A History of the Medical Control of Fertility in Peru, 1895-1976

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Abstract

Demographic transition theorists posit that, beginning in the 1960s, biomedical contraceptive technologies and foreign countries, the United States in particular, have been primarily responsible for changes in medical fertility control ideas and practices in Peru. This dissertation argues that biomedical technologies and transnational political actors have played a role, but not always in the ways that demographic transition theorists indicate. The mass distribution of contraceptives such as the pill and the intra-uterine device, for example, depended on the existence of US-funded birth control organizations. However, these birth control organizations did not justify their existence in Peru only in terms of the promotion of development, but also by making appeals to the integrity of the family, values that many local physicians cherished. In addition, biomedical knowledge concerning the control of fertility began to be applied long before the 1960s, and not all of it originated in the United States nor was it all oriented towards the limitation of birth rates. Moreover, demographic transition theory's assumption that financial calculations were the primary reason for the prevention or spacing of births overlooks other factors, such as marital strife, that also affected the desire for offspring. Through archival material and oral histories in Peru and the United States, this dissertation raises questions about the ideologies and practices of medical experts, and their interactions with state agencies, foreign governments, the Catholic Church, and people who had abortions.

Résumé

La théorie de la transition demographique suggere une transformation telle que, depuis les années 1960, les technologies biomédicales et les pays étrangers, espécialement les États-Unis, fut principalement responsables pour les changements des idées et pratiques en matière du contrôle medical de la fertilité au Pérou. Cette thèse argumente que les technologies biomédicales aussi que les acteurs politiques transnationaux en effet jouèrent un rôle, mais pas toujours dans la façon prévue par les théoristes de la transition demographique. La distribution massive des méthodes contraceptifs, tel que la pillule et le dispositif intra-uterin, par example, dépendit de l'existence des organismes de contrôle de la natalité financiés par les États-Unis. Cependent, cettes organismes ne justifièrent leur présence au Pérou seulement par la promotion du developement. Ils attachaient aussi de l'importance à l'integrité de la famille, un valeur que beaucoup des médecins entretinrent. D'ailleurs, des connaissances biomédicales sur le contrôle de la fertilité commencèrent à être appliquées avant les années 1960, et une partie importante d'entre elles ne provinrent pas des États-Unis. De plus, la supposition que la théorie de la transition demographique fasse sur la prevention ou l'espacement des naissances comme simples resultats des calculs economiques néglige autres facteurs, tel que les querelles des couples, lesquelles affectaient aussi le désir d'avoir des enfants. A travers des materiaux d'archives et des intervues au Pérou et aux États-Unis, cette thèse nous emmene a considerer les ideologies et les pratiques des experts médicaux, aussi que les interactions entre eux et des agences gouvernamentales, des gouvernements étrangers, l'église Catholique, et des gens qui avortaient.

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Chapter One

Medical Control and Fertility in Peru, 1895-1976

In 1995, Peruvian President Alberto Fujimori gave a speech as the only male head of state attending the Fourth World Conference on Women in Beijing.[1] Fujimori praised the skilled ways in which women in poor countries were able to organize themselves to overcome economic hardship. To a standing ovation, he also announced the recent legalization of surgical sterilization as a contraceptive in Peru.[2] Just a few years later, the Peruvian press began publishing a series of accusations about forced surgical sterilizations of hundreds of poor women in several rural areas of my country, Peru.[3] The reports involved officers from the Ministry of Health, directors of rural health centers, and even the United States Agency for International Development, and they led to investigations by the Peruvian Ombudsman's Office and the US House of Representatives.[4]

I began to keep track of these stories in 1996, and soon it became apparent that there was more to the story than powerful agencies and physicians victimizing poor, illiterate, non-white, rural women. The same newspapers that brought the abuses to light

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[1] "Discurso del Presidente Fujimori en la 4ta Conferencia de la Mujer en Beijing, 15 de Setiembre de 1995," Boletín del Consejo Nacional de Población 4 (Setiembre 1995): 13-14.
[2] Amendment 155/95 to the National Population Policy (Decreto Ley 346). Approved 7 September 1995.
[3] Esperanza Reyes, "'No Somos Bultos Para Ser Tratados Así': El Programa de Planificación Familiar, 1996-1998," Allpanchis 31, 56 (2000): 107-128.
[4] See Informe de la Defensoría del Pueblo 01-98 (26 January 1998); and United States House of Representatives Committee on International Relations, Subcommittee on International Operations and Human Rights, Hearing on the Peruvian Population Control Program (Washington, DC: 25 February 1998).

reported details that made guilt seem less than straightforward. The Catholic Church, today an opponent of all contraceptive methods, had been behind many of the accusations of forced sterilization.[5] Were the accusations less credible because of that association? Moreover, some politicians lamented the illegal sterilizations as tragic in a country that they considered underpopulated. How did they determine such want of population? Physicians themselves were perplexed by accusations of abuse, as they believed they acted according to the standards of their profession in securing informed consent from women and in performing the surgeries. Finally, at least some of the women who had undergone the surgeries were satisfied with the outcomes. Not only had such women agreed to the operations voluntarily, but they had even traveled in search of the free-of-charge surgeries when these were not performed near their places of residence.[6]

President Fujimori's legalization of surgical sterilization had been, at least in part, an effort to provide men and women with another safe and effective contraceptive. Unwanted pregnancies often led Peruvian women to induce their own miscarriages, or to procure illegal abortions from different types of providers.[7] Injuries, hospitalization, and even death were frequent results. Physicians and feminist critics in Peru argued that greater access to more effective and safer contraceptives could help diminish the recourse to abortions and also teen pregnancies, both of which contributed to the country's

[5] The Catholic Church approves only of periodic abstinence from sex to regulate fertility.
[6] See special issues of the following Peruvian newspapers: El Comercio (12 July 1996), La República (31 May 1998), and Expreso (31 May 1998).
[7] Therapeutic abortions, performed by a physician when a pregnancy puts a woman's life or health at risk, are the only kind of abortion that is legal in Peru.

maternal mortality rate.[8] By 1995, the year surgical sterilizations became legal in Peru, the country's maternal mortality rate was 240 per 100,000 live births.[9]

In the aftermath of the surgical contraception scandal, Congress changed the Ministry of Health's Family Planning Manual to emphasize the importance of informed consent for sterilization surgeries and the provision of information on all contraceptive methods in state health centers.[10] By 2005, Peru's maternal mortality rate had dropped to 185 per 100,000 live births, an improvement, but one that did not match other countries' gains in Latin America and the Caribbean. In the region, only Bolivia's and Haiti's maternal mortality rates were higher than Peru's, and yet Peru's 2005 per capita income was more than twice that of Bolivia and more than three times that of Haiti.[11] Rural populations in Peru historically have garnered little of the state's attention in terms of social development services such as education, health, and the building of infrastructure.[12] It is in these areas where the fewest health personnel work, where the quality of their interaction with patients is worst and, not surprisingly, where maternal mortality rates are highest.[13]

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[8] Delicia Ferrando, El Aborto Clandestino en el Perú: Hechos y Cifras (Lima: Flora Tristán and Pathfinder International, 2002).
[9] Carla Abou-Zahr and Tessa Wardlaw, Maternal Mortality in 1995: Estimates Developed by WHO, UNICEF, and UNFPA (Geneva: World Health Organization, 2001).
[10] "Normas del Programa Nacional de Planificación Familiar," Resolución Ministerial del Ministerio de Salud del Perú 465-99-SA/DM. Lima, 22 Setiembre 1999.
[11] Pan-American Health Organization, United Nations Fund for Population Activities, and United Nations Development Fund for Women, "Gender, Health and Development in the Americas: Basic Indicators 2005."
[12] Juan Arroyo (ed.), La Salud Peruana en el Siglo XXI: Retos y Propuestas de Política (Lima: Consorcio de Investigación Económica y Social, 2002).
[13] Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer y Centro Legal para Derechos Reproductivos y Políticas Públicas, Silencio y Complicidad: Violencia contra las Mujeres en los Servicios Públicos de Salud en el Perú (Lima: CLADEM, 1998).

Conflicting political interests, lopsided economic growth, unclear professional standards, and popular and pragmatic demand for contraceptives make Peru one of the most unjust countries in the Americas when it comes to the provision of family planning services, and an interesting case study for the history of fertility control. The latter issue has long been contentious in the country. Medical researchers carried out clinical trials with contraceptives since the 1960s. Earlier, in the 1940s, rapid population growth made policy makers fearful that the state would not be able to satisfy the needs of its citizens. Even before that, a group of medical professionals and intellectuals at the turn of the twentieth century promoted the notion that multiple factors threatened a much-needed population increase. At the same time, fertility was not just contentious because of its links to new technologies or population size, but also because it was, as it is today arguably everywhere, a part of daily life. Peruvian men and women of the late nineteenth and early twentieth centuries developed rich ways to speak about events such as miscarriages and abortions. This dissertation deals with all of these subjects, which raise questions about the ideologies and practices of medical experts, and their interactions with state agencies, foreign governments, the Catholic Church, and people who had abortions.

Despite the diversity of interventions discussed, the focus is on the relations between modern medicine and fertility control. This does not mean that other social actors are less important, only that the participation of medical experts has left visible historical traces, and continues to animate social, demographic, economic, and human rights debates in Peru. Still, what is not covered in this dissertation, due to time and resource limits, is as great or greater than what is. Thus, topics like midwifery and

traditional birth attendants, the role of demographers, and the experiences of users of contraceptive methods receive only some mention in the course of discussing other events, even though such topics deserve fuller treatment than I am here able to provide. The questions I address in this dissertation are the following:

1. Who were the medical experts who argued in the late nineteenth century that national progress was only possible through increasing and improving Peru's population? Why did they believe this? What did they accomplish?
2. Why did physicians in the early twentieth century consider abortion a threat to demographic growth? How did they translate those beliefs into criminal charges? How were lay people able to avoid and deflect these accusations?
3. What was the scientific and social status of birth control technologies in the early- to mid-twentieth century? How did foreign birth control organizations promote themselves in Peru and acquire allies among local health workers in the mid-twentieth century?
4. How did Peruvian policymakers establish a link between rapid population growth and industrialization in the mid-twentieth century? How did family planning fit within the creation of a population policy in the 1960s and 1970s?
5. How did the Catholic Church participate in the national debates about birth control, population growth, and national development in the twentieth century?

Main Propositions

I am especially interested in how biomedical power promoted or failed to produce changes in fertility control practices in Peru. This question flows out of the way in which

scholars have applied demographic transition theory to understand Latin America's fertility rate reduction in the second half of the twentieth century. Demographic transition theory, whose origins date to the late 1920s, has had a deep impact on our understanding of why population sizes change over time within a given territory. Its main tenets continue to guide the work of international family planning organizations, and influence technical assistance decisions by governments and popular analyses in the media.[14]

Demographers such as Warren Thompson, Alexander Carr-Saunders, Adolphe Landry, Charles Blacker, and Frank Notestein pioneered what came to be known as demographic transition theory by studying the drop in birth rates in Europe in the nineteenth century.[15] According to the theory, the first stage of the demographic transition, the longest in human history, consisted of an equilibrium of population size achieved through high birth rates and high death rates.[16] The lack of agriculture and

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[14] See for example Michael Teitelbaum, "Relevance of Demographic Transition Theory for Developing Countries," Science 188, 4187 (1975): 420-425; Paul Demeny, "Social Science and Population Policy," Population and Development Review 14, 3 (1988): 451-479; and David Phillips, Health and Health Care in the Third World (New York: Longman, 1990).

[15] Warren Thompson, Danger Spots in World Population (New York: A.A. Knopf, 1929); Alexander Carr-Saunders, World Population: Past Growth and Present Trends (London: F. Cass, 1936); Charles Blacker, Voluntary Sterilization (London: Oxford University, 1934); Adolphe Landry, La Révolution Démographique: Études et Essais sur les Problèmes de la Population (Paris: Institut Nationale d'Études Démographiques, 1934); Frank Notestein, "Population: The Long View," in Theodore Schultz (ed.), Food for the World (Chicago: University of Chicago Press, 1945).

[16] Demographer Louis Henry coined the term "natural fertility" to refer to this earliest stage, in which presumably fertility was not deliberately limited. See Louis Henry, "Some Data on Natural Fertility," Eugenics Quarterly 8, 2 (1961): 81-91. Anthropologist Don Dumond challenged this view by proposing that "natural fertility" only emerged once most human groups became sedentary agriculturalists, as opposed to hunter-gatherers. The earliest human females, Dumond claimed, limited their fertility in different ways, so as to be able to perform different tasks. Dumond suggested that extended families began to take a larger role in the raising of offspring among sedentary agriculturalists, making birth limitation less necessary. See Don Dumond, "The Limitation of Human Population:

sanitation made life spans short, which over time led to the evolution of powerful pro-natalist institutions, in the shape of religious beliefs, moral codes of behavior, and marriage patterns. This pro-natalism was quite rational, the theorists argued, as it allowed "primitive" societies to endure the passage of time. In fact, children's work became an economic advantage in these societies. In the second stage of the demographic transition, the theory continues, mortality began to decline through improvements in diet and sanitation.[17] Fertility, however, remained high, leading to rapid population growth. Finally, in the third stage, birth rates declined and a new equilibrium was established with low birth and death rates. This declining birth rate was accomplished when new social institutions replaced the pro-natalist ones.

Demographic transition theorists credited processes such as urbanization and industrialization with the weakening of pro-natalist social conventions, and used various names to refer to the process of completing the transition, particularly "modernization." In "modern" societies, the labor of children, which might have been an advantage in rural and pre-industrial settings, made less sense. In fact, a large number of offspring could become a liability, because "modern" societies required greater expenditures in the education and health maintenance of children.[18] This mentality shift in favor of smaller families was an eminently rational act of adapting to new circumstances, demographic transition theorists posited. The pursuit of smaller families in the European transition relied not on technically sophisticated contraceptives, but on techniques such as coitus

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A Natural History," in Landy, David (ed.), Culture, Disease and Healing: Studies in Medical Anthropology (New York: Macmillan, 1977).

[17] See the classic by Thomas McKeown, The Modern Rise of Population (London: Edward Arnold, 1976).

[18] Philippe Ariès, Centuries of Childhood: A Social History of Family Life (New York: Vintage Books, 1962).

interruptus, abortion, and the delaying of marriage. In addition, demographic transition theorists suggested that people in "modern" societies had more ambitious individualistic aspirations. They sought better health, wealth, and education for themselves, and they increasingly saw having many children as obstacles to those goals.[19]

More recent demographic research has helped qualify and specify the limits of demographic transition theory. For example, it has shown how diverse European regions were in the onset and duration of their demographic transitions.[20] Others have insisted on the importance of migration as an understudied aspect of changing population sizes.[21] Most importantly for our purposes, since the 1960s scholars have attempted to clarify the conditions under which the demographic transition theory is applicable to the developing world, particularly Latin America.[22] Four things are remarkable about this literature: first, it dates the onset of the Latin American demographic transition to the first half of the 1960s, a period during which Latin Americans presumably began to value smaller family sizes; second, it indicates that the reduction of birth rates in Latin America occurred not

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[19] John Caldwell, "Toward a Restatement of Demographic Transition Theory," Population and Development Review 2, 3-4 (1976): 321-366.

[20] Ansley Coale and Susan Cotts Watkins (eds.), The Decline of Fertility in Europe (Princeton: Princeton University Press, 1986); David Reher and Pedro Iriso-Napal, "Marital Fertility and Its Determinants in Rural and Urban Spain, 1887-1930," Population Studies 43 (1989): 405-427; Jane Schneider and Peter Schneider, Festival of the Poor: Fertility Decline and the Ideology of Class in Sicily, 1860-1980 (Tucson: University of Arizona, 1996); Kate Fischer, "Uncertain Aims and Tacit Negotiation: Birth Control Practices in Britain 1925-1950," Population and Development Review 26 (2000): 295-317.

[21] Jean-Claude Chesnais, The Demographic Transition: Stages, Patterns and Economic Implications (Oxford: Clarendon, 1992).

[22] See special issues of the Milbank Memorial Fund Quarterly 43 (1965) and 46 (1968). See also Clyde Kiser, "Population Trends and Public Health in Latin America," Milbank Memorial Fund Quarterly 45 (1967): 43-59. For an early assessment of the role of cities in Latin American demographic change, see Kingsley Davis and Ana Casis, "Urbanization in Latin America," Milbank Memorial Fund Quarterly 24 (1946): 186-207 and 292-314.

through the means used in the European demographic transition, but through sophisticated biomedical technologies used primarily by women; third, it assumes that it was the United States that hegemonically extended the small nuclear family ideal and the biomedical knowledge networks necessary to reach this ideal; and fourth, it praises family size limitation as conducive to greater industrialization and wealth, and to fewer urban problems, such as unemployment and lack of educational opportunities.[23]

These arguments are indicative of how politically charged population growth in Latin America had become during the 1960s, a point to which I will return in chapters four to six. They also suggest that demographic transition theorists viewed small nuclear families as inspired by US norms and as necessary for Latin American "modernization."[24] In fact, these scholars began to write of opposition to the use of contraceptives as a misinformed or, worse, irrational attitude, and an obstacle to development that must be overcome. Finally, the literature on the Latin American demographic transition credits biomedical contraceptive technologies with reducing population growth, easing economic development, and changing Latin American pro-natalist mentalities. In other words, it

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[23] Betsy Hartmann, Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice (New York: Harper & Row, 1987); Barbara Crane, "The Transnational Politics of Abortion," Population and Development Review 20 (1994 Supplement): 241-262; José Miguel Guzmán, Susheela Singh, Germán Rodríguez and Edith Pantelides (eds.), The Fertility Transition in Latin America (Oxford: Clarendon, 1996); Carmen Yon Leau, Hablan las Mujeres Andinas: Preferencias Reproductivas y Anticoncepción (Lima: Manuela Ramos, 2000).

[24] Note how industrialization, the greater use of technology, urbanization, wealth generation and the extension of educational opportunities constitute the classic prerequisites for the sustainability of democratic institutions according to modernization theory. See Seymour Martin Lipset, "Some Social Requisites of Democracy: Economic Development and Political Legitimacy," American Political Science Review 53, 1 (1959): 69-105; and Walt Rostow, The Stages of Economic Growth, A Non-Communist Manifesto (Cambridge: Cambridge University, 1960).

credits the medical control of fertility with important population, economic, and cultural changes in the region.[25]

My main contention is that biomedical technologies, knowledge networks, and transnational political actors indeed promoted changes in fertility control practices in Peru, just not always in the ways that demographic transition theorists indicate. The mass distribution of contraceptives such as the pill and the intra-uterine device, for example, depended on the existence of US-funded birth control organizations. However, these birth control organizations did not justify their existence in Peru only in terms of the promotion of development, but also by making appeals to the integrity of the family, values that many local physicians cherished.[26] In other words, foreign birth control organizations in Peru had to negotiate their interests with those of pre-existing local actors in order to take root in the country. A second challenge to demographic transition theory has to do with the sources of biomedical knowledge deployed in Peru to control fertility. Not all of this knowledge began to be applied in the early 1960s, nor did all of it originate in the United States or was oriented towards the limitation of birth rates. For example, a rich and mostly oral tradition about the fertility enhancing or limiting properties of certain plants

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[25] Alexander Kessler and C.C. Stanley, "Human Reproduction and Family Planning: Research Strategies in Developing Countries," Nature 251 (1974): 577-579; Gisele Maynard Tucker, "Barriers to Modern Contraceptive Use in Rural Peru," Studies in Family Planning 17, 6 (1986): 308-316; Jason Finkle and C. Alison McIntosh, "The New Politics of Population," Population and Development Review 20 (1994 Supplement): 3-34; Gisele Maynard-Tucker, "Haiti: Unions, Fertility and the Quest for Survival," Social Science and Medicine 43, 9 (1996): 1379-1387. Johnson-Hanks also discerns this attitude among family planning organizations that work in Africa. See Jennifer Johnson-Hanks, "On the Modernity of Traditional Contraception: Time and the Social Context of Fertility," Population and Development Review 28, 2 (2002): 229-249.

