as "business as usual." The Peruvian state seemingly wants to know the ethnic and bio-realities of the Quechua (and other) population(s), and the already-stretched and demonized *obstetras* are apparently charged with this task.

Conclusion: The Limited Agency of *Obstetras*

As I have shown, life as an *obstetra* in a rural Peruvian health network is precarious, and is complicated by significant expectations of goal-fulfilling, census-taking, and form-filling to keep one's job. All such acts may indeed contribute toward the realization of questionable outcomes, as with the past forced sterilizations of Indigenous women. However, in

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this chapter, I have attempted to underscore the limited agency held by *obstetras* in the face of such scenarios, and have discussed the ways in which their lived realities are imbued with bureaucratic stresses that detract from providing optimal services to Quechua patients. Thus I argue that, particularly when addressing sterilizations but also when discussing contemporary issues in rural Peruvian reproductive care, it is important to take note of the ways in which healthcare providers fit into the wider State system. Under other circumstances, many *obstetras* in Vilcashuaman may also be considered Indigenous women for whom protections could be sought, and it is important to extend certain considerations, such as their positionality and working conditions, to them when they are employed by, and subsumed under, the State apparatus. Medical anthropologist Paul Farmer once advised that "You can't sympathize with the staff too much, or you risk not sympathizing with the patients" (quoted in Kidder 2009:25); this chapter has been an attempt to refute such a statement. Instead, I argue that to sympathize with and understand the experiences of care receivers, we need to also understand and sympathize with the care providers.

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Notes

1. Shining Path was a Peruvian Maoist revolutionary movement founded in Ayacucho in 1970 and led by Abimael Guzmán until his capture and imprisonment in 1992.
2. It is possible that *obstetras* falsify information in order to reach *metas*. As Cal Biruk suggests in an ethnography of African healthcare system staff "inventing" information that goes toward statistics: "Cooking data refers to fabricating, falsifying, or fudging the information one is meant to collect from survey respondents in a standardized and accurate manner" (2018:3). However, in the absence of any evidence to suggest this possibility, it cannot be included as an argument in this present chapter.

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