[26] As late as the mid-1990s, family planning activities in the country were predicated on the maintenance of these two values. See Stéphanie Rousseau, "The Politics of Reproductive Health in Peru: Gender and Social Policy in the Global South," Social Politics 14, 1 (2007): 93-125.

exists in Peru at least since the colonial period. Likewise, French puericulture, a medical approach for the protection of pregnant women and infants that emphasized the need to enhance the quantity and quality of population, was popular among Peruvian physicians beginning in the late nineteenth century. Moreover, knowledge about fertility control produced by Latin American physicians circulated in regional conferences since the early twentieth century and influenced Peruvian physicians' views about the importance of both increasing and limiting fertility. A third challenge to demographic transition theory concerns its assumption that financial calculations were the primary reason for the prevention or spacing of births. While children certainly required time, energy, and financial investments, Peruvian women who had abortions teach us that fertility limitation often had more to do with other reasons, such as the troubled interpersonal relations between women and their sexual partners.

The Medical Control of Fertility

Fertility is a complex phenomenon. The number of offspring a woman has is not its only important dimension. Male and female infertility, and the physical changes in a woman's body as a result of a pregnancy, for example, remind us that fertility is a biological phenomenon and not simply a statistical one. Different events can disrupt fertility from what societies deem organically normal; hence there is a longstanding link between fertility, health, and healing that gave rise to the knowledge of birth attendants and faith healers in multiple cultural contexts. These specialists developed ways to care for bodily ailments such as impotence, hemorrhages during birth, and the transmission of

genetic diseases.[27] Nevertheless, the disruption of an organic function need not be automatically deemed a disease. Some changes linked to fertility, such as menopause, point less to a quantitative loss of or increase in health, than to what Georges Canguilhem dubbed "new dimensions of life", that permit or precede new behaviors and experiences while precluding others.[28] To make matters still more complex, fertility involves not only statistical and biological dimensions, but also social and cultural ones. The socioeconomic status of parents, the timing and geographic location of births, the assistance of certain individuals before, during and after birth, as well as the reasons for the spacing of births, among other considerations, make fertility socially meaningful and tie it to the waxing and waning of wealth and prestige.[29]

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[27] See for example Ronald Schwartz, "The Midwife in Contemporary Latin America," Medical Anthropology 5, 1 (1981): 51-71; Edward Shorter, A History of Women's Bodies (New York: Basic Books, 1982); Judith Leavitt, Brought to Bed: Childbearing in America, 1750-1950 (New York: Oxford University Press, 1986); Roger Jeffery and Patricia Jeffery, "Traditional Births Attendants in Rural North India: The Social Organization of Childbearing," in Shirley Lindenbaum and Margaret Lock (eds.), Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life (Berkeley: University of California Press, 1993); Rosana Vargas and Paola Naccarato, Allá, las Antiguas Abuelas Eran Parteras (Lima: Flora Tristán, 1995); Elisha Renne, "The Pregnancy that Doesn't Stay: The Practice and Perception of Abortion by Ekiti Yoruba Women," Social Science and Medicine 42, 4, (1996): 483-494; Robbie Davis-Floyd and Carolyn Sargent (eds.), Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives (Berkeley: University of California Press, 1997); Caroline Bledsoe, Contingent Lives: Fertility, Time and Aging in West Africa (Chicago: University of Chicago Press, 2002); Lee Penyak, "Obstetrics and the Emergence of Women in Mexico's Medical Establishment," The Americas 60, 1 (2003): 59-85.

[28] Georges Canguilhem, Le Normal et le Pathologique (Paris: Presses Universitaires Françaises, 1966, 186).

[29] See Emily Martin, The Woman in the Body: A Cultural Analysis of Reproduction (Boston: Beacon, 1987); Faye Ginsburg and Rayna Rapp (eds.), Conceiving the New World Order: The Global Politics of Reproduction (Berkeley: University of California Press, 1995); Susan Sherwin (ed.), The Politics of Women's Health: Exploring Agency and Autonomy (Philadelphia: Temple University Press, 1998); Kalpana Ram and Margaret Jolly (eds.), Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific (Cambridge: Cambridge University Press, 1998).

Scholarly debates about medical power are closely linked to the work of Michel Foucault. Foucault described Western society since the late eighteenth century as increasingly controlled by forms of knowledge production about the human body that relied on medical techniques and categories.[30] This medical control, he claimed, acquired allies in governments because the latter desired to have larger and more productive populations to compete against other nations, and medical knowledge helped in that regard.[31] According to Foucault, new disciplines emerged as a result, such as public health and the social sciences, which resulted in greater knowledge about humans, and also in greater governmental capacities to calculate, plan, and implement reforms to modify individual behaviors.[32]

Historians have lobbed several critiques at Foucault's view of European history.[33] Chief among them is the charge that the "medicalization" of society does not address the cultural and institutional mediations between medical discourse and individual experience. How, for example, did state bureaucracies, moral reform movements, the press, and professional associations, among others, promote or hinder the medical control of social life? Critics such as Roy Porter and Guenther Risse emphasize, as Foucault did, that European urbanization and industrialization in the late eighteenth century led to the

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[30] See the following by Michel Foucault, The Birth of the Clinic: An Archeology of Medical Perception (New York: Vintage, 1975); Discipline and Punish: The Birth of the Prison (New York: Pantheon, 1977); The History of Sexuality (New York: Pantheon, 1978); and Power/Knowledge: Selected Interviews and Other Writings, 1972-1977 (New York: Pantheon, 1980), especially the chapter on "Body/Power".

[31] Michel Foucault, Sécurité, Territoire, Population: Cours au Collège de France, 1977-1978 (Paris: Hautes Etudes-Gallimard-Seuil, 2004).

[32] Nikolas Rose, "Medicine, History and the Present," in Colin Jones and Roy Porter (eds.), Reassessing Foucault: Power, Medicine and the Body (London: Routledge, 1980.

[33] For a good summary of these criticisms and critics, see Robert Nye, "The Evolution of the Concept of Medicalization in the Late Twentieth Century," Journal of History of the Behavioral Sciences, 39, 2 (2003): 115–129.

greater salience of sanitation and hygiene for governments. But, unlike Foucault, Porter and Risse also underscore the importance of factors such as improved medical education, safer medical technologies, larger hospitals, and social insurance schemes to account for the greater status of physicians and medical science in Europe and the United States.[34] In addition, Foucault's early use of the term "medicalization" implied that medical knowledge established a one-directional and non-negotiable dominion over society, without clearly specifying how this process took place.[35]

Despite these criticisms, we ought not to chuck the proverbial baby out with the bathwater at least for three reasons. First, the notion of "medical control" allowed Foucault to develop important points about the origins of the clinical perspective. According to him, the latter resulted from a kind of epistemic specialization through which the expert paid less attention to individual sufferers and more attention to discrete pathologies that could be comprehended and acted upon irrespective of the person afflicted. This insight has reappeared in more recent historical works to explain the emergence of clinical nosologies and diagnostic specificity.[36]

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[34] Dorothy Porter and Roy Porter, "What Was Social Medicine? An Historiographical Essay," Journal of Historical Sociology 1, 1 (1988): 90-106; and Guenther Risse, "Medicine in the Age of Enlightenment," in Andrew Wear (ed.), Medicine in Society: Historical Essays (Cambridge: Cambridge University Press, 1992). See also Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry (New York: Basic Books, 1982); Matthew Ramsey, "The Politics of Professional Monopoly in Nineteenth-Century Medicine: The French Model and Its Rivals," in Gerald Geison (ed.), Professions and the French State 1700-1900 (Philadelphia: University of Pennsylvania Press, 1984); Keith Wailoo, Drawing Blood: Technology and Disease Identity in Twentieth-Century America (Baltimore: Johns Hopkins University Press, 1997).

[35] See especially Foucault, Birth of the Clinic.

[36] John Warner, The Therapeutic Perspective: Medical Practice, Knowledge and Identity in America, 1820-1885 (Cambridge: Harvard University Press, 1986); Charles Rosenberg and Janet Golden (eds.), Framing Disease: Studies in Cultural History (New Brunswick:

Second, contemporary scholars are aware that medical control is not a one-directional and non-negotiable phenomenon. Recent historical and social science analyses emphasize that different social phenomena can be treated as medical problems, though rarely without significant contestation. Thus, topics such as homosexuality, diet, immigration, addiction, genetics, ethnicity, tropical geographies, shyness, and shopping, to name but a few, are among those fruitfully studied through the medical control lens.[37] Human reproduction has not escaped this trend. Medical discourses and practices related to population growth, menopause, infant mortality, pregnancy, male impotence, infertility, and menstruation have also been objects of recent scholarship.[38]

Rutgers University Press, 1992); Charles Rosenberg, "The Tyranny of Diagnosis: Specific Entities and Individual Experience," The Milbank Quarterly 80, 2 (2002): 237-260.

[37] Peter Conrad and Joseph Schneider, Deviance and Medicalization: From Badness to Sickness (Philadelphia: Temple University Press, 1980); Paul Farmer, AIDS and Accusation: Haiti and the Geography of Blame (Berkeley: University of California Press, 1992); David Arnold, Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India (Berkeley: University of California Press, 1993); Alan Kraut, Silent Travelers: Germs, Genes and the "Immigrant Menace" (Baltimore: Johns Hopkins University Press, 1994); Judith Farquhar, Appetites: Food and Sex in Post-Socialist China (Durham: Duke University Press, 2002); Troy Duster, Backdoor to Eugenics (New York: Routledge, 2003); Charles Briggs and Clara Mantini-Briggs, Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare (Berkeley: University of California Press, 2003); Shirley Lee and Avis Mysyk, "The Medicalization of Compulsive Buying," Social Science and Medicine 58, 9 (2004): 1709-1718; Anne Perez Hattori, Colonial Dis-Ease: US Navy Policies and the Chamorros of Guam, 1898-1941 (Honolulu: University of Hawai'I Press, 2004); Warwick Anderson, Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines (Durham: Duke University Press, 2006); Stephanie Lloyd, "The Clinical Clash over Social Phobia: The Americanization of French Experiences?" BioSocieties 1 (2006): 229-249.

[38] Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," Signs 16, 4 (1991): 787-807; Margaret Lock, Encounters with Aging: Mythologies of Menopause in Japan and North America (Berkeley: University of California Press, 1993); Margaret Lock and Patricia Kaufert (eds.), Pragmatic Women and Body Politics (Cambridge: Cambridge University Press, 1998); Nancy Rose Hunt, A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo (Durham: Duke University Press, 1999); Laura Mamo and Jennifer Fishman, "Potency in All the

Third, the idea of medical control points to the historical emergence of a specific form of knowledge that became politically strong both through imposition by governments, and through its own effectiveness at preserving and improving the quality of life. In other words, medical control points not necessarily to some conspiracy by physicians to impose their beliefs on everyone else. Rather, it refers to a process of persuasion by which individuals come to consent to medical precepts and advice. Medical control is, then, medicine's achievement of a hegemonic position. To extend this insight, the medical control of fertility can be defined as that state in which people consent to the idea that medical science is the best way to make fertility into a positive and enriching aspect of life.

This point brings us closer to understanding medical control as a form of social control. Control implies the use of power in social relations, but thinking of medical power as solely restrictive, one-directional, and non-negotiable is insufficient.[39] Medical power would be brittle if it only repressed, censored, or excluded; this power is strong because it also produces pleasure, knowledge, and sensible ways of life. We must broaden our survey of the forms of the medical power implicated in fertility control to include the ways in which this power produced something new: institutions, scientific disciplines, and consumer demand for contraceptives, for example; how it created

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Right Places: Viagra as a Technology of the Gendered Body," Body and Society 7, 4 (2001): 13-35; Marcia Inhorn, Local Babies, Global Science: Gender, Religion and In Vitro Fertilization in Egypt (New York: Routledge, 2003); Matthew Connelly, Fatal Misconception: The Struggle to Control World Population (Cambridge: Harvard University Press, 2008).

[39] Some of the scholars who wrote in this vein include Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (Garden City: Anchor, 1961); Thomas Szasz, Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers (Garden City: Anchor, 1974); Ivan Illich, Medical Nemesis: The Expropriation of Health (London: Boyars, 1976).

interdependencies, such as those between abortion seekers and abortion providers; and how it was negotiated, as when foreign birth control institutions sought to take part in the national life of a country, such as Peru, that had little familiarity with them. These episodes, discussed in this dissertation, can help us better understand the nature and extent of the power of biomedical science.

The Peruvian case compels us to take seriously Antonio Gramsci's view of the resilience of civil society. The status quo is not necessarily maintained by repressive states that intrude into every aspect of life and threaten the existence or property of non-conformists. Rather, order is maintained voluntarily because we grow accustomed to certain forms of life that multiple civil society institutions buttress. Medicine too enables forms of life that different people find agreeable. This popular consent to social conditions is the basis of what Gramci called hegemony. Groups may consent, readily even, to some forms of power, but not to others. Hegemony is in part a function of social homogeneity. Heterogeneous collectivities have difficulty agreeing on the superiority of any one approach to social organization.[40] Peru's heterogeneous society, hewn by racial, cultural, religious, economic, and political faults, is a case in point. There, as I will show, foreign biomedical discourses on contraception met the power of local lay practices; anxieties over the "population explosion" of the 1960s clashed with religious and military opposition to "*el birthcontrol*"; and women's fears of being dishonored by out-of-wedlock pregnancies outraged local male physicians' self-appointed right to police female honor. As I will argue throughout, the medical control of fertility was enabled and constrained by forms of knowledge produced outside Peru, by lay ideas about pregnancy,

[40] Antonio Gramsci, Selections from the Prison Notebooks (New York: International Publishers, 1999). See especially book two, chapter two, "State and Civil Society."

by government bureaucracies, by foreign agencies and states, and by the Catholic Church. That, however, does not mean that medicine and health institutions are entirely dependent on the above factors. What it does mean is that hegemony of any kind is not easy to achieve.[41] In fact, as I will show in the following chapters, the striving for medical control over fertility has been an important engine of social change in Peru.

Fertility in the Historiography of Latin America

Since the 1990s, a growing body of literature connects the medical control of fertility to medical professionalization and to elite projects to "civilize" all Latin Americans along Western lines.[42] One important point of convergence for these disparate works is their emphasis on the late nineteenth century as the period during which the medical profession became a politically strong collectivity. This process coincided, not by chance, with the acceleration of Latin American nation-states' insertion into transnational capitalist networks. Latin American countries participated in these networks mostly as producers of raw materials, which generated new prosperity (albeit for a

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[41] On the difficulties of establishing a hegemonic position, see also James Scott, Domination and the Arts of Resistance: Hidden Transcripts (New Haven: Yale University Press, 1990); and Nicholas Abercrombie, Stephen Hill, and Bryan Turner, The Dominant Ideology Thesis (London: George Allen & Unwin, 1980).

[42] María Emma Mannarelli, Limpias y Modernas: Género, Higiene y Cultura en la Lima del Novecientos (Lima: Flora Tristán, 1999); Ana María Carrillo, "Nacimiento y Muerte de una Profesión: Las Parteras Tituladas en México," Dynamis 19 (1999): 167-190; Laura Briggs, Reproducing Empire: Race, Sex, Science and US Imperialism in Puerto Rico (Berkeley: University of California Press, 2002); Kristin Ruggiero, Modernity in the Flesh: Medicine, Law and Society in Turn-of-the-Century Argentina (Stanford: Stanford University Press, 2004); Julia Rodríguez, Civilizing Argentina: Science, Medicine, and the Modern State (Chapel Hill: University of North Carolina Press, 2006); Claudia Agostoni, "Las Mensajeras de la Salud: Enfermeras Visitadoras en la Ciudad de México durante la Década de los 20," Estudios de Historia Moderna y Contemporánea de México 33 (2007): 89-120; María Soledad Zárate, Dar a Luz en Chile, Siglo XIX: De la "Ciencia de Hembra" a la Ciencia Obstétrica (Santiago: Universidad Alberto Hurtado, 2007).

minority), attracted new immigrants, encouraged population growth, and promoted the growth of cities.[43] In this context, Peruvian and other Latin American elites embraced science, Positivism and European tastes as markers of high culture, and as prerequisites for national progress.[44] To these elites, the growth of medical science became a necessary part of becoming a civilized nation.

Peruvian physicians of the late nineteenth and early twentieth centuries were part of this elite. They benefited from European-originated medical innovations such as vaccines, anesthesia, x-rays, and the germ theory, as well as from the support of philanthropic organizations such as the US Rockefeller Foundation, which provided funding and technical support to battle several diseases, including yellow fever and hookworm.[45] These contributions from without enhanced the prestige and effectiveness of medical science at home and cemented its links to increasingly better-organized government agencies. Medicine's ability to improve the quality of life in turn enhanced the authority of the Peruvian government and made physicians more willing and able to assert their dominance over competitors in the health field.[46] By the early twentieth

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[43] Tulio Halperín Donghi, Historia Contemporánea de América Latina (Madrid: Alianza, 1970); Christopher Abel, Health, Hygiene and Sanitation in Latin America c. 1870 to 1950 (London: University of London Press, 1996); Victor Bulmer-Thomas, The Economic History of Latin America since Independence (Cambridge: Cambridge University Press, 2003).

[44] Charles Hale, "Political Ideas and Ideologies in Latin America, 1870-1930," in Leslie Bethell (ed.), Ideas and Ideologies in Twentieth Century Latin America (Cambridge: Cambridge University Press, 1996).

[45] Marcos Cueto (ed.), Missionaries of Science: The Rockefeller Foundation and Latin America (Bloomington: Indiana University Press, 1994). For other Latin American countries, see Anne-Emanuelle Birn, Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico (Rochester: University of Rochester Press, 2006). See also the special issue of the Canadian Bulletin of Medical History 25, 1 (2008).

[46] Marcos Cueto, Excelencia Científica en la Periferia: Actividades Científicas e Investigación Biomédica en el Perú, 1890-1950 (Lima: GRADE-CONCYTEC, 1989);

century there was mutual feedback between the political and economic consolidation of Latin American states, and their legitimacy before certain groups in society: wealthy producers of export commodities, urban dwellers, and professionals such as physicians, who were the agents of many new state-sponsored preventive and therapeutic interventions.[47]

Physicians became interested in fertility thanks in part to advances in European medical technologies, namely the introduction of anesthesia to midwifery in 1863, Lister's invention of antisepsis in 1867, and the development of the dilation and curettage operation to induce abortions and treat incomplete ones in 1874.[48] The medical inclination to intervene in pregnancy and birthing did not necessarily mean safer deliveries or surgeries, however. In fact, before the widespread use of sulpha drugs in the mid-1930s and penicillin in the mid-1940s, European physicians were consistently

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Marcos Cueto, El Regreso de las Epidemias (Lima: IEP, 1997). For other Latin American countries, see Ana María Carrillo, "Economía, Política y Salud Pública en el México Porfiriano (1876-1910)," Historia, Ciências, Saúde – Manguinhos 9 (2002 suplemento): 67-87; William Sater, "The Politics of Public Health: Smallpox in Chile," Journal of Latin American Studies 35 (2003): 513-543; Emilio Quevedo, Catalina Borda, Juan Carlos Eslava, Claudia García, María del Pilar Guzmán, Paola Mejía and Carlos Noguera, Café y Gusanos, Mosquitos y Petroleo: El Tránsito desde la Higiene hacia la Medicina Tropical y la Salud Pública en Colombia, 1873-1953 (Bogotá: Universidad Nacional de Colombia, 2004); Ann Zulawski, Unequal Cures: Public Health and Political Change in Bolivia, 1900-1950 (Durham: Duke University Press, 2007).

[47] For some fine examples of the links between medicine and the consolidation of state power in Latin America see Nancy Stepan, Beginnings of Brazilian Science: Oswaldo Cruz, Medical Research and Policy, 1890-1920 (New York: Science History Publications, 1981); Diego Armus (ed.) Disease in the History of Modern Latin America: From Malaria to AIDS (Durham: Duke University Press, 2003); and Gilberto Hochman and Diego Armus (eds.) Cuidar, Controlar, Curar: Ensaios Históricos sobre Saude e Doença na América Latina (Rio de Janeiro: Fiocruz, 2004).

[48] Henry David, "Abortion in Europe, 1920-91: A Public Health Perspective," Studies in Family Planning 23, 1 (1992): 1-22; Vincent de Brouwere, "The Comparative Study of Maternal Mortality over Time: The Role of the Professionalization of Childbirth," Social History of Medicine 20, 3 (2008): 541-562.

troubled by high maternal mortality rates due to sepsis, hemorrhage, and eclampsia. To their dismay, Latin American as much as European physicians found that better hygiene and training were not sufficient to reduce the maternal and neonatal mortality caused by these factors.[49] Throughout Europe, this uncertainty strengthened propositions to increase medical surveillance over women, such as the prohibition of dangerous activities (including physical work and strenuous exercise), and greater post-birth state support (through neo-natal clinics and laws providing maternity leaves from work). These initiatives became popular beyond Europe rapidly. Medical advice for the protection of pregnant, potentially pregnant, and puerperal women took on various shapes throughout the world, depending on local historical conditions.[50]

Among the local conditions that affected the diffusion of medical ideas about fertility in Peru was the practice of non-Western healing techniques and rituals. Several

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[49] Anne-Emanuelle Birn, "'No More Surprising than a Broken Pitcher'? Maternal and Child Health in the Early Years of the Pan American Sanitary Bureau," Canadian Bulletin of Medical History 19 (2002): 17-46; Ilana Löwy, "The Social History of Medicine: Beyond the Local," Social History of Medicine 20, 3 (2008): 465-481.

[50] See for example Jane Lewis, The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939 (London: Croom Helm, 1980); Mary Lynn McDougall, "Protecting Infants: The French Campaign for Maternity Leaves, 1890s-1913," French Historical Studies 13, 1 (1983): 79-105; Gisela Bock and Pat Thane (eds.) Maternity and Gender Policies: Women and the Rise of the European Welfare States, 1880-1950s (London: Routledge, 1991); Seth Koven and Sonya Michel (eds.) Mothers of a New World: Maternalist Politics and the Origins of Welfare States (New York: Routledge, 1993); Alisa Klaus, Every Child a Lion: The Origins of Maternal and Infant Health Policy in the United States and France, 1890-1920 (Ithaca: Cornell University Press, 1993); Katherine Arnup, Education for Motherhood: Advice for Mothers in twentieth Century Canada (Toronto: University of Toronto Press, 1994); Susan Pedersen, Family, Dependence, and the Origins of the Welfare State: Britain and France, 1914-1945 (Cambridge: Cambridge University Press, 1995); Susanne Klausen, Race, Maternity and the Politics of Birth Control in South Africa, 1910-39 (New York: Palgrave Macmillan, 2004); Rima Apple, Perfect Motherhood: Science and Childrearing in America (New Brunswick: Rutgers University Press, 2006); Sarah Hodges (ed.), Reproductive Health in India: History, Politics, Controversies (New Delhi: Orient Longman, 2006).

scholars have stressed the point that knowledge about healing has never been the exclusive province of academically trained experts. Practitioners such as faith healers, herbalists, and traditional birth attendants have successfully taken part in this enterprise, and continue to exert considerable power among health consumers.[51] This medical pluralism, in addition to the chronic financial and organizational limitations of public health care institutions in Peru, help explain why biomedical knowledge never succeeded in becoming the hegemonic force for making sense of fertility.

A separate but related body of literature, on elite projects to "civilize" Latin America, indicates that medical developments were not the only reason why fertility became a salient topic in the late nineteenth century. During this period, several Peruvian professionals and intellectuals adopted the view that racial degeneration progressively led to national decline. This was an adaptation of contemporary European, especially French, ideas linking slow population growth and criminality to national weakness.[52] The

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[51] Néstor Chambi, Walter Chambi, Víctor Quiso, Sabino Cutipa, Valeriano Gordillo, and Jorge Apaza, Así Nomás Nos Curamos: La Medicina en los Andes (Puno: Asociación Chuyma, 1997. For other Latin American examples, see Setha Low, "The Medicalization of Healing Cults in Latin America," American Ethnologist 15 (1988): 136-154; Libbet Crandon-Malamud, From the Fat of Our Souls: Social Change, Political Process and Medical Pluralism in Bolivia (Berkeley: University of California Press, 1993); George Foster, Hippocrates' Latin American Legacy: Humoral Medicine in the New World (Langhorne: Gordon and Breach, 1994); Few, Women Who Live Evil Lives; David Sowell, "Contending Medical Ideologies and State Formation: The Nineteenth Century Origins of Medical Pluralism in Contemporary Colombia," Bulletin of the History of Medicine 77 (2003): 900-926; Steven Palmer, From Popular Medicine to Medical Populism: Doctors, Healers and Public Power in Costa Rica, 1800-1940 (Durham: Duke University Press, 2003).

[52] Robert Nye, Crime, Madness and Politics in Modern France: The Medical Concept of National Decline (Princeton: Princeton University Press, 1984); Karen Offen, "Depopulation, Nationalism, and Feminism in Fin-de-Siecle France," American Historical Review 89, 3 (1984): 648-676; Daniel Pick, Faces of Degeneration: A European Disorder, 1848-1918 (Cambridge: Cambridge University Press, 1993); Arthur Herman, The Idea of Decline in Western History (New York: Free Press, 1997); Sean

Peruvians' plight was urgent, according to them, because Peru was a young and politically unstable republic, because it had experienced tremendous demographic losses since the early colonial period, and because of the many racially and culturally diverse populations that dwelled within the borders of the nation and that stubbornly refused to become civilized according to the Western template.[53] To counter the entropic forces threatening the national racial stock, some Peruvian professionals welcomed the allegedly civilizing influences of white Western European immigrants, of education for the masses, and of greater surveillance of individuals' reproductive potential. The latter often

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Quinlan, "Inheriting Vice, Acquiring Virtue: Hereditary Disease and Moral Hygiene in Eighteenth-Century France," Bulletin of the History of Medicine 80, 4 (2006): 649-676.

[53] On the link between national decline and racial and cultural diversity in Peru see David Parker, "Civilizing the City of Kings: Hygiene and Housing in Lima," in Ronn Pinneo and James Baer (eds.) Cities of Hope and Despair: Urbanization in Latin America, 1870-1930 (Boulder: Westview, 1997); and Fanni Muñoz Cabrejo, Diversiones Públicas en Lima 1890-1920: La Experiencia de la Modernidad (Lima: Red para el Desarrollo de las Ciencias Sociales, 2001). For other Latin American examples of this link, see Nancy Appelbaum, Anne McPherson and Karin Rosemblatt (eds.) Race and Nation in Modern Latin America (Chapel Hill: University of North Carolina, 2003). On elite projects to "civilize" diverse Latin American populations according to a Western template see Nicole Trujillo-Pagan, "Health Beyond Prescription: A Post-Colonial History of Puerto Rican Medicine at the Turn of the Twentieth Century," (PhD diss., University of Michigan, 2003); Vera Blinn Reber, "Blood, Coughs and Fever: Tuberculosis and the Working Class of Buenos Aires, Argentina, 1885-1915," Social History of Medicine 12, 1 (1999): 73-100; Alexandra Stern, "Buildings, Boundaries and Blood: Medicalization and Nation-Building on the US-Mexico Border, 1910-1930," Hispanic American Historical Review 79, 1 (1999): 41-81; Jeffrey Needell, "The Revolta Contra Vacina of 1904: The Revolt against "Modernization" in Belle-Epoque Rio de Janeiro," Hispanic American Historical Review 67, 2 (1987): 233-269. On the Western path to "civilizing", see Norbert Elias, The Civilizing Process (Oxford: Blackwell, 1994); and Michael Adas, Machines as the Measure of Men: Science, Technology and Ideologies of Western Dominance (Ithaca: Cornell University, 1989). On Latin American demographic losses during the Colonial period see Noble David Cook, Born to Die: Disease and New World Conquest, 1492-1650 (Cambridge: Cambridge University Press, 1998).

involved techniques like pre-marital health certificates and strict gender-specific honor codes that emphasized women's domesticity.[54]

The Peruvians who worried about racial degeneration or national decline were an elite urban minority made up of professionals and intellectuals, in a country that was overwhelmingly non-white and rural. A few intellectuals were optimistic about the potential of racial mixing. They saw in the mestizo, the mixed-blood offspring of Spanish and indigenous, a hardy and virtuous racial synthesis that adapted well to the particular

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[54] On civilization through Europeanization in Peru, see Pilar García Jordán, Cruz y Arado, Fusiles y Discursos: La Construcción de los Orientes en el Perú y Bolivia (Lima: IEP, 2001). For other Latin American examples, see Thomas Skidmore, Black into White: Race and Nationality in Brazilian Thought (Durham: Duke University Press, 1974); Richard Graham, (ed.), The Idea of Race in Latin America, 1870-1940 (Austin: University of Texas Press, 1990); Dain Borges, "'Puffy, Ugly, Slothful and Inert': Degeneration in Brazilian Social Thought, 1880-1940," Journal of Latin American Studies 25, 2 (1993): 235-256; Sidney Chalhoub, "The Politics of Disease Control: Yellow Fever and Race in Nineteenth Century Rio de Janeiro," Journal of Latin American Studies 25 (1993): 441-463; Teresa Meade, "Civilizing" Rio: Reform and Resistance in a Brazilian City, 1889-1930 (University Park: Pennsylvania State University Press, 1997); Alejandra Stern, "Responsible Mothers and Normal Children: Eugenics, Nationalism and Welfare in Post-Revolutionary Mexico, 1920-1940," Journal of Historical Sociology 12, 4 (1999): 369-397; Hector Palma, "Gobernar es Seleccionar": Apuntes Sobre la Eugenesia (Buenos Aires: Jorge Baudino, 2002). On the greater surveillance of women's reproductive potential in Peru, see Sarah Chambers, De Subditos a Ciudadanos: Honor, Genero y Politica en Arequipa, 1780-1854 (Lima: Red para el Desarrollo de las Ciencias Sociales, 2003). For other Latin American examples, see Donna Guy, Sex and Danger in Buenos Aires: Prostitution, Family and Nation in Argentina (Lincoln: University of Nebraska Press, 1990); Jean Franco, "The Gender Wars," NACLA 29, 4 (1996): 6-9; Eileen Suárez Findlay, Imposing Decency: The Politics of Sexuality and Race in Puerto Rico, 1870-1920 (Durham: Duke University Press, 1999); Susan Caulfield, "The History of Gender in the Historiography of Latin America," Hispanic American Historical Review 81, 3-4 (2001): 449-490; Jessica Gregg, Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil (Stanford: Stanford University Press, 2003); Yolanda Eraso, "Biotypology, Endocrinology and Sterilization: The Practice of Eugenics in the Treatment of Argentinian Women during the 1930s," Bulletin of the History of Medicine 81, 4 (2008): 793-822. On the greater importance of mass education in Peru, see Antonio Espinoza, "Moldeando a los Ciudadanos del Mañana: El Proyecto Educativo Disciplinador en Lima entre 1850 y 1900," in Paulo Drinot and Leo Garofalo (eds.) Mas Allá de la Dominación y la Resistencia: Estudios de Historia Peruana, Siglos XVI-XX (Lima: IEP, 2005).

geographies and social realities of the country.[55] In fact, even though some Peruvian professionals and intellectuals held on to the superiority of Europeanness, most believed that education could "civilize" the majority of mestizo and indigenous Peru.[56]

Within the literature on the "civilizing" of Peru, the topic of gender is especially salient. As several scholars have pointed out, Peruvian women had played various roles in the nineteenth and twentieth centuries: as heads of households, political activists, salespeople, soldiers, and writers.[57] Scholars have also documented how Peruvian women commonly partook in the dispensation of potions to enhance sexual potency and in the procurement of abortions; as well as the fact that many women were untroubled by their

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[55] Aníbal Quijano, La Emergencia del Grupo Cholo y sus Implicancias en la Sociedad Peruana (Lima: IEP, 1967); and Marisol de la Cadena, Indigenous Mestizos: The Politics of Race and Culture in Cuzco, Peru, 1919-1991 (Durham: Duke University Press, 2000).. For other Latin American examples, see Julyan Peard, Race, Place and Medicine: The Idea of the Tropics in Nineteenth-Century Brazilian Medicine (Durham: Duke University Press, 1999); Stanley Blake, "The Medicalization of Nordestinos: Public Health and Regional Identity in Northeastern Brazil, 1889-1930," The Americas 60, 2 (2003): 217-248.

[56] Marcos Cueto, "Social Medicine and 'Leprosy' in the Peruvian Amazon," The Americas 61, 1 (2004): 55-80.

[57] See Mary Weismantel, Cholas and Pishtacos: Stories of Race and Sex in the Andes (Chicago: University of Chicago Press, 2001); Alicia del Aguila, Los Velos y las Pieles: Cuerpo, Genero y Reordenamiento Social en el Peru Republicano (Lima: IEP, 2003) and Scarlett O'Phelan and Margarita Zegarra (eds.), Mujeres, Familia y Sociedad en la Historia de América Latina, Siglos XVIII-XXI (Lima: CENDOC-Mujer, 2006). For other Latin American examples, see Asunción Lavrin (ed.), Latin American Women: Historical Perspectives (Westport: Greenwood, 1978); Anna Macias, "Women and the Mexican Revolution," The Americas 37, 1 (1980): 53-82; Donna Guy, "Women, Peonage, and Industrialization: Argentina, 1810-1914," Latin American Research Review 16, 3 (1981): 65-89; Sandra Lauderdale Graham, House and Street: The Domestic World of Servants and Masters in Nineteenth-Century Rio de Janeiro (Cambridge: Cambridge University Pres, 1988); Francie Chassen-López, "A Patron of Progress: Juana Catarina Romero, the Nineteenth-Century Cacica of Tehuantepec," Hispanic American Historical Review 88, 3 (2008): 393-426.

regular use of contraceptive potions or by having multiple partners before marriage.[58] None of this is consistent with the exhortations by some nineteenth century professionals and intellectuals that civilized women had best keep to the domestic sphere lest they ruin their valuable reproductive potential and thus hurt the nation. Confining female participation to the private realm of the family, or enforcing strict gendered honor codes would have been the equivalent of restraining a genie that had never met the bottle.[59] In fact, complete avoidance of the public sphere was unlikely for most Latin American women.[60]

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[58] Ralph Bolton and Enrique Mayer (eds.), Andean Kinship and Marriage (Washington, DC: American Anthropological Association, 1977); Luis Millones and Mary Pratt, Amor Brujo: Imagen y Cultura del Amor en los Andes (Lima: IEP, 1989); Alejandro Ortiz Rescaniere, La Pareja y el Mito: Estudios sobre las Concepciones de la Persona y de la Pareja en los Andes (Lima: PUCP, 1993). For other Latin American examples see Xochitl Castañeda, Cecilia García, and Ana Langer, "Ethnography of Fertility and Menstruation in Rural Mexico," Social Science and Medicine 42, 1 (1996): 133-140; Marta Sainz de la Maza Kaufmann, "Contraception in Three Chibcha Communities and the Concept of Natural Fertility (Guaymi, Hueter, Bribri, and Cabecar Indians)," Current Anthropology 38, 4 (1997): 681-687; Martha Few, Women Who Live Evil Lives: Gender, Religion and the Politics of Power in Colonial Guatemala (Austin: University of Texas Press, 2002); Zárate, Dar a Luz en Chile, Siglo XIX.

[59] On the relationship between the Peruvian elite's nation building project in the late nineteenth century and the construction of gender roles see Christine Hunefeldt, Liberalism in the Bedroom: Quarreling Spouses in Nineteenth Century Lima (University Park: Penn State University Press, 2000). For other Latin American examples, see Elizabeth Dore and Maxine Molyneux (eds.), Hidden Histories of Gender and the State in Latin America (Durham: Duke University Press, 2000); Sueann Caulfield, In Defense of Honor: Sexual Morality, Modernity and Nation in Early Twnetieth-Century Brazil (Durham: Duke University Press, 2000); Katherine Bliss, Compromised Positions: Prostitution, Public Health, and Gender Politcs in Revolutionary Mexico City (University Park: Penn State University Press, 2001); and Elizabeth Quay Hutchison "Add Gender and Stir: Cooking Up Gendered Histories of Modern Latin America," Latin American Research Review 38, 1 (2003): 266-287.

[60] Evelyn Stevens, "Marianismo: The Other Face of Machismo in Latin America," in Ann Pescatello (ed.) Female and Male in Latin America (Pittsburgh: University of Pittsburgh Press, 1973); Elsa Chaney, Supermadre: Women in Politics in Latin America (Austin: University of Texas Press, 1979); Karin Rosemblatt, Gendered Compromises: Political

This rich and still growing literature connects the medical control of fertility to state formation, to elite projects to "civilize" Peru, as well as to epistemically diverse ways to make sense of fertility. Yet there are gaps that have only begun to be addressed. Among these is the period after the Second World War. A new transnational power configuration emerged out of this conflict that pitted a capitalist against a communist superpower, and turned countries such as Peru into members of a new category, known as the "Third World" or the "underdeveloped countries."[61]

Population size became a strategic factor in the Cold War, as will be explained in greater detail in chapters four and five. During this period, Peru and other Latin American nations were affected by the growth of a US-based network of advocates of population reduction. This movement relied on the ingenuity of medical workers for the large-scale production and distribution of contraceptives, as well as on the prestige and political power of different experts to implement government policies to limit population growth. Transnational networks to effect health policy changes were not new in Peru, as the influence of the Rockefeller Foundation and the Pan-American Medical Congresses from the 1910s on make evident.[62] Institutions such as the Milbank Memorial Foundation, the Population Council, and the International Planned Parenthood Federation contributed knowledge and funding to treat what they deemed an unhealthy and dangerous trend,

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Cultures and the State in Chile, 1920-1950 (Chapel Hill: University of North Carolina Press, 2000).

[61] See Arturo Escobar, Encountering Development: The Making and Unmaking of the Third World (Princeton: Princeton University Press, 1995); and Gilbert Joseph and Daniela Spenser (eds.), In From the Cold: Latin America's New Encounter with the Cold War (Durham: Duke University Press, 2008).

[62] Cueto, Missionaries of Science; Marta de Almeida, "Circuito Aberto: Idéias e Intercâmbios Médico-Científicos na América Latina nos Primórdios do Século XX," História, Ciências, Saúde – Manguinhos 13, 3 (2006): 733-757).

population growth, in Peru. The activities of these institutions and their Peruvian allies have not yet been studied.[63] How did they make sense of population growth? What did this growth threaten?

Another possible direction for the literature on the medical control of fertility concerns the role of lay knowledge of one's own body. As Kleinman notes, humans view their own bodies as subject to manipulation (by oneself or by others) and as knowledge-producing organizers of experiences. [64] Humans regularly tap into this knowledge of their own bodies to care for themselves, and to explain the causes of their bodily shortcomings in ways that are shared with people in circumstances similar to their own.[65] These forms of personal and local lay knowledge production can and have been at odds with scientific knowledge at different times in history.[66]

One specific and, in Peru, understudied, way in which lay knowledge enters the realm of fertility control concerns abortion. Seeking or performing an abortion was not only illegal but even taboo in Peru throughout the nineteenth and twentieth centuries. Yet, undoubtedly, abortions have been and continue to be sought and carried out. By learning

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[63] Few works deal with this subject in Latin America. See for example Jadwiga Pieper, "From Contested Duties to Disputed Rights: The Social Politics of Fertility Regulation in Chile, 1964-1989," (PhD diss., Rutgers University, 2000); see also Briggs, Reproducing Empire, on Puerto Rico.

[64] Arthur Kleinman, The Illness Narratives: Suffering, Healing and the Human Condition (New York: Basic Books, 1988). See also Jeanine Anderson, Tendiendo Puentes: Calidad de Atención desde la Perspectiva de las Mujeres Rurales y de los Proveedores de los Servicios de Salud (Lima: Manuela Ramos, 2001).

[65] Michael Polanyi, Personal Knowledge: Towards a Post-Critical Philosophy (Chicago: University of Chicago Press, 1958); Byron Good, Medicine, Rationality and Experience: An Anthropological Perspective (Cambridge: Cambridge University Press, 1994).

[66] Phil Brown and Edwin Mikkelsen, No Safe Place: Toxic Waste, Leukemia, and Community Action (Berkeley: University of California Press, 1990); Steven Epstein, Impure Science: AIDS, Activism, and the Politics of Knowledge (Berkeley: University of California Press, 1996).

more about why and how women sought to help themselves by getting rid of unwanted pregnancies we may learn much about people's social support networks, as well as their sometimes embattled relations with lovers, neighbors, physicians, and the police. This means seeing women seeking abortions not only as criminals or victims of injustice, but also as people making the best of the bad hands that fortune sometimes dealt them.[67] It also means recognizing that the meaning of "abortion" is a heavily contested one.[68] This leads us to consider scarcely addressed issues, including the way in which women seeking to end their pregnancies made sense of what they did, the public's reaction to these actions, and the connections between the world of abortion seekers and providers, and that of family planning policy makers.

Overview of Peru between 1895 and 1976

The years 1895 and 1976 mark important transitions between military and civilian rule, as well as periods of economic reconstruction following war, recession, and the failure of economic policies in Peru. This project's timeline begins with the national reconstruction period of the 1890s, widely acknowledged by Peruvianists as the dawn of modern Peru. It was in the late nineteenth century that the medical profession began to acquire the influence that would permit it to launch some of the first effective initiatives for the control of fertility. The dissertation ends with the creation, in 1976, of the

[67] Scholars writing in this vein include Steven Stern, The Secret History of Gender: Women, Men and Power in Late Colonial Mexico (Chapel Hill: University of North Carolina Press, 1995); and Leslie Reagan, When Abortion Was a Crime: Women, Medicine and the Law in the United States, 1867-1973 (Berkeley: University of California Press, 1997).
[68] Lynn Morgan, "Imagining the Unborn in the Ecuadorian Andes," Feminist Studies 23, 2 (1997): 323- 350.

country's first population policy sanctioning the use of family planning. Through this, the Peruvian government legalized some birth control technologies, and assumed responsibility for their distribution and for the education of Peruvian citizens regarding the use of contraceptives.[69]

General Andrés Avelino Cáceres remained in power until 1895, thanks to an effective, if unpopular, network of political patronage. The civilian strongman Nicolás de Piérola successfully challenged Cáceres in a short civil war, and became President in 1895, with the support of the Civilista Party. The latter party had presided through the War of the Pacific debacle, and it still represented the wealthiest Peruvians. Piérola's rule signaled the transition towards what is known in Peruvian history as the "Aristocratic Republic", the period with which this dissertation begins. The Aristocratic Republic, which lasted until 1919, was characterized by the growing political power of a small tight-knitted oligarchy that defended economic liberalism, scientific positivism, and bureaucratic improvements. Its leaders embraced a nationalist vision of Peru as an orderly, prosperous, and cultured country on the European model.[70]

Politically, the early twentieth century was characterized by the power of the Civilista Party. Coastal hacienda owners, noted university professors, and wealthy urban merchants from the Lima area were its most prominent members. However, members of urban middle groups and rural elites established complex cooperation and competition

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[69] Carlos Contreras and Marcos Cueto, Historia del Perú Contemporáneo (Lima: IEP, 2000, 192); Manuel Burga, La Historia y los Historiadores en el Perú (Lima: Universidad Nacional Mayor de San Marcos, 2005).

[70] On the establishment of Peruvian political elites, see Manuel Burga and Alberto Flores Galindo, Apogeo y Crisis de la República Aristocrática (Lima: Rikchay, 1979); Heraclio Bonilla, Un Siglo a la Deriva: Ensayos sobre el Perú, Bolivia y la Guerra (Lima: IEP, 1981); Nelson Manrique, Yawar Mayu: Sociedades Terratenientes Serranas, 1879- 1910 (Lima: DESCO-IFEA, 1988).

links with the Civilista leaders. Just as important, the Civilistas never fully incorporated the regional power networks that controlled the northern and southern highlands. The Civilistas favored the economic specialization of Peru as a primary commodity exporter, and the attraction of foreign investment capital and of European immigrants. The central government acted vigorously to improve tax collection, the army, primary education, and public health, and to place these activities under its control, to the detriment of municipal power. To the Civilistas, the upgrading of the central administrative apparatus was essential to make a cohesive whole out of Peru's natural and human diversity. Yet, only coastal cities and its inhabitants, not the majority of Peruvians at that time, were the biggest beneficiaries of Civilista initiatives.[71]

As will be shown in the next chapter, Peruvian physicians tried to assist the Peruvian governments of the late nineteenth and early twentieth centuries in their efforts to make the country a more attractive investment locale and immigration destination. The government and the medical profession shared a clear pro-natalist orientation, both in discourse and practice. Civilistas' appreciation for scientific knowledge buttressed the ambitions of medical professionals. However, the ruling party's almost exclusive concern with urban areas made it difficult to extend health and sanitation services to the majority of Peruvians, who lived in rural areas at the time. In other words, medical power in modern Peru emerged almost exclusively as an urban phenomenon, as detached from rural areas, and thus the majority of the country, as the Civilistas were.

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[71] On Civilista ideologies, see Carmen McEvoy, La Utopía Republicana: Ideales y Realidades en la Formación de la Cultura Política Peruana, 1871-1919 (Lima: PUCP, 1997).

This situation was reversed towards the 1960s and 1970s, the period this dissertation analyzes in its latter chapters. Migration from rural to urban areas, which accelerated beginning in the 1930s, meant that a majority of Peru's population lived in urban areas by the 1970s.[72] Political parties in the second half of the twentieth century reflected the rise of middle and working classes, socialist reformers, and critics of the traditional export-oriented elite. At the same time, the military governments that ruled the country enacted a series of reforms to develop previously overlooked geographic areas and curry the favor of the populations living therein. The intentions of the military became clear following the contested election of 1962. The results of that election showed that Victor Raul Haya de la Torre, leader of the Popular Revolutionary Alliance of the Americas (APRA) defeated Fernando Belaúnde, leader of *Acción Popular*, but not by the constitutionally mandated margin.[73] Rather than letting the APRA-dominated Congress elect the new President, as the 1933 Constitution directed, the Peruvian army, navy, and air force set up a ruling Junta.

The Junta established a national strategic planning unit as part of the executive branch, and began a small-scale agrarian reform to promote a more equitable distribution of lands in the Peruvian interior. Almost immediately after the coup, the Junta called for

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[72] Jürgen Golte and Norma Adams, Los Caballos de Troya de los Invasores: Estrategias Campesinas en la Conquista de la Gran Lima (Lima: IEP, 1990).

[73] *Acción Popular*'s support base consisted of urban professionals skeptical of the military's authoritarianism, and of Peruvian Communists' tendency to point to US imperialism as the root of most social problems. APRA was then Peru's largest and, still, best organized political party. On APRA's history, including its origins as a non-elite political organization in the 1920s, see Victor Raúl Haya de la Torre, El Antimperialismo y el APRA (Santiago: Ercilla, 1936); Peter Klaren, Formación de las Haciendas Azucareras y Orígenes del APRA (Lima: IEP, 1976); Steve Stein, Populism in Peru: The Emergence of the Masses and the Politics of Social Control (Madison: University of Wisconsin Press, 1980).

elections, which were held in 1963. Following these elections, Belaúnde became President, but his party did not win a majority in Congress. Congressional opposition blocked many of the reforms Belaúnde attempted. Among these were an agrarian reform, a series of housing projects, the promotion of local industry, and the building of highways to better integrate the Amazon region to the rest of the country.[74] Frustrated by this stalemate, a faction of the military, led by General Juan Velasco Alvarado, toppled Belaúnde and dissolved Congress in 1968.[75]

The most ambitious and, ultimately, least successful of Velasco's initiatives, was the agrarian reform. By 1969, the year the reform began, 76% of all arable land in Peru was in the hands of just 0.5% of all landowners. Deciding how to change this glaringly unjust land tenure system was difficult. In the end, the agrarian reform affected all land holdings over fifty hectares, including the machinery, built structures, and cattle settled therein. Former owners were compensated, though they often complained that the government had underestimated the value of their former properties. Once the land expropriations were complete, former tenants began to manage the day-to-day operations of newly reorganized agrarian cooperatives. Unfortunately, lack of managerial skill, corruption, unavailability of agricultural technology, and the scarcity of credit for

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[74] On Belaúnde's incomplete reforms, see José María Caballero, Economía Agraria de la Sierra Peruana antes de la Reforma Agraria de 1969 (Lima: IEP, 1969).
[75] On the reforms implemented by Velasco, see Henry Pease, El Ocaso del Poder Oligárquico: Lucha Política en la Escena Oficial, 1968-1975 (Lima: DESCO, 1977); and Steve Stein and Carlos Monge, La Crisis del Estado Patrimonial en el Perú (Lima: IEP, 1988).

agricultural activities plagued the cooperatives, many of which soon found themselves beset by debt and low productivity.[76]

General Velasco had tried to build a political group of followers through an office that channeled funds to organizations friendly to the Junta. By 1974, all efforts to build up this constituency could not quell the discontent stemming from different social and political groups over the ineffectiveness of the regime's reforms. In August of 1975, a sector of the military, dissatisfied with Velasco's ineffective and authoritarian approach to social reform, quietly removed him from power. General Francisco Morales Bermúdez, Velasco's former Minister of Finance, became the new President. He restored the freedom of the press and re-legalized political parties. He also attempted diplomatic overtures to improve the rocky relations between Peru and the United States.

It was in this context that the first family planning services began to be offered in Peru. Medical workers controlled access to such services. Some of these experts were concerned with the effects of rapid population growth on the country's economic and social welfare. Yet military regimes, the Catholic Church, and physicians themselves were cautious about foreign pressures to limit population growth in the country. What these groups favored, instead, was "responsible parenthood" (a term explained in greater detail in chapters five and six) as a means to reconcile the freedom of couples to decide how many children to have, and their duty to provide for those children. The agreement regarding responsible parenthood became institutionalized in Peru's first population

[76] José Matos Mar and José Manuel Mejía, La Reforma Agraria en el Perú (Lima: IEP, 1980); Cynthia McClintock and Abraham Lowenthal (eds.), The Peruvian Experiment Reconsidered (Princeton: Princeton University Press, 1983).

policy of 1976 and, later, in the 1979 Constitution, which signaled the transition from General Morales Bermúdez's military regime to civilian rule.[77]

Scholarly Contributions

The medical control of fertility is a sort of power that is neither imposed nor unconditionally accepted, but one that is negotiated and creates institutions, consumers, and ways of life over time. This medical control is also a tenuous accomplishment. This project's view of medical power as fragile yet productive contributes to medical history, the history of Peru, and of US-Latin America relations.

The protection of a nation's reproductive potential in the late nineteenth century is a topic regularly emphasized by the literature on eugenics.[78] Nancy Stepan and Maria

[77] Article six of the 1979 Constitution states that "the state protects and favors [*ampara*] responsible parenthood."

[78] The eugenics literature is vast and global in scope, though no single monograph is dedicated to Peru. For studies on eugenics in Latin America see Nancy Stepan, The Hour of Eugenics: Race, Gender, and Nation in Latin America (Ithaca: Cornell University Press, 1991); and Palma, "Gobernar es Seleccionar". For studies of eugenics in other parts of the world, see Daniel Kevles, In the Name of Eugenics: Genetics and the Uses of Human Heredity (New York: Alfred A. Knopf, 1985); Pauline Mazumdar, Eugenics, Human Genetics and Human Failings: The Eugenics Society, Its Source and Its Critics in Britain (London: Routledge, 1992); Mary Nash, "Social Eugenics and Nationalist Race Hygiene in Early Twentieth Century Spain," History of European Ideas 15, 4-6 (1992): 741-748; Edward Larson, Sex, Race, and Science: Eugenics in the Deep South (Baltimore: Johns Hopkins University Press, 1995); Gunnar Broberg and Nils Roll-Hansen (eds.), Eugenics and the Welfare State: Sterilization Policy in Denmark, Sweden, Norway, and Finland (East Lansing: Michigan State University Press, 1996); Frank Dikötter, Imperfect Conceptions: Medical Knowledge, Birth Defects, and Eugenics in China (London: Hurst & Co., 1998); Sumiko Otsubo, "Eugenics in Japan," Science in Context 11, 3-4 (1998): 545-565; Wendy Kline, Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom Berkeley: University of California Press, 2001); Alexandra Stern, Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America (Berkeley: University of California Press, 2005); and Hodges, Reproductive Health in India.

Emma Mannarelli have studied this for the Peruvian case.[79] However, Stepan's work deals mostly with Argentina, Brazil, and Mexico, and Mannarelli's focuses on medical ideas, and not on actual practice. Chapter two addresses that vacuum, paying special attention to the way in which race and maleness affected medical conceptualizations of the nation's reproductive potential. Medical discourses about the need for more and healthier individuals raised by proper families were influential not only in late nineteenth century Peru but throughout the twentieth century, and affected the implementation of family planning programs and that of population policies in the 1960s.

Another contribution to the history of medicine and that of Peru is this project's attention to the Catholic Church. Much of the literature on the birth control movement disregards the subject or assumes a direct relation between religion and conservatism regarding the adoption of modern contraceptives.[80] This dissertation describes how, in fact, there has been a great deal of flexibility in Catholic ideology and practice regarding contraception. It is important to acknowledge this fact as the Catholic Church in Peru and Latin America continues to be a strong political actor that should be seen as more than an antagonist for the extension of women's sexual and reproductive rights.

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[79] Stepan, The Hour of Eugenics; Mannarelli, Limpias y Modernas.

[80] Key works on the history of the birth control movement include Linda Gordon, Woman's Body, Woman's Right: A Social History of Birth Control in America (New York: Grossman, 1976); Angus McLaren, Historia de los Anticonceptivos (Madrid: Minerva, 1990); Elizabeth Watkins, On the Pill: A Social History of Oral Contraceptives, 1950-1970 (Baltimore: Johns Hopkins University Press, 1998); Lara Marks, Sexual Chemistry: History of the Contraceptive Pill (New Haven: Yale University Press, 2001); Andrea Tone, Devices and Desires: A History of Contraceptives in America (New York: Hill and Wang, 2001); Hera Cook, The Long Sexual Revolution: English Women, Sex and Contraception (Oxford: Oxford University Press, 2004); Jimmy Elaine Wilkinson Meyer, Any Friend of the Movement: Networking for Birth Control: 1920-1940 (Columbus: Ohio State University Press, 2004).

The efforts of women and men to avail themselves of abortions are also relevant to medical and Peruvian history in three ways. (1) This dissertation increases our knowledge of how social networks are constructed and used for illegal means, and of the way in which popular notions of the body intersect with medical knowledge. (2) The evidence gathered from criminal trials highlights the difficulties Peruvian state agencies had monitoring and punishing crime. (3) The historical study of abortion enriches the public health portrayal of female abortion seekers as victims of their own actions and of unscrupulous abortion providers, which has been common in Peru at least since the 1960s. Anthropologists, epidemiologists, historians, and social workers have called this characterization into question, but often emphasizing the circumstances of individual abortions, not the long-term context in which abortions took place.[81]

The dissertation also addresses how contraceptive technologies and the, mostly United States-based, institutions that supported their mass distribution became visible in the 1960s. This complements the existing historiography of birth control, much of which focuses on Western Europe and the United States, not on how agencies and individuals in these countries related to people and governments in developing countries.[82] It is also important to analyze, as chapters four, five and six do, how contraceptives have mediated the relation between the US and Latin America. As Ricardo Salvatore has argued, United States experts produced images, texts, and maps throughout the twentieth century in an

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[81] See for example Nancy Scheper-Hughes, Death Without Weeping: The Violence of Everyday Life in Brazil (Berkeley: University of California Press, 1992); and Claudio Lanata, "Children's Health in Developing Countries: Issues of Coping, Child Neglect and Marginalization", in David Leon and Gill Walt (eds.), Poverty, Inequality and Health: An International Perspective (Oxford: Oxford University Press, 2000).
[82] See footnote 80.

effort to rend Latin America coherent to US audiences.[83] Similarly, in the context of the Cold War, rapid population growth in Latin America became a concern for US social scientists, public health experts, and policy makers, who presented this growth as a threat to the interests of the US in the Americas. Their preferred solution to this particular rendering of Latin America was technical. Led by these experts, the US sponsored the mass diffusion of contraceptives such as the pill and the intra-uterine device to cut down birth rates. We must pay more attention than we have so far to the US experts who created the representations of 1960s Latin America as a demographic danger zone, as well as to their Latin American allies. The predilection for simple technical solutions to complex social problems, and their inability or unwillingness to see the lifestyles of US citizens or wealthy Latin Americans as part of the problems they sought to address are eerily reminiscent of contemporary US-led geopolitical strategies such as the War on Drugs. Thus, this dissertation also contributes to our understanding of a style of intervention that has characterized US-Latin American relations in the post-Second World War period.

Outline of Chapters

Chapter two, "The Nation's Reproductive Potential, 1895-1940", deals with the notion of national progress that an elite group of physicians in Peru embraced beginning in the late nineteenth century. To them, progress was a state of economic and moral

[83] Ricardo Salvatore, "The Enterprise of Knowledge: Representational Machines of Informal Empire", in Gilbert Joseph, Catherine LeGrand and Ricardo Salvatore (eds.), Close Encounters of Empire: Writing the Cultural History of US-Latin American Relations (Durham: Duke University Press, 1998); Joseph and Spenser, In From the Cold. See also Emily Rosenberg, Spreading the American Dream: American Economic and Cultural Expansion, 1890-1945 (New York: Hill and Wang, 1982).

wellbeing, grounded on the nation's favorable position as a commodity exporter. Conscious of Peru's position in a transnational economic order in which Europe and, increasingly, the United States made the rules, these physicians viewed their populations as possible assets and also as liabilities. The "right" kind of population could unleash the vast economic potential of under-colonized portions of the country. The "wrong" kind could destabilize the young republic and lead it down a path of "degeneracy." These elite physicians believed that Peru's population was under siege from multiple enemies: high rates of infant mortality, morbidity, and abortion, as well as the backwardness of indigenous peoples, venereal diseases, alcoholism, and individual moral shortcomings. Elite physicians believed that Peru's progress ought to be safeguarded via surveillance of and medical interventions on potential parents throughout the life course. In addition, these medical experts treated indigenous Peruvians and Andean culture as sources of particular challenges to the nation's reproductive potential.

Chapter three, "Accusation and Abortion, 1890s-1940s", analyzes the state of medical knowledge about abortion between the late nineteenth and early twentieth centuries, as well as how this led (or failed to lead) to accusations against people for causing abortions. The Peruvian medical establishment considered pregnancy losses from abortion an important cause of demographic stagnation already in the late eighteenth century. By the mid-twentieth century, this establishment also construed unsafe illegal abortions as a cause of maternal mortality that suggested the need to improve the medical care of women, and to reduce or space fertility. In addition to indicating the refusal of Peruvian women to bear children, abortion also raised important issues about lay

knowledge of bodily processes, the use of social networks to avail oneself of illegal services, and the emergence of tensions between sexual partners.

Chapter four, "The Institutionalization of Birth Control in Peru I: Transnational Discourses and Local Actions, 1930s-1974", documents the slow but radical shift that took place in Peru between the 1930s and the mid-1970s regarding the use of contraceptives. The belief in the importance of population growth as an engine of economic development and national vigor waned and, in its stead, medical institutions came to embrace the value of smaller families and more limited demographic growth. In this chapter, I delve into how these broad changes were experienced, enacted, and challenged by supporters of family planning in Peru, a group of contraception researchers and advocates linked to foreign scientific networks. These actors converged around the problem of high maternal mortality, which they claimed was exacerbated by unsafe abortive practices of women who did not wish to have children. The explicit purpose of these birth control advocates was the protection of the lives of women from risky pregnancies and of the integrity of families from the entropic forces of poverty. However, the movement also profited from the association with foreign donors such as contraceptive manufacturers and population limitation organizations.

Chapter five, "The Institutionalization of Birth Control in Peru II: The Making of a Population Policy, 1968-1976", discusses the first governmental policy that sanctioned the use of family planning programs as part of a national population policy. The contents of this document, the 1976 Guideline for Population Policy, built upon thirty years of local debates and transnational political economic decisions. In this chapter, I analyze the ideological and practical precedents of the Guideline, particularly the influence of pan-

Latin American agreements, the United States Agency for International Development, and the military government of General Juan Velasco Alvarado. The Peruvian government, through this policy, embraced the position that lowering fertility rates through family planning was only one, and not the most important, activity among many in which the state should be engaged in order to more effectively bring about economic development.

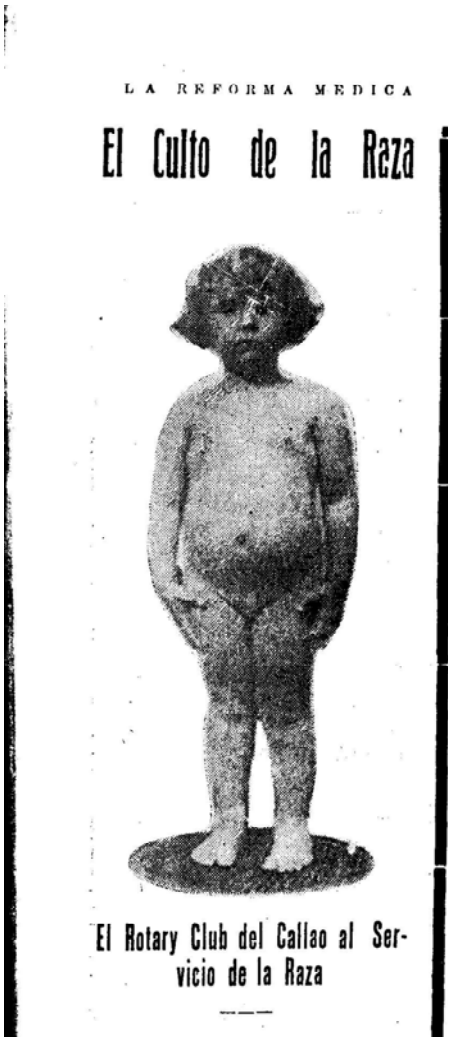
Chapter six, "Priests and Pills: Catholic Family Planning in Peru, 1967-1976", deals with the Catholic Church's response to the demographic challenges of the late twentieth century. The substance of the chapter is an analysis of a program sponsored by the Catholic Church of Peru, which combined the provision of contraceptive pills with sexual education and "responsible parenthood" training for couples in poor urban areas of the country. This program was based on the belief by Church authorities that the doctrine was compatible with controlling one's fertility. At the same time, Catholic leaders were reluctant to treat fertility control as a prerogative of individual women, instead emphasizing its family and community dimensions.

Chapter Two

The Nation's Reproductive Potential, 1895-1940

In the summer of 1933, the Rotary Club readied for "Child's Week", an event the club sponsored in Callao, Peru's most important port city, west of Lima. Under the enthusiastic leadership of Dr. Alberto Sabogal, Child's Week consisted of a series of activities to kindle interest in all things toddler. Luisa Arróspide Bueno won the contest for the child with the best "vital traits." At two years, eleven months, and seventeen days, Luisa had uncommonly good physical proportions, according to the judges: she stood just over a meter tall, weighed twenty-one kilos, and had sixty-two centimeters of thorax. She had also been exclusively breastfed during her first two months of life. The news item about Luisa's accolade emphasized Luisa's mother's clever and careful food choices for her daughter, as well as Luisa's father's complete devotion to his family. A naked Luisa stared at the camera with a vacant look, making obvious what La Reforma Médica did not: she was a white child, all brown locks, and chubbiness. The article's message, explicit in its final lines, was that children such as Luisa, with her white skin, doting parents, and scientifically monitored development, were urgently needed for the progress of the nation.[1]

[1] "El Culto de la Raza," La Reforma Médica 20, 183 (15 March 1934): 290.


LA REFORMA MEDICA

El Culto de la Raza

El Rotary Club del Callao al Servicio de la Raza

This chapter deals with physicians such as Dr. Sabogal, and the particular notion of national progress they espoused. Who were these physicians? What did they advocate? What were the reasons for their beliefs? Whom did they influence? What did they concretely accomplish in pursuit of their vision of national progress? Why did they matter? As I will show, a politically influential group of medical practitioners associated with the Faculty of Medicine of Lima argued in the late nineteenth century that national progress was only possible through increasing and improving Peru's population.

Peru did not conduct any national censuses between 1876 and 1940. This, however, did not quell physicians' concerns over the size and rate of growth of Peru's population. These physicians believed that the country's population was under siege from multiple real and imagined enemies: high rates of infant mortality, the backwardness of indigenous peoples, venereal diseases, alcoholism, the ignorance of women who neglected their maternal duties, and the carelessness of two-timing men who fathered children out of wedlock. At a time when no other organized group paid much attention to demographic growth, Peruvian academic physicians of the late nineteenth and early twentieth century claimed that Peru could fulfill its reproductive potential were this area entrusted to their leadership.

Pro-natalism figures prominently in Latin America's historiography in two ways. Scholars have discussed it, first, as a corollary of the political imperative to populate the region so as to maximize each country's ability to produce primary commodities for export. Several Latin American nations adopted, from the mid-nineteenth century on, versions of the Alberdian motto that "to govern is to populate."[2] Inasmuch as economic productivity was a cherished goal, Latin American political elites favored populating their countries with the citizens of nations deemed most prosperous and "civilized", that is, European ones. Attracting European immigrants to lead the evolution of national demographics became the concern of political elites in countries like Peru, Colombia, Brazil, Uruguay and Argentina.[3]

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[2] "*Gobernar es poblar*" is attributed to Argentinian political theorist Juan Bautista Alberdi in 1852. See Juan Bautista Alberdi, Bases y Puntos de Partida para la Organización Política de la República de Argentina (Lima: Unknown, 1879).

[3] Peter Wade, Blackness and Race Mixture: The Dynamics of Racial Identity in Colombia (Baltimore: Johns Hopkins University Press, 1993); Carlos Contreras, "Sobre los

Eugenics highlights a different aspect of the Latin American pro-natalism historiography. As a field of knowledge, eugenics first emerged in England in the 1860s, through the writings of Francis Galton. Although originally concerned with the biological underpinnings of the inheritance of intelligence, by the 1890s Galton veered towards the study of the means to improve the mental and physical qualities of the nation as a whole. Several members of the English middle class found these ideas persuasive, convinced as they were of England's decline, brought about by socially undesirable traits such as pauperism and mental illness. Where were these ills located? How could they be uprooted? Eugenics provided answers to these questions in authoritative scientific terms. Most appealing to this English middle class was the notion that traits such as epilepsy, alcoholism, pauperism, criminality, and especially "feeblemindedness" could be genetically inherited.[4] Reproduction and immigration, thus, became matters of public interest due to their consequences for the composition of the national population.

As Frank Dikötter has noted, eugenic ideas spread rapidly in the early twentieth century, becoming part of the "political vocabulary of virtually every significant modernizing force between the two world wars."[5] Eugenics entered public discussions of evolution, civilization, public health, criminality, psychiatry, and racial degeneration in

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Orígenes de la Explosión Demográfica en el Perú: 1876-1940," Documento de Trabajo 61, Serie Economía 21 (Lima: IEP, 1994); Frédéric Martínez, "Apogeo y Decadencia del Ideal de la Inmigración Europea en Colombia, Siglo XIX," Boletín Cultural y Bibliográfico 44, 34 (1997): 1-30; Skidmore, Black into White; A. Reggiani and H. González Bollo, "Dénatalité, 'Crise de la Race' et Politiques Démographiques en Argentine (1920-1940)," Vingtième Siècle 3, 95 (2007): 29-44; Anne-Emanuelle Birn, "Doctors on Record: Uruguay's Infant Mortality Stagnation and Its Remedies, 1895-1945," Bulletin of the History of Medicine 82, 2 (2008): 311-354.

[4] Kevles, In the Name of Eugenics.

[5] Frank Dikötter, "Race Culture: Recent Perspectives on the History of Eugenics," American Historical Review (1998): 467-478, 467.

several countries, many of which witnessed the development of scientific societies, lobbies and political institutions that supported various combinations of eugenics-based policies. These policies included the identification of the eugenically fit and the promotion of their increased reproduction or immigration, the limitation of the fertility of those deemed eugenically unfit (both coercively and through incentives), and the elimination of the environmental factors that damaged a person's genetic make-up. As it spread worldwide, eugenics permitted local elites to debate social problems in scientific terms. This allowed elites to represent their prescriptive claims about the social order as objective statements grounded in nature's laws.

Beginning in the early twentieth century, and especially during the 1920s and 1930s, the idea that some people were more genetically fit than others, and thus worthier of reproducing or immigrating, added a biomedical aspect to the already familiar concern with increasing population growth in Latin America.[6] In countries such as Argentina, Mexico, Brazil, Peru and Cuba eugenic ideas increasingly made the private realm of reproductive behaviors a public matter, as these behaviors could alter the long-term wellbeing of the nation. In addition, eugenics made it possible for new groups of biomedical experts and social activists to acquire a measure of political visibility in societies where, formerly, one's closeness to transnational capital was the strongest determinant of political power.

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[6] Stepan, The Hour of Eugenics; Stern, "Responsible Mothers and Normal Children"; Armando García González and Raquel Alvarez Peláez, En Busca de la Raza Perfecta: Eugenesia e Higiene en Cuba, 1898-1958 (Madrid: CSIC, 1999); Palma, "Gobernar es Seleccionar"; Marta Saade Granados, "¿Quienes Deben Procrear? Los Médicos Eugenistas Bajo el Signo Social, Mexico 1931-1940," Cuicuilco 11, 31 (2004): 1-36; Marisa Miranda, "La Biotipología en el Pronatalismo Argentino, 1930-1983," Asclepio 57, 1 (2005): 189-218. See also references to the history of eugenics in chapter one.

An analysis of Peruvian physicians' publications, books, periodicals and theses, as well as official documents from Peru's sanitary and public health agencies, reveals the growing assertiveness of physicians in the late eighteenth century and the challenges they faced from the nineteenth until the mid-twentieth centuries to impose their views about the importance of population growth. Peruvian medical pro-natalism idealized women and men as potential parents. Scholars of pro-natalism have found this to be a common trait in several countries although, at least in the Latin American historiography, women figure more prominently than men as the objects of pro-natalist interest.[7] As I will show below, the reproductive potential of both men and women mattered to Peruvian physicians of the late nineteenth and early twentieth centuries. This is an important complement to our knowledge of Latin American pro-natalism.

More peculiar to the Peruvian milieu than idealizing women and men as potential parents was the way in which physicians combined their support for population growth with their selective adaptation of European ideas about Social Medicine. Social Medicine emerged in nineteenth-century France partly as an effort to contain the social disorder that came with urbanization and industrialization. Its aim was to organize social life in

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[7] The Latin American historiography on this topic includes Guy, Sex and Danger in Buenos Aires; Mannarelli, Limpias y Modernas; Sarah Anne Buck, Activists and Mothers: Feminist and Maternalist Politics in Mexico, 1923–1953 (Piscataway: Rutgers University Press, 2002). Examples of pro-natalism beyond Latin America include Rima Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries," Social History of Medicine 8, 2 (1995): 161-178; Laura Lovett, Conceiving the Future: Pronatalism, Reproduction, and the Family in the United States, 1890-1938 (Chapel Hill: University of North Carolina Press, 2007); Elisa Camiscioli, "Reproducing the 'French Race': Immigration and Pronatalism in Early-Twentieth Century France," in Tony Ballantyne and Antoinette Burton (eds.), Bodies in Contact: Rethinking Colonial Encounters in World History (Durham: Duke University Press, 2005); Heather Paxson, Making Modern Mothers: Ethics and Family Planning in Urban Greece (Berkeley: University of California Press, 2004).

order to prevent the emergence of pathologies. Social Medicine helped legitimize the state's role in preserving the public's health while demanding greater state intervention in people's private lives and a more thorough regulation of populations.[8] Bacteriology and hospital medicine buttressed the prestige of European medical science abroad, easing the way for the acceptance of further European innovations in countries such as Peru.[9] Not surprisingly, Social Medicine became very popular in early twentieth-century Latin America and, as I will show, it came to justify maternal and child assistance programs and anti-venereal disease campaigns in Peru.[10] Yet the local medical elite that deemed Social Medicine useful and made it relevant in the country appropriated its precepts through a pre-existing mentality, making a sharp and simplistic hierarchical distinction between urban white creoles and rural indigenous Peruvians. Explaining the roots and manifestations of this mentality illustrates how medical ideas are not static objects but dynamic constructs that different actors use to maximize their own social standing.

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[8] Erwin Ackerknecht, Rudolf Virchow: Doctor, Statesman, Anthropologist (Madison: University of Wisconsin Press, 1953); George Rosen, From Medical Police to Social Medicine: Essays on the History of Health Care (New York: Science History Publications, 1974); Porter and Porter, "What Was Social Medicine?"; Deborah Lupton, The Imperative of Health: Public Health and the Regulated Body (London: Sage, 1995).

[9] For the case of Peru, see Cueto, El Regreso de las Epidemias. For additional studies about the prestige of European medicine in Latin America, see Nancy Stepan, "The Interplay Between Socio-Economic Factors and Medical Science: Yellow Fever Research, Cuba and the United States," Social Studies of Science 8, 4 (1978): 397-423; Stepan, Beginnings of Brazilian Science; Carrillo, "Economía, Política y Salud Pública en el México Porfiriano"; Trujillo-Pagan, "Health Beyond Prescription."

[10] See Meade, "Civilizing" Rio; Adrián López Denis, "Higiene Pública contra Higiene Privada: Cólera, Limpieza y Poder en La Habana Colonial," Estudios Interdisciplinarios de America Latina y el Caribe 14, 1 (2003): 1-30. Contemporary Latin American Social Medicine still emphasizes the economic, social and political determinants of the health, disease and medical care in human collectives, and is bound with political and social reform attempts. See Débora Tajer, "Latin American Social Medicine: Roots, Development During the 1990s and Current Challenges," American Journal of Public Health 93, 12 (2003): 2023-2027.

Indeed, the Peruvian physicians who promoted demographic growth claimed such growth could help recover the population lost between the colonial period and the onset of the republican one, as well as unleash the country's reputedly vast economic potential, as long as it were done following social medical principles.

This chapter is divided into four sections. First, I describe the institutional context of Peruvian medicine between the late eighteenth and early twentieth centuries. The second section deals with the European notion of degeneracy, which played an influential role in the way Peruvian physicians interpreted risks to the country's population. Section three focuses on the medical advice about and interventions on women's and men's fertility. The final section discusses the context of Peruvian pro-natalism and its relationship to Social Medicine ideas.

The Institutional Development of Medicine in Peru

The medical experts who rose to prominence advocating the link between pro-natalism and national progress were all linked, especially as instructors, to the Faculty of Medicine of Lima. Until 1961, medical training was available in Peru only at San Marcos University. The university was founded in 1551, while Peru was still a Spanish colony, and its first medical courses began in 1571. Early medical education was more theoretical than practical, with instructors reading aloud to students classic works by Aristotle, Hippocrates, Avicenna, and Galen. The earliest practical training began with the establishment of the Anatomy course in 1711, in which students could witness

dissections of bodies at San Andrés Hospital, founded in Lima in 1557.[11] That same year, Archbishop Hierónimo de Loayza founded the Santa Ana Hospital, in close proximity to San Andrés Hospital.[12]

In addition to the Faculty of Medicine, a second institution played an important role in Peruvian medicine during the colonial period and the early republican period: the *Tribunal del Protomedicato*. The *Protomedicato* was established in Spain in 1442, and reproduced as a colonial entity in Peru in 1570, when formal medical training began in the Viceroyalty. The role of the *Protomedicato* was to evaluate the competence of all practitioners who aspired to be recognized as healers in Peru. These included not just physicians, but also surgeons, midwives, bloodletters and herbalists. In addition, the *Protomedicato* oversaw the operation of pharmacies in hospitals and advised the Viceroy in sanitation matters.[13]

Dr. Hipólito Unanue directed the *Protomedicato* and was appointed the Chair of Anatomy at the Faculty of Medicine in 1792. Unanue was one of the foremost promoters of the adaptation of European science to Peru's needs, through organizations like the *Sociedad de Amantes del País*, of which he was a founding member, and the newspaper El Mercurio Peruano, which he published.[14] Unanue was frustrated by the stagnation of medical training in Peru, exemplified by the unfulfilled promise to build an anatomical

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[11] Agustín Iza and Oswaldo Salaverry, "El Hospital Real de San Andrés," Anales de la Facultad de Medicina 61, 3 (2000): 247-252.
[12] Jorge Vidal Amat y León, Historia de la Obstetricia y Ginecología en el Perú (Lima: MAD, 2004).
[13] Carlos Enrique Paz Soldán, La Escuela Médica Peruana (Lima: Biblioteca del Centenario de Hipólito Unanue, 1932).
[14] John Woodham, "The Influence of Hipólito Unanue on Peruvian Medical Science, 1789-1820: A Reappraisal," Hispanic American Historical Review 50, 4 (1970): 693-714; Oswaldo Salaverry, "Los Orígenes del Pensamiento Médico de Hipólito Unanue," Anales de la Facultad de Medicina 66, 4 (2005): 357-370.

amphitheater at San Andrés Hospital. Although Viceroy José Antonio Manso de Velasco had ordered its construction in 1753, it was not until 1792 that Viceroy Francisco Gil de Taboada y Lemos finally had it built. Unanue's speech on the "Decadence and Restoration of Peru" at the inauguration of the anatomical amphitheater is one of the founding texts of Peruvian medicine, outlining the reasons for the specificity of Peru's health challenges.[15]

On the subject of demographic growth, Unanue described Peru as wanting in population due to disease, brought in the early days of the colony. According to him, epidemics had not existed in the land before the arrival of Spaniards. Diseases such as smallpox and the measles first spread because of "trade, luxurious lifestyles and miscegenation."[16] Moreover, Unanue believed that sugar cane liquor (*aguardiente*) weakened the bodies of the natives; and that the arrival of Africans worsened things, as they brought with them leprosy, scabies, and gonorrhea. To Unanue, "lacking in arms to tend the fields, break the entrails of the earth, and push forward the arts and commerce, misery will extract helpless moans from any country where nature has liberally poured the treasures of its inexhaustible fecundity."[17] Unanue's was not a helpless moan, however. He believed that the colony's population size could be increased with the help of more scientists, physicians, and midwives. He advocated a frontal battle against charlatans, safer working conditions in mining, and more funds for the Faculty of

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[15] Juan Pablo Murillo Peña, "Hipólito Unanue y el Proceso de Construcción del Discurso Epidemiológico Peruano," Anales de la Facultad de Medicina de Lima 66, 4 (2005): 344-356.
[16] Hipólito Unánue, Decadencia y Restauración del Perú (Lima: Imprenta Real de los Niños Expósitos, 1793: 12).
[17] Unánue, Decadencia y Restauración, 6.

Medicine, which received less funding than the Faculties of Law, Theology and Philosophy.

With the Viceroy's acquiescence, and using the Paris Medical Faculty as a model, Unanue went on to modify the curriculum of the Faculty of Medicine, which would thenceforth consist of courses in four fields: math, physics, natural history, and medicine. The newly structured Faculty of Medicine, renamed the *Real Colegio de Medicina y Cirugía de San Fernando*, was inaugurated in 1811. The 1810s, however, were politically turbulent. Agitation in favor of independence had begun in Spanish America, resulting in a smaller budget for the Faculty of Medicine, fewer enrollments, and fewer instructors. General José de San Martín, commander of one of the pro-independence armies of South America and self-titled Protector of Peru, renamed the Faculty of Medicine the *Colegio de la Independencia* in 1821. However, with much of the country in financial difficulties, the Faculty of Medicine went through frequent periods of inactivity after the country's independence in 1824.[18] One notable, though short-lived, exception in this period was the establishment of the first government-sanctioned program for the training of midwives at the Faculty of Medicine. The woman responsible was Paulina Benita Cadeau de Fessel, who trained at the Paris Maternity Hospital and arrived in Lima with her husband, a physician, in 1826. By 1836, when she returned to France, de Fessel had trained only five midwives. Further training stopped with her departure.[19]

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[18] Oswaldo Salaverry, "El Inicio de la Educación Médica Moderna en el Perú: La Creación de la Facultad de Medicina de San Fernando," Acta Médica Peruana 23, 2 (2006): 122-131.
[19] Juan Lastres, Historia de la Medicina Peruana, Vol. 1 (Lima: Santa María, 1951).

Medicine as an institution began to recover in the mid-nineteenth century, as the Peruvian state became wealthier through the revenues generated by the export of guano.[20] President Ramón Castilla signed off on the budgetary allocation for the Faculty of Medicine in 1856, renaming it the *Facultad de Medicina de San Fernando*. He appointed Dr. Cayetano Heredia as the Faculty's Dean. Heredia had been the head of the *Protomedicato* between 1843 and 1848, as well as the Professor of Anatomy at the Faculty. By then, several physicians had come to consider the *Protomedicato* a colonial throwback, out of tune with the demands of contemporary medicine. Moreover, they pointed out how the *Protomedicato* simply rubberstamped the degrees granted by the Faculty, since the members of the *Protomedicato* were also professors at the Faculty. President Castilla agreed and eliminated the *Protomedicato* in 1848.

Like Unanue before him, Heredia tried to emulate the Paris Medical Faculty when he reorganized physician education at the Faculty of Medicine. Heredia's new curriculum consisted of seven years of classroom training in anatomy, botany, chemistry, physics, zoology, mineralogy, pathology, surgery, hygiene, pharmacology, and obstetrics.[21] The training of midwives resumed. Training lasted four years, and consisted of courses on anatomy of the female genitals, birthing procedures, and bloodletting.[22] From 1856 on, practical training for physicians took place at San Andrés Hospital, which excluded

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[20] On the boom-bust cycle of the guano economy in Peru see Heraclio Bonilla, Guano y Burguesía en el Perú (Lima: IEP, 1974).
[21] Eduardo Zárate, Los Inicios de la Escuela de Medicina de Lima: Cayetano Heredia, El Organizador (Lima: Asamblea Nacional de Rectores, 2005); Javier Arias Stella, "Anatomía Patológica en el Perú: Un Enfoque Histórico," Revista Médica Herediana 9, 2 (1998): 81-83.
[22] Lastres, Historia de la Medicina Peruana.

women. The latter were admitted only at the Santa Ana Hospital; therefore, obstetrics training and all practical training in midwifery occurred there.[23]

Thanks to the 1856 reforms, medicine became the first profession in Peru to establish a unified standard curriculum for its new practitioners, doing away with the distinction between physicians and surgeons and creating instead a new type of hybrid specialist.[24] Heredia's reforms were possible because of the greater prosperity of the Peruvian state as a whole, and also because of the greater determination of physicians to concentrate their institutional authority solely in the Faculty of Medicine, instead of dividing it between the Faculty and the *Protomedicato*. From then on, professors at the Faculty of Medicine became more hostile towards medical practitioners not trained by or affiliated with the Faculty, especially in Lima.[25]

Heredia looked to Europe to improve the quality of the specialized training of medical doctors in Peru. The scientific developments in pathological anatomy of the Paris Medical Faculty, in particular, appealed to him.[26] In the 1850s, Heredia personally funded training trips to France for some of his most promising students, including José Casimiro Ulloa, Celso Bambarén, and Francisco Rosas. Inspired by the work of scientists such as Claude Bernard and Louis Pasteur, other wealthy Peruvian physicians used their own

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[23] Iza and Salaverry, "El Hospital Real de San Andrés."
[24] On the history of medical specialization in Peru, see Cueto, Excelencia Científica en la Periferia.
[25] Carlos Enrique Paz Soldán, Heredia y sus Discípulos (Lima: Instituto de Medicina Social, 1956).
[26] The Paris Medical School was at the forefront of important scientific, professional, and organizational innovations from the late eighteenth century on. See Lindsay Graham, "The Hospital," in William Bynum and Roy Porter (eds.) Companion Encyclopedia of the History of Medicine, Vol. 2 (London: Routledge, 1993: 1180-1203); and George Weisz, Divide and Conquer: A Comparative History of Medical Specialization (Oxford: Oxford University Press, 2006).

funds to travel to Paris to further their training as well.[27] These trips were important not only because of the advanced training acquired, but also because the young physicians made it a point to send back European books and pedagogical materials for the university library. Perhaps more crucially, these physicians returned to take up teaching jobs at the Faculty of Medicine of Lima.[28] In 1856, Heredia became one of the editors of the first periodical published by Peruvian physicians, the Gaceta Médica de Lima.[29]

By 1875, authorities at the Faculty of Medicine determined that San Andrés Hospital no longer fulfilled their training and treatment needs. They closed down the hospital and moved all its functions to the new Dos de Mayo Hospital. That was the last notable institutional development in Peruvian medicine before the War of the Pacific against Chile (1879-1883), which left the country, and the Faculty of Medicine, in financial ruin. Nevertheless, as the nineteenth century came to a close, Peru experienced yet another bonanza, this time underwritten by the export of copper, sugar, cotton, oil, wool, rubber, coffee, and silver. Economic historian Carlos Contreras refers to the 1890-1930 period as "four unprecedented decades" of economic growth and production diversification.[30]

This new period of economic expansion was the backdrop for the increase in training offerings in Peru. "Bacteriology and Microscopy" was the first of the newly available courses, taught by the London-trained David Matto. The Gynecology and

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[27] Juan Manuel Cuba, "Influencia de la Medicina Francesa en la Medicina Peruana," Revista Peruana de Neurología 8, 1 (2002): 31-40.
[28] Carlos Bustios Romaní, "Notas sobre la Historia de la Educación Médica en el Perú, Primera Parte, 1568-1933" Acta Médica Peruana 20, 2 (2003): 94-108.
[29] Oscar Pamo Reyna, "Estado Actual de las Publicaciones Periódicas Científicas Médicas del Perú," Revista Médica Herediana 16 (2004): 65-73.
[30] Carlos Contreras, El Aprendizaje del Capitalismo: Estudios de Historia Económica y Social del Perú Republicano (Lima: IEP, 2004, 176).

Obstetrics course was created in 1895, taught by the Paris-trained Constantino T. Carvallo until 1920.[31] Carvallo introduced techniques such as asepsis in surgical practice, as well as the use of rubber gloves and radium therapy for cancer. In 1896 he took an x-ray of Peruvian President Nicolás de Piérola's hand, the first x-ray in the country.[32] The Pediatrics course followed in 1896, chaired by Francisco Almenara Butler and Rómulo Eyzaguirre until 1919.[33] Ricardo Florez taught Ophtamology starting in 1897; in 1909, the Paris-trained Juvenal Denegri began teaching the Ear, Nose and Throat course, and Ricardo Pazos Varela began teaching Urology. Another Paris-trainee, Belisario Sosa, taught Dermatosyphilis since 1911. Hermilio Valdizán started teaching Neuropsichiatry in 1916.[34] The same year, the Faculty of Medicine began offering the Tropical Diseases course, which was taught by Julian Arce.[35] The Hygiene specialty was created in the early twentieth century and was chaired by Francisco García Calderón until 1919, when Carlos Enrique Paz Soldán succeeded him.[36]

Peru's late nineteenth-century economic expansion was also the context for the formation of new professional associations of physicians. In 1888, Oswaldo Hercelles

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[31] Claudia Ugarte Taboada, "Historia de los Servicios de Emergencia de Lima y Callao," Revista Médica Herediana 11, 3 (2000): 97-106; Vidal, Historia de la Obstetricia y Ginecología en el Perú.

[32] Victor Bazul, "El Profesor Doctor Constantino T. Carvallo y la Creación de la Cátedra de Ginecología en la Facultad de Medicina," Anales de la Facultad de Medicina 57, 2-4 (1996): 40-42. Note how Wilhelm Roentgen had discovered x-rays only a year earlier, in 1895. On the diffusion of x-ray technology, see Bettyann Kevles, Naked to the Bone: Medical Imaging in the Twentieth Century (New Brunswick: Rutgers University Press, 1997).

[33] Gamaniel Guevara Chacabana, "Aspectos Históricos de la Enseñanza de la Pediatría y la Atención de la Salud Infantil en el Perú," Paediatrica 8, 1 (2006): 20-26.

[34] Javier Mariátegui, "Hermilio Valdizán y la Facultad de Medicina San Fernando," Anales de la Facultad de Medicina 58, 3 (1997): 1-4.

[35] Bustios Romaní, "Educación Médica en el Perú, Primera Parte."

[36] Marcos Cueto, "La Vocación por Volver a Empezar: Las Políticas de Población en el Perú," Revista Peruana de Medicina Experimental y Salud Pública 23, 2 (2006): 123-131.

and Carlos Enrique Paz Soldán founded the *Academia Nacional de Medicina*. All forty founding members were also professors at the Faculty of Medicine. The *Academia* set itself up as a consulting body for the Peruvian government, with the mandate to "organize conferences, contests, debates and studies for the advancement of medicine, to protect professional rights, and to evaluate healing substances and mineral waters at the state's behest or at will." In addition, the *Academia* sponsored the formation of ad-hoc commissions to study specific issues, such as alcoholism, tuberculosis, military medicine, medical geography, and "indigenous problems."[37]

In 1897, the Academia began publishing the Anales de la Academia Nacional de Medicina. However, theirs was not the first medical periodical to emerge in post-War of the Pacific Peru. In 1884, an enterprising medical student named Leonidas Avendaño had begun to publish La Crónica Médica, with fellow medical students. A year later, the Paris-trained Casimiro Ulloa followed with El Monitor Médico.[38] In the 1910s, two more medical journals began to be published, La Reforma Médica, and the Anales de la Facultad de Medicina. Hygiene specialists Carlos Enrique Paz Soldán and Baltazar Caravedo founded the latter in 1915. Paz Soldán also founded La Acción Médica in the 1920s, along with fellow Hygiene experts Francisco Graña and Sebastián Lorente.[39] Lacking advertisements, these journals were funded by subscription. Rather than publishing original research, they devoted their pages to debates about public health

[37] Anales de la Academia Nacional de Medicina de Lima 1 (1919): 1.
[38] Pamo Reyna, "Estado Actual de las Publicaciones." La Crónica Médica, published until 1970, has been the longest-running medical periodical in Peru.
[39] See the first available issue of La Acción Médica (January 1927): 1.

policy, defending professional prerogatives, and to discussions of cases writers deemed interesting.[40]

In addition to creating new specialties and medical associations and publications, in the late nineteenth century Peruvian physicians began attending regional professional conferences, such as the Pan-American Medical Congresses and the Latin American Medical Congresses. Five Peruvian physicians attended the Second Pan-American Medical Congress, held in Mexico City in 1896; sixteen had attended the first, held in Washington, D.C. in 1893.[41] These transnational meetings not only helped colleagues exchange scientific information, but also aided in professional organization and in the building of a transnational esprit de corps. For example, the members of the Obstetrics Section at the First Pan-American Medical Congresses of Washington, D.C. joined forces to pass a unanimous resolution to "protest against the irregular practice of obstetrics by midwives, and [to], in view of the grave dangers to the community incident thereto, recommend that the boards of health or licensing boards of the various States refuse to grant licenses to applicants to practice midwifery who have not received technical instructions and preliminary training of at least one year in competent schools, and passed an examination in obstetrics equivalent to that required from the applicant for a degree in medicine."[42] Likewise, as Marta de Almeida found, the Latin American Medical Congresses held between 1901 and 1922 emphasized the establishment of equivalencies

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[40] See the first issue of La Reforma Médica 1 (15 April 1915); and the Anuario de la Academia Nacional de Medicina 1 (1952-1953).
[41] Transactions of the First Pan-American Medical Congress, Washington DC, 5-8 September 1893 (Washington DC: Government Printing Office, 1895); Memorias del Segundo Congreso Médico Pan-Americano de México 16-19 de Noviembre de 1896 (Mexico: Hoeck & Hamilton, 1898).
[42] Transactions of the First Pan-American Medical Congress, 905.

in medical education throughout the region, the formal adoption of a Pan-American pharmacopeia classifying all indigenous medicinal plants, the organization of campaigns against tuberculosis, and the creation of courses in Legal Medicine.[43]

Finally, the Faculty of Medicine was an important presence in Peruvian policymaking. Physicians had been consistently elected to Congress since the formation of the Peruvian legislative power in 1822.[44] Professor of Hygiene Carlos Enrique Paz Soldán, for example, was elected to the *Cámara de Diputados* for Lima in 1919.[45] Even when not elected, academic physicians exerted their influence as ministers and advisors to ministers. Dr. David Matto, for example, the Chair of Bacteriology and Microscopy, became the Minister of *Fomento* (Economic Development) in 1903.[46] In addition, the Ministry of Justice set up a special committee in 1896 to recommend a bill against alcohol consumption. Only physicians from the Faculty of Medicine were selected for this committee.[47]

Even more indicative of the power of academic medicine in late nineteenth-century Peru was the establishment of the *Dirección de Salubridad Pública* (Office of Public Sanitation, or DSP), forerunner to Peru's Ministry of Health.[48] Until 1873, municipalities had been in charge of sanitary matters. Then, in 1903, the Ministry of

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[43] de Almeida, "Circuito Aberto."
[44] Eight medical doctors were elected to the first Congress of Peru in 1822, out of 87 members of Congress. See Archivo del Congreso del Perú (hereafter "ACP"), Reseña Histórica del Congreso, 2008.
[45] Luis Ugarte, "Dr. Carlos E. Paz Soldán," Galeno 51 (May 1975): 24-30. In 1919, Perú had two Congressional chambers, *Diputados* and *Senadores*. The former were elected in local elections, while the latter were elected from a nation-wide contest.
[46] Bustios Romaní, "Educación Médica en el Perú, Primera Parte," 104.
[47] ACP : Catálogo de los Expedientes del Congreso y de la Camara de Diputados, Libro 12, legajo 9, cuaderno 1, expediente 16: "Asuntos de interés general pendientes en la Comisión Principal de Legislación: Represión del alcoholismo," 1905.
[48] Finally created in 1935.

Economic Development took over all sanitary initiatives and brought them under the jurisdiction of the newly created DSP. The DSP's main function was to coordinate national efforts against tuberculosis, plague, yellow fever, and malaria. Led by Julián Arce, Professor of Tropical Diseases at the Faculty of Medicine, the DSP was divided into a Hygiene Section, directed by Dr. Daniel Lavorería, and a Demography Section, directed by the Faculty of Medicine's Professor of Pediatrics, Rómulo Eyzaguirre. Other academic physicians joined the DSP's board of advisors, the *Junta Suprema de Sanidad*, which was chaired by the Minister of Economic Development, and included the Director of the Beneficence Society (the largest charitable organization in Peru), the Chief of the Navy, a representative of the diplomatic corps, an engineer, the President of the Chamber of Commerce of Lima, and the Mayor of Lima.[49]

Thus, by the early twentieth century, Peruvian academic physicians constituted an elite based at the expanding and specializing Faculty of Medicine, with students and instructors who received part of their training abroad, and networked with colleagues throughout the Americas. Physicians also founded new medical associations and journals, and their expertise was in demand not only in Congress but in the executive branch of government. As Cueto has already pointed out, however, this academic elite was not a strong proponent of original research. Such work mattered less to them than the application of knowledge developed abroad and the enforcement of quarantines and

[49] AGN: Archivo histórico del Ministerio de Hacienda, Dirección de Salubridad Pública, H6-0610, Boletín del Ministerio de Fomento 1, 5 (30 November 1905).

sanitary measures for the control of epidemics.[50] This lack of originality was also apparent, to a degree, in the way they discussed population problems.

Depopulation, Degeneration and the Nation

Peruvian physicians of the late nineteenth century emphasized, as Hipólito Unanue had in the eighteenth, the need for population increases, along with an overall betterment of the "Peruvian race." Racial degeneration had been a concern of intellectuals in Spanish America at least since the seventeenth century. As Cañizares Esguerra has noted, these intellectuals sought to defend American settlers against negative European characterizations of loss or dilution of physical, intellectual, and moral strength through exposure to tropical environments. Instead, writers such as Buenaventura Salinas de Córdoba and Antonio León Pinelo argued that the strong and resilient Iberian minds and bodies could thrive in newly colonized spaces, "improving" the indigenous racial stock via miscegenation, and morally inspiring indigenous peoples by acting as role models.[51]

By the mid-eighteenth century, the European body's imperviousness to change no longer seemed as certain. For one, the Spanish imperial experience had produced, as Serge Gruzinski has shown, a variety of cultural and physiognomic hybrids that defied

[50] Cueto, Excelencia Científica en la Periferia. Note the contrast with the expansion of medical science in the US and France, for example. See Morris Vogel and Charles Rosenberg (eds.), The Therapeutic Revolution: Essays in the Social History of American Medicine (Philadelphia: University of Pennsylvania Press, 1979); and Warner, The Therapeutic Perspective.

[51] Jorge Cañizares-Esguerra, Nature, Empire and Nation: Explorations of the History of Science in the Iberian World (Stanford: Stanford University Press, 2006).

the officially existing categories of "Indian" and "Spanish."[52] Moreover, the more that eighteenth-century Peruvian intellectuals such as Unanue, Pablo de Olavide, Pedro Peralta y Barnuevo and Manuel Lorenzo de Vidaurre came to value the European Enlightenment, the more familiar they became with a new language of degeneration that French scientists had begun to use to describe aspects of their society.[53] Unlike the discourse of degeneration that Spanish American intellectuals produced in the seventeenth century, the late eighteenth century French discourse of degeneration emphasized less the effects of tropical environments and more those of heredity. As Sean Quinlan has shown, for example, French medical experts such as Charles-Auguste Vandermonde, Dean of the Paris Medical Faculty, argued that the luxury, libertinism, and decadence of King Louis XIV's courtly society weakened the mind and body. Such weakness could become entrenched in family lineages, particularly through its effects on women's reproductive capacity. This justified a greater activism by scientists to change the natural and moral environments in which humans, especially women, lived.[54]

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[52] Serge Gruzinski, The Mestizo Mind: The Intellectual Dynamics of Colonization and Globalization (New York: Routledge, 2002). Contrast this Ibero-American process of cultural and phenotypical *mestizaje* or *métissage* to the case of British and US colonialism, which was more often characterized by the construction and enforcement of racial boundaries between colonizers and colonized. See for example Warwick Anderson, "Immunities of Empire: Race, Disease and the New Tropical Medicine, 1900-1920," Bulletin of the History of Medicine 70, 1 (1996): 94-118; Warwick Anderson, "Leprosy and Citizenship," Positions 6, 3 (1998): 707-730; Perez Hattori, Colonial Dis-Ease; David Arnold (ed.), Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900 (Amsterdam: Rodopi, 1996); Alison Bashford, Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health (London: Palgrave Macmillan, 2004).

[53] Estuardo Núñez, Las Letras de Francia y el Perú: Apuntaciones de Literatura Comparada (Lima: UNMSM, 1997).

[54] Quinlan, "Inheriting Vice, Acquiring Virtue."

By the mid-nineteenth century, the French medical establishment seemed certain that pathological features and predispositions to criminality provided a link between parents' temperaments (or physical constitutions) and those of their children.[55] According to Daniel Pick, influential physicians such as Benedict Augustin Morel defined this racial degeneration as a process of morbidity that extended over generations through idiocy, sterility, and, ultimately, premature death.[56] Race, in this case, referred not to a specific phenotype, but rather to the inhabitants of a national territory. This was also the way in which Peruvian intellectuals of the late-nineteenth century used the term. A vast range of physical deformities, alcoholism, sterility, and madness were the symptoms of such racial degeneration, which, if unchecked, could engulf the nation. As Nye has observed, medical professionals' concept of racial degeneration enjoyed wide appeal in France because it explained the root cause of several social problems. "Racial degeneration" could even explain France's defeat in the 1870 Franco-Prussian War. At the same time, the concept provided some potential solutions. Racial degeneration originated within pathological environments. Envisaged as an illness that advanced slowly, scientists had time to intervene at different stages of its progression. The promotion of invigorating sports or of school hygiene, for example, could be vehicles for improving national health.[57]

By the late nineteenth century, racial degeneration had become a component of medical debates in Latin America too. The fear of racial degeneration furnished an

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[55] Carlos López-Beltrán, "Heredity Old and New: French Physicians and L'Hérédité Naturelle," in Hans-Jörg Rheinberger and Staffan Müller-Wille (eds.), A Cultural History of Heredity II: 18th and 19th Centuries (Berlin: Max Planck Institute for the History of Science, 2003).
[56] Pick, Faces of Degeneration.
[57] Nye, Crime, Madness and Politics in Modern France.

ideological common denominator for diverse reform proposals of governments in the region: European immigration, urban renewal, sanitary campaigns, and the regulation of prostitution were advocated to restore the energy and health of the body of the nation.[58] In particular, Peruvian intellectuals felt that waning national health and energy were at the core of Peru's defeat in the War of the Pacific against Chile. Essayist José Gálvez, for example, lamented the corruption of beloved urban male types as a result of poverty, lack of vigor and pride, and increasing foreign cultural influence. The merry and virile *mozo malo* (bad boy), who periodically abandoned his starchy bourgeois home to be the soul of rambunctious lower-class parties, returned from the war transformed into a base street fighter or, perhaps worse, into an effeminate man whose picaresque inner spark had been extinguished by a need to accumulate wealth and knowledge.[59] Likewise, the anarchist critic Manuel González Prada focused on two divergent paths for Chile and Peru to explain why the war was lost. While Chile had embraced what González Prada dubbed a "progressive path to scientific modernity," by opening itself up to the influence of northern European immigrants who could help formulate rational laws and policies, Peru had insisted on a chauvinist and conservative path based on an obsolete and pro-aristocratic Spanish tradition.[60]

Like González Prada, other Peruvian intellectuals (geographers, economists, and sociologists, in particular) were also drawn towards Positivism's ideal of science-driven

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[58] Borges, "'Puffy, Ugly, Slothful and Inert'"; Abel, Health, Hygiene and Sanitation in Latin America c. 1870 to 1950; Katherine Bliss, "Between Risk and Confession: State and Popular Perspectives of Syphilis Infection in Revolutionary Mexico," in Diego Armus (ed.), Disease in the History of Modern Latin America: From Malaria to AIDS (Durham: Duke University Press, 2003); Sater, "The Politics of Public Health"; Blake, "The Medicalization of Nordestinos"; Ruggiero, Modernity in the Flesh.
[59] José Gálvez, Una Lima Que Se Va (Lima: Universitaria, 1913).
[60] Manuel González Prada, Pájinas Libres (Lima: P. Dupont, 1894, 38).

national progress.[61] Many of them blamed Spain for instilling a culture of laziness and conservatism among Peruvians and for the catastrophic depopulation of the country during the colonial period.[62] Writing in 1912, for example, Joaquín Capelo, a civil engineer who had served as a member of Peru's Constituent Assembly of 1885, estimated the Inka Empire population in 1533 to have been about 8 million, only to drop to barely over 1.2 million by 1795, under Viceroy Francisco Gil, rising modestly to 3.31 million under Leguía in 1911.[63] The corollary of the depopulation argument was the need for demographic growth. Sociologist and San Marcos University Professor Carlos Lissón, for example, argued in 1887 that a large population could buttress Peru's position as a trade partner in South America.[64] Economist Alejandro Garland, Minister of Economic Development in 1905, helped popularize the view that Peru had natural resources unavailable anywhere else, but was in need of a larger labor force to exploit them.[65]

Physicians in Peru reacted to the depopulation argument by supporting immigration from abroad and endogenous population growth. Dr. Julián Arce, soon to become head of the Office of Public Sanitation, argued in 1901 that such population growth could consolidate the economic growth of coastal haciendas.[66] Focusing more specifically on Peru's history of demographic loss, Hygiene Professor Francisco Graña

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[61] Pablo Quintanilla Pérez-Wicht, "La Recepción del Positivismo en Latinoamérica," Pontificia Universidad Católica del Perú, Departamento de Filosofía.
[62] On demographic losses in the Americas, see Cook, Born to Die.
[63] Joaquín Capelo, La Despoblación (Lima: Sanmartí y Cia., 1912); Richard Morse, "The Lima of Joaquín Capelo: A Latin American Archetype," Journal of Contemporary History 4, 3 (1969): 95-110.
[64] Carlos Lissón, Breves Apuntes sobre la Sociología del Perú en 1886 (Lima: Benito Gil, 1887, 80).
[65] Alejandro Garland, Reseña Industrial del Perú (Lima, Imprenta La Industrial, 1905, 4).
[66] Arce's essay, "Provisión de Brazos para la Agricultura" ("On the Provision of Labor for Agriculture") earned him an award from Peru's National Agricultural Society. Cited in Francisco Tudela, El Problema de la Población el el Perú (Lima: San Pedro, 1908).

described the Spanish colonial administration as entirely antithetical to the historical, biological and moral traits of the colonized indigenous society, which explained the latter's demographic dwindling and cultural near-demise.[67] On the bright side, Graña claimed, the 1862 and 1876 national censuses indicated that Peru's birth rate was approximately 40 per 1,000 annually. The downside was that the mortality rate also hovered around 40 per 1,000. Breaking this net demographic stagnation, according to Graña, required sanitary campaigns against smallpox and malaria, as well as the promotion of the immigration of European peoples. He was, however, skeptical of the success of new immigration schemes until Peru became more "progressive, attractive and healthy"; only then could Europeans be tempted to give Peru "their blood, their intelligence and their culture."[68]

The promotion of European immigration had strong supporters not only among Peruvian intellectuals, but also among legislators. *Diputado* for Lima Matías Manzanilla, for example, promoted Italian immigration, through a bill introduced at the behest of the *Sociedad de Inmigración y Colonización Italiana en el Perú*, which was presided over by the then Director of the *Banco del Perú y Londres*.[69] The bill, however, failed. Anti-immigration sentiments also had supporters in early twentieth-century Peru, particularly against the Chinese. Chinese settlers began arriving in large numbers in the mid-

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[67] Francisco Graña, La Población del Perú a través de la Historia (Lima: Torres Aguirre, 1916). Graña delivered this lecture at the opening of the 1916 academic year at the Faculty of Medicine of Lima.
[68] Graña, La Población del Perú, 41.
[69] ACP: Catálogo de los Expedientes del Congreso y de la Camara de Diputados, Libro 12, legajo 4, cuaderno 1, expediente 8: "Asuntos de interés general resueltos por Diputados: 'Inmigración y colonización Italiana – Protección,' 1906." The Banco del Perú y Londres was the most important bank of Peru at the time. See Alfonso Quiroz, Banqueros en Conflicto: Estructura Financiera y Economía Peruana, 1884-1930 (Lima: Universidad del Pacífico, 1989).

nineteenth century as farm hands, guano collectors, and railroad workers, and created a vibrant society within urban Peruvian society, especially in coastal cities.[70] However, living in some of the most crowded and unsanitary quarters of Lima, the Chinese became scapegoats during the 1903 plague epidemic in the city.[71] Wealthy Peruvian traders also accused Chinese merchants of unfair competition, because the latter charged less for their products and services.[72] Some Peruvian physicians considered that miscegenation with the Chinese weakened the national hereditary stock, though most of them were more critical of the fact that the un-schooled Chinese sold herbal remedies that were cheap and popular.[73] These physicians tried in vain to bring Chinese pharmacies under the regulatory eye of the Faculty of Medicine.[74] Congress took notice of the ill sentiments

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[70] On the Chinese in Peru, see Humberto Rodriguez Pastor, Hijos del Celeste Imperio en el Perú, 1850-1900 (Lima: Instituto de Apoyo Agrario, 1989); Carlota Casalino Sen, "De Cómo los 'Chinos' Se Transformaron y nos Transformaron en Peruanos," Investigaciones Sociales 9, 15 (2005): 109-132. On the distinctiveness of Chinese culture and pastimes, see Muñoz Cabrejo, Diversiones Públicas en Lima 1890-1920.

[71] Cueto, El Regreso de las Epidemias. See also Myron Echenberg, Plague Ports: The Global Urban Impact of Bubonic Plague, 1894-1901 (New York: New York University Press, 2007).

[72] Agitating against Chinese immigration was the *raison d'être* of two newspapers in Peru, both of which stopped circulating in the 1930s: Anti-Asia and Fuera Chinos ("Out with the Chinese").

[73] Salvador Olivares, "Sobre el Mejoramiento de la Raza," La Unión Médica 1, 2 (1 February 1932): 7.

[74] The Faculty of Medicine had jurisdiction over Chinese pharmacies since 1916. See "Las Herbolerías Chinas," La Reforma Médica 2, 23 (15 July 1916): 48. The Chinese were not allowed to treat patients or call themselves health professionals, only to sell medicines to customers. However, this was not enforced. For example, Chinese herbalists and representatives of an artisans' federation, the *Confederación de Artesanos Unión Universal*, exchanged letters. The former thanked the artisans for their continuing patronage and the latter thanked the Chinese for "so disinterestedly offering your professional knowledge for the good of the least fortunate classes." The exchange is disapprovingly reproduced in the Faculty of Medicine's pharmacy periodical. See El Boletín Farmacéutico 5, 54 (September 1922): 24.

toward the Chinese and twice, in 1909 and in 1916, it tried unsuccessfully to pass laws to limit Chinese immigration to the country.[75]

Although much desired by Peruvian physicians, European immigration to Peru failed to effect demographic growth for the country.[76] Instead, the position that gained purchase by the early twentieth century was the one seeking to increase endogenous population growth. As Dr. Julio Egoaguirre put it in 1929, "Peru is underpopulated, and we had better defend the lives we produce naturally. […] Our inhabitants must be healthy, robust, capable of procreating healthy children, because the nation's territory demands workers for fields, mines, industry and civic life. It is not appropriate to seek this growth through other races, which often do not blend well with our ethnic traits, and prevent us from fulfilling the maxim 'to govern is to populate.'"[77]

Defending this endogenous population growth had been a goal of Peruvian physicians' since the institution of the Office of Public Sanitation (DSP) in 1903. The DSP's programmatic statement in 1905 called for the centralization of all sanitary work under the supervision of Social Medicine professionals, and for the envisioning of population as a national economic resource that should be cared for and harnessed to

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[75] ACP : Catálogo de los Expedientes del Congreso y de la Cámara de Diputados, Libro 12, legajo 6, cuaderno 1, expediente 1: "Asuntos de carácter general pendientes en la Comision Auxiliar de Gobierno: 'Inmigración china, prohibiéndola en el territorio de la República,' 1909"; Libro 12, legajo 7, cuaderno 1, expediente 26: "Asuntos de carácter general pendientes en la Comisión de Inmigración: 'Inmigración asiática, prohibiéndola en la República,' 1916." The failure of these bills is not surprising. Chinese workers were a source of cheap labor at a time when Peru experienced an expansion in railroad building and agricultural production in the coast.

[76] On European migration to Peru, see Giovanni Bonfiglio, La Presencia Europea en el Perú (Lima: Congreso del Perú, 2001); and Pascal Riviale, Una Historia de la Presencia Francesa en el Perú, del Siglo de las Luces a los Años Locos (Lima: IEP, 2008).

[77] Ernesto Egoaguirre, "La Natalidad y la Mortalidad General e Infantil en el Callao," La Acción Médica (2 February 1929): 5.

produce more wealth. In their efforts to protect this "human capital", the DSP promoted the control of epidemics, hygiene courses in schools, the creation of health clinics and milk distribution centers for newborn, and the building of hygienic housing for workers.[78]

These interventions, or the conceiving of population as a form of capital in need of protection and expansion, were not original to Peru, but can be traced back to the rise of Social Medicine in nineteenth-century Europe.[79] In fact, so great was the influence of European Social Medicine that the DSP's 1905 programmatic statement copied large portions of an article published in the Revue d'Hygiène in 1904 by N. Ensch, a Belgian physician who directed the Schaerbech Hygiene Department. Nevertheless, the DSP's 1905 statement also reveals that the government of Peru had a clear rationale for emulating European ideas. The loss of population during the colonial period and the contemporary high mortality due to diseases were real. Likewise, the defeat in the War of the Pacific was a defining experience for the generation of intellectuals who directed agencies like the DSP and professional organizations like the *Academia Nacional de Medicina*. They entertained hereditary racial degeneration as a real underlying cause for such a defeat, and did not simply treat it as a European fad. This is why their rhetoric and actions to protect endogenous population growth went beyond improving the sanitary environment and led them to attempt to regulate the more intimate realms of mate selection and reproduction. As the authors of the 1905 DSP statement put it, "in recent years there have been attempts to restrict the freedom to marry, by giving the physician

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[78] AGN : Archivo Histórico del Ministerio de Hacienda, Dirección de Salubridad Pública. H6-0609, Boletín del Ministerio de Fomento 1, 4 (1905): 62-116; and Enrique León García, "Alojamientos para la Clase Obrera en el Perú," Boletín del Ministerio de Fomento 2, 1 (1906): 53-83. See also "¿Por Qué Se Abandona a los Niños?" El Universal (17 November 1936): 7.

[79] On the rise of Social Medicine, see Rosen, From Medical Police to Social Medicine.

the power to control the health of those called to propagate the human race. This is certainly one of the most logical remedies against degeneration."[80] For Peruvian physicians, depopulation and racial degeneration were interconnected. In the next sections I will discuss some of the ways in which these physicians dealt with such issues.

Puericulture, the Protection of Women, and the Restraining of Men

As argued above, population growth and the fear of degeneration were the lenses through which physicians first envisioned the question of the reproductive potential of the nation. Managing the reproductive capacity of Peruvians was their goal, but gender informed their approaches. While physicians treated women primarily as potential mothers in need of protection, they saw men as lusty and irresponsible, less in need of protection than containment and even intimidation. Different strategies flowed from this gendered characterization. Some of these came to fruition, while others failed. In this section I discuss such strategies, which must be seen in the context of the adoption in Peru of French puericulture and, later, eugenics.

Parisian physician Alfred Caron coined the term "puericulture" in 1865 to refer to the improvement of the health of newborns. However, the notion did not catch on until Adolphe Pinard, head of the Baudeloque Maternity Clinic and Chair of Clinical Obstetrics at the Paris Medical Faculty, revived it in the 1890s. Inspired by the weight gains among infants born to mothers who spent time in a maternity clinic before giving birth, Pinard began to advocate special care and rest for pregnant women before delivery. Based on these findings, French pediatricians and obstetricians supported Pinard, as they

[80] AGN: Boletín del Ministerio de Fomento 1, 4 (1905): 106.

worried that physical exertion and psychological stress could provoke the premature expulsion of the fetus. Premature infants, if they survived, would presumably grow to become weak individuals prone to disease, and mental and moral degeneration.[81] From the outset, then, puericulture was deeply concerned with the familiar theme of national decline and degeneration in France, something that resonated strongly with the priorities of Peruvian intellectuals following the country's defeat in the War of the Pacific.

Pinard also believed that both family traits and the health status of parents at the time of conception could be passed along to a new generation. He singled out syphilis and alcoholism as the two most debilitating influences on the newborn's health, and suggested that people who suffered from either ailment should abstain from procreating. He also deemed reasonable a wife's refusal to have intercourse when her husband was intoxicated or had a genital ulcer, and endorsed the idea of mandatory pre-marital physical exams. Not surprisingly, puericulture attracted the interest of newly formed temperance and anti-venereal disease organizations in France.

Even as local enthusiasm for the French approach grew in the 1920s, however, the United States became more influential in Peru's medical establishment. The number of Peruvian university graduates awarded technical training fellowships to US universities increased during Augusto B. Leguía's presidency (1919-1930), as did the number of US physicians and engineers working in Peru.[82] Leguía even appointed Dr. Henry Hanson, a

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[81] William Schneider, "Puericulture, and the Style of French Eugenics," History and Philosophy of the Life Sciences 8 (1986): 265-277; Nadine Lefaucheur, "La Puériculture d'Adolphe Pinard," in Patrick Tort (ed.), Darwinisme et Societé (Paris: Presses Universitaires Françaises, 1992); Offen, "Depopulation, Nationalism, and Feminism in Fin-de-Siècle France."

[82] Bustios Romaní, "Educación Médica en el Perú, Primera Parte," 100-101. Augusto B. Leguía's presidency was characterized by (1) an increased political participation of urban

US physician, as head of the country's Office of Public Sanitation in 1919, and then Dr. William Wrighton, another US physician, as Hanson's successor in 1921. It was also under Leguía that the Rockefeller Foundation established itself in the country, to help control a yellow fever outbreak in 1922.[83] A few years later, in 1927, the Faculty of Medicine created its *Instituto de Medicina Social* (Institute for Social Medicine, IMS).[84] Modeled after the Johns Hopkins School of Public Health, the IMS gathered medical statistics, studied foreign sanitary regulations, compared hygienic practices between different populations of Peru, and developed plans for the country's "bio-social improvement." The IMS received significant US support, including financial and in-kind aid from the Rockefeller Foundation, the School of Hygiene and Public Health at Johns Hopkins University, and the Panamerican Sanitary Office.[85] As Elizabeth Fee has shown, when the Rockefeller Foundation first funded the Johns Hopkins School of Hygiene and Public Health in 1913, its officers imagined it would serve as a research center to create

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working classes and middle classes; (2) the creation of a larger state bureaucracy; and (3) the maintenance of an authoritarian executive power that encouraged foreign direct investments in the country, especially by the United States. On the Leguía presidency, see Burga and Flores Galindo, Apogeo y Crisis de la República Aristocrática. Importantly, between 1920 and 1930, the number of locally trained physicians working in the country grew from 284 to 536. See Contreras and Cueto, Historia del Perú Contemporáneo, 224.

[83] Nilo Vallejo Espinoza, "Homenaje a los Pioneros de Salud Pública en el Perú," Revista de la Academia Peruana de Salud 1 (2002): 11-15. On the medical philanthropy of the Rockefeller Foundation in Latin America see Cueto, El Regreso de las Epidemias; Quevedo et al., Café y Gusanos; Birn, Marriage of Convenience; Zulawski, Unequal Cures; Marcos Cueto, Cold War, Deadly Fevers: Malaria Eradication in Mexico, 1955-1975 (Baltimore: Johns Hopkins University Press, 2007); Ligia Peña and Steven Palmer, "A Rockefeller Foundation Health Primer for US-Occupied Nicaragua, 1914-1928," Canadian Bulletin of Medical History 25, 1 (2008): 43-69.

[84] Memoria del Instituto de Medicina Social (Lima: Universidad de San Marcos, 1927, anexo 4). See also Walter Mendoza and Oscar Martinez, "Las Ideas Eugenésicas en la Creación del Instituto de Medicina Social," Anales de la Facultad de Medicina 60, 1 (1999): 55-60.

[85] Memoria del Instituto de Medicina Social (Lima: Universidad de San Marcos, 1927, 19).

and disseminate public health knowledge to a network of universities and public health practitioners within the US. It was with similar intentions that the Rockefeller Foundation supported the creation of university-affiliated research centers in Latin America, such as the IMS. These, it was hoped, would continue training local public health personnel after the Foundation's withdrawal.[86]

Thus, French puericulture interested Peruvian academic physicians within the context of rising US participation in the country's public health decisions, apparently without friction arising. How did Peruvian physicians express this interest in puericulture? In his address to the Sixth Latin American Medical Congress that met in Lima in 1922, Dr. Leonidas Avendaño, Chair of Legal Medicine at the Faculty of Medicine, echoed the tenets of puericulture as he zeroed in on the high infant mortality that did not permit an optimal endogenous demographic growth in Peru. Excessive work for women in urban factories and the inheritability of tuberculosis, alcoholism, and syphilis were the main culprits for this infant mortality, according to Avendaño. Nevertheless, he also blamed lecherous men who did not care for the children they fathered, the "despicable" providers of abortions, and the voluntary practice of "*el birthcontrol*."[87]

To physicians such as Avendaño, threats to the nation's reproductive potential were everywhere. The basis of all these threats, Avendaño argued, was a comfort-induced relaxation of morals that seeped into dress styles, manners, the media and even daily

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[86] Elizabeth Fee, Disease and Discovery: A History of the Johns Hopkins School of Hygiene and Public Health, 1916-1939 (Baltimore: Johns Hopkins University Press, 1987).
[87] Leonidas Avendaño and Guillermo Fernandez Dávila, La Despoblación en su Aspecto Social y Medico-Legal (Lima: Sanmartí y Cia., 1922).

conversations, awakening disorderly appetites, especially among women. "There are no mothers," Avendaño declared, because women instead had their minds filled "with worry and ignorance. […] How can we make her abandon obsolete routines and the advice of the so-called wiser older women?" To him, this was best accomplished through scientifically managed state assistance to pregnant women.[88]

In the 1920s, it was the Beneficence Society and the Catholic Church that provided most charitable support for pregnant women and infants.[89] Physicians had been interested in these services since the late nineteenth century. Control of the quality of milk served in hospices and orphanages was one of their first causes. Dr. Luis Deustua, for example, questioned whether women really knew from where that milk came. Was it mixed with water or donkey milk? Was it collected from black wet nurses, "known for their bad habits, excesses and unsanitariness", or from sick or overworked women?[90] His conclusion was clear: only the medical profession could guarantee the nutritiousness, hygiene, and proper supply of milk given to infants by charitable organizations. To this end, a wet nurse service was established at the Santa Ana Hospital in the early twentieth century. There, physicians admitted as wet nurses only healthy, multiparous women between 20 and 30 years of age who had given birth within the last two months. Being chosen as a wet nurse did not depend on one's race, although Dr. Alejandro Lawezzari

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[88] Avendaño and Fernandez Dávila, La Despoblación, 20, 22. See also AGN: Archivo Histórico del Ministerio de Hacienda, Dirección de Salubridad Pública, Rómulo Eyzaguirre, "Demografía Sanitaria," Boletín del Ministerio de Fomento 2, 1 (1906): 1-22.
[89] This was far from exclusive to Peru in this period. See for example Bock and Thane, Maternity and Gender Policies; Rachel Fuchs, Poor and Pregnant in Paris: Strategies for Survival in the Nineteenth Century (New Brunswick: Rutgers University Press, 1992); and Koven and Michel, Mothers of a New World.
[90] Luis Fidel Deustua, "Higiene de la Lactancia," (Tesis de Grado, Facultad de Medicina de San Fernando, 1884, 6).

expressed a certain bias for black wet nurses, who had "sanguine temperaments" and were "less likely to have venereal diseases" than Indian wet nurses. Lawezzari lavished praise on the "healthy tripod" created by milk, physician and mother (in that order).[91]

Puericulturists further strengthened their role in the assistance of mothers and infants in 1894, when a wealthy Lima philantropist, Mrs. Juana Alarco de Dammert, founded the *Sociedad Auxiliadora de la Infancia* (Society for the Protection of Children), a charitable organization that hired physicians to care for the health of children under seven, and that oversaw the operation of the country's first day care center (founded in 1901) and pasteurized milk distribution center (founded in 1908).[92] Dr. Francisco Graña, Chair of Hygiene at the Faculty of Medicine, used his influence at the Beneficence Society of Lima to create another milk distribution center in the city in 1912.[93] The same year, Mrs. María de Piaggio, a Callao philantropist, founded a day care center overseen by physicians on the second floor of the town's central market.[94]

In 1918 the Peruvian Congress legalized paid leaves from work for pregnant women from twenty days before to forty days after birth, stipulating that they would receive up to 60 percent of their wages. In addition, consistent with the trend toward the establishment of physician-overseen day care and milk-distribution centers, the law

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[91] Alejandro Lawezzari, "Algunas Consideraciones sobre la Protección de la Infancia en Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1908, 52).
[92] Guevara Chacabana, "Aspectos Históricos de la Enseñanza de la Pediatría." This milk distribution center was among the first in the world outside of Western Europe, and second in Latin America only to Uruguay's, which was established in 1907. See C. Rollet, Le Modèle de la Goutte de Lait dans le Monde: Diffusion et Variantes (Fécamp: Musées Municipaux de Fécamp, 1997).
[93] Carlos Enrique Paz Soldán, La Protección a la Infancia en el Perú (Lima: Centro Editorial, 1914).
[94] Manuel Salomón Román Arredondo, "Contribución al Mejoramiento de la Asistencia Médico-Social del Niño Chalaco," (Tesis de Grado, Facultad de Medicina de San Fernando, 1940).

mandated that workplaces with more than 25 female workers over the age of 17 must provide day care for infants. This law was the brainchild of *Diputado* for Lima Matías Manzanilla, a member of the elite Civilista Party and a strong advocate of workplace safety, the curtailment of female and child labor, and the eight-hour day for female workers.[95] Unfortunately, even when employers obeyed the law, this only applied to women working in the industrial sector in urban areas, and not to women in rural areas or to domestic workers.[96] In other words, it excluded the majority of working women of Peru.

When Augusto B. Leguía became President in 1919, he too supported puericulturists' initiatives to protect infants and pregnant women. In 1920, Leguía sponsored Dr. Enrique León García, recently appointed Chair of Pediatrics at the Faculty of Medicine, when he proposed to conduct the nation's first survey of hospital infant mortality. The sobering conclusion was that, between 1919 and 1924, 37.4 percent of all babies born at the Santa Ana Hospital died within a year.[97] The Santa Ana Hospital was closed in 1924. Most of its operations were taken over by the newly created Arzobispo Loayza Hospital, but its obstetrics and gynecology ward moved to a new specialized hospital, the *Hospital de Maternidad*.

Another indicator of puericulturists' sway in Leguía's administration was the creation in 1922 of the *Junta de Defensa de la Infancia* (Board for the Defense of

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[95] These reforms in Peru emulated European legislation passed in the same period for the protection of female workers. See for example McDougall, "Protecting Infants"; and Pedersen, Family, Dependence, and the Origins of the Welfare State.
[96] ACP : Ley 2851: "Trabajo de los Niños y Mujeres por Cuenta Ajena," (23 November 1918). See also J.M. Barandiarán, "Descanso y Protección de la Mujer Embarazada," (Tesis de Grado, Facultad de Medicina de San Fernando, 1922).
[97] Guevara Chacabana, "Aspectos Históricos de la Enseñanza de la Pediatría."

Children), the first state agency dedicated to the protection of underprivileged mothers and children. Professor of Hygiene Carlos Enrique Paz Soldán lobbied for the establishment of the *Junta* after his election to Congress for Lima. The *Junta* organized its first conference in July of 1922, with Paz Soldán as Secretary General, and President Augusto B. Leguía as honorary speaker. Presenters outlined the major challenges facing population growth in Peru. The Faculty of Medicine's former Chair of Pediatrics, Rómulo Eyzaguirre, claimed that the country's high infant mortality rate eliminated the "advantageous" birth rate of 35 per 1,000 Peru had relative to Europe (25 per 1,000, Eyzaguirre claimed). Out-of-wedlock births accounted for much of this loss of "human capital", as the parents of these children did not care for them properly, which caused the latter to succumb often to gastrointestinal diseases, respiratory ailments, and meningitis. Dr. Pedro Villanueva agreed, and added that women's desire not to have children could be overcome by assuring them that they would have support from the state to raise those children. Food choices were the concern of Dr. Guillermo Arosemena, who seemed appalled at women's boasts that their babies were used to eating everything, instead of only breast milk or pasteurized cow's milk.[98]

One of the main conclusions of the *Junta*'s first conference was the need to create an *Instituto Nacional del Niño* (National Child Institute), with more power and responsibilities than the *Junta*. Once again, President Leguía offered his support, and the Institute was created in 1925, with Paz Soldán as Director. By 1930, the Institute had replaced charitable organizations in the management of infant health clinics, day care centers, and milk distribution centers. The Institute's personnel also began to lobby for

[98] Carlos Enrique Paz Soldán (ed.), Actas y Trabajos de la Primera Conferencia Nacional sobre el Niño Peruano (Lima: Unión, 1922).

the creation of a hospital that would focus on the care of children. President Leguía backed this initiative as well, and founded the *Hospital del Niño* (Children's Hospital) in 1929.[99]

The National Child Institute's mandate to represent the state in all matters relating to the protection of children extended, for Paz Soldán at least, to what was termed "extra-uterine puericulture." It was not enough to protect pregnant women to ensure healthy and abundant offspring. The Institute sought to have a hand in the design of education curricula, the promotion of sports, sexual education, and home economics for women. The Institute's outreach mission was to be carried out by its corps of *visitadoras sociales*, female social workers who knocked on doors and delivered information to women about proper feeding and hygiene habits, and exhorted them to marry the men with whom they lived. Home visits by social workers were an innovation that Paz Soldán adopted from French puericulture. Adolphe Pinard established a training course for visiting nurses during his tenure as director of the French School of Puericulture (1919 until his death in 1934).[100] Charged with propagating ideas about hygiene to the farthest and most neglected areas of France, the visiting nurse's role was to battle the sanitary ignorance of mothers and ensure the infant's proper development in his environment. Peruvian *visitadoras sociales* fulfilled the same roles and were, in addition, the support staff at the National Child Institute's six pregnancy consultation clinics, thirteen milk distribution centers, six day care centers, and two children's hospices, dispersed throughout Peruvian

[99] Boletín del Departamento de Protección Materno Infantil 1, 1 (1922).
[100] Marianne Robinot, "L'École de Puériculture de la Faculté de Médecine de Paris," Révue de la Societé Française d'Histoire des Hôpitaux 110 (2003): 7-16.

cities.[101] It is important to note that, although not always performing optimally, these services for pregnant women and infants more than rivaled those available in wealthier Western nations.

The first Peruvian *visitadora social* training program began at the National Child Institute in September of 1925. The training was designed as a specialization course for midwives.[102] Peruvian midwives had been subject to strict performance standards since the creation Office of Public Sanitation (DSP) in 1903. The DSP demanded that midwives report on their activities every six months, established how much midwives could charge for their services, and, in 1909, stipulated that they must provide assistance free of charge "to poor women who need their help, at any time of the day or night."[103] This strict management and the low pay dissuaded midwives from working for the state, as midwives or as *visitadoras sociales*, and, some physicians believed, pushed midwives to provide abortions as a way to make ends meet.[104] The situation was especially dire in the country's smallest villages and rural areas. The town of Huanuco could not attract a

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[101] The *visitadora social* was a professional in demand in several Latin American countries at the time. See Carrillo, "Nacimiento y Muerte de una Profesión"; Penyak, "Obstetrics and the Emergence of Women in Mexico's Medical Establishment"; Zárate, Dar a Luz en Chile, Siglo XIX; Agostoni, "Las Mensajeras de la Salud." The visiting nurse has also a rich history in Africa. See Summers, "Intimate Colonialism."

[102] After Madame de Fessel's first midwife training experience in the 1830s, the Faculty of Medicine took up formal midwifery training again in 1879, and founded its *Escuela de Obstetrices* (School of Midwives) in 1911. See Miguel Rabí Chara, De la Casa de Maternidad de Lima al Instituto Nacional Materno Perinatal, 1826-2006 (Lima: Hospital Nacional San Bartolomé, 2006).

[103] AGN: Ministerio de Hacienda, David Matto, Memoria del Ministro de Fomento a la Legislatura Ordinaria de 1909. See point 228, on "Atribuciones de las Obstetrices Titulares," 295.

[104] "La Profesión de Obstetriz y Su Papel en la Demogénesis Peruana," La Reforma Médica 33, 492-493 (February 1947): 77-87.

university-trained midwife in 1917, even though the DSP ordered it to do so.[105] By 1940, although the School of Midwives had 273 graduates, 210 of them worked in Lima. Meanwhile not a single university-trained midwife could be found in Tumbes, Amazonas, San Martin, Ancash, Huancavelica, Apurimac, Madre de Dios, or Moquegua. Not surprisingly, most births in Peru between the 1910s and the 1930s occurred without the assistance of a university-trained expert.[106]

The responsibilities of the National Child Institute and the Institute for Social Medicine (IMS) included the training of more midwives and *visitadoras sociales*. However, the budgets of these institutions were small, and personnel education suffered as a result.[107] The IMS's limitations are demonstrated by the fact that between 1927 and 1933 only 17 new visiting social workers (or "maternologists," as Peruvian hygienists called them) graduated.[108] Maternologists were to be the foot soldiers of the nation's "*demogénesis*": "the cluster of biosocial phenomena that determine how a race is to endure within a geographical area."[109] Despite their meager resources, maternologists valiantly took an oath "for maternity, home and fatherland," and swore to "ensure the

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[105] AGN: Ministerio de Hacienda, Carta de Abel Olaechea, Dirección de Salubridad Pública, al Ministerio de Hacienda (23 January 1917).

[106] According to Dr. Hipólito Larrabure, of the 33,124 births registered in Lima between 1914 and 1922, 14,605 did not receive any medical attention at all. For this reason, he insisted on the need to train more midwives. See Larrabure's intervention in Paz Soldán, Actas y Trabajos de la Primera Conferencia Nacional sobre el Niño Peruano. See also Félix López Cornejo, Las Realidades de la Asistencia del Parto en el Perú (Tesis de Grado, Facultad de Medicina de San Fernando, 1940).

[107] On the diminishing importance of the IMS to Peru's public health, see Carlos Bustios Romaní, "Notas sobre la Historia de la Educación Médica, 1933-1980, Segunda Parte," Acta Médica Peruana 20, 3 (2003): 133-149.

[108] "Acción Social de las Visitadoras de Higiene Infantil," Boletín del Instituto Nacional del Niño 1, 1 (June 1933): 12-14. See also Benigno González, "Contribución a la Maternología Nacional" (Tesis de Grado, Facultad de Medicina de San Fernando, 1929).

[109] "La Profesion de Obstetriz y Su Papel en la Demogenesis Peruana," 77.

springing of new seedlings with the utmost guarantees of life and health."[110] Their most common form of intervention consisted of simple advice to women, about the importance of appropriate clothing, nutritious food, physical exercise, sexual education, and marriage. Such advice was geared towards making women aware that their main function in life was to bear many children within formalized unions, and that just about every aspect of their behavior and physical state could affect such delicate functions.[111]

This "extrauterine puericulture" promoted by academic physicians such as Paz Soldán and Avendaño converged with eugenic ideas and did not exclude men. Peruvian physicians were receptive to eugenics' ultimate goal of promoting the birth of "fit" individuals and discouraging that of "unfit" ones. However, eugenics in Latin America did not develop as it did in Europe or the United States. It did not focus on what Kevles called "negative" eugenics initiatives such as the promotion of sterilization, abortion, and birth control for the so-called less fit.[112] Rather, Peruvian eugenicists favored a preventive eugenics inspired by René Sand's Social Medicine, to improve the nation by eliminating from it those factors that could damage people's hereditary health, including alcohol,

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[110] "Hacia la Reforma Universitaria: La Enseñanza de la Obstetricia," La Acción Médica (17 Marzo 1928): 3.

[111] See various issues of La Acción Médica, for example "La Maternidad y la Alimentación" (23 March 1929): 6; "Educacion Física Femenina," (28 September 1929): 4-5; Samuel Gajardo, "Las Deficiencias del Hogar como Factor de Delincencia de Menores," La Acción Médica (2 November 1929): 1-2, 15; "Aspectos Sociales de la Educacion Sexual" (9 November 1929): 3; and "El Papel Preponderante de la Madre en la Educación Sexual de sus Hijos," (16 November 1929): 10-11. See also issues of Acción Católica Peruana (12 February 1933): 27, (26 November 1933): 191; as well as "Orígenes, Desarrollo y Finalidades de la Cruz Roja: A los Pueblos de América," Anales de la Cruz Roja Peruana 31 (August 1934): 35-44.

[112] Kevles, In the Name of Eugenics.

tuberculosis and syphilis.[113] According to Nancy Stepan, it was the focus on these so-called "racial poisons" and on preventive interventions that gave Latin American eugenics its distinctiveness.[114]

The first Peruvian eugenics organization was the *Liga Nacional de Higiene y Profilaxis Social* (National League of Hygiene and Social Prophylaxis, hereafter referred to as the *Liga*). Several individuals and institutions convened to form it in 1923, including the Peruvian chapter of the Red Cross, Faculty of Medicine Professors like Miguel Aljovín, Leonidas Avendaño, and Rómulo Eyzaguirre, and female activists like the San Marcos University educator Esther Festini de Ramos Ocampo. The *Liga* supported the outreach mission of the Institute of Social Medicine to educate women about the importance of hygiene, to raise awareness about infectious diseases (especially tuberculosis, malaria and syphilis), to promote the idea that people should be responsible when choosing a mate, and to condemn alcoholism. The *Liga* also advocated the building of better houses for members of the working class, the opening of more venereal disease clinics, and the curbing of the pornography industry.[115]

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[113] René Sand, The Advance to Social Medicine (London: Staples, 1952). However, there were Peruvian physicians who unsuccessfully promoted negative eugenics. See for example, Alejandro Benavente Alcázar, "Plan de Protección al Niño y Su Carácter Integral," La Prensa Médica 2, 19 (November 1928): 177-192; and Rafael Fosalba, "Ideas Generales sobre la Herencia," (Tesis de Grado, Facultad de Medicina de San Fernando, 1928). For the most part, however, prominent Peruvian hygienists like Paz Soldán did not shy away from picking fights with Latin American collagues who embraced aberrant notions like "*el birthcontrol*." See the polemic between Paz Soldán and the Uruguayan gynecologist Augusto Turenne in "La Decadencia de la Maternidad," La Reforma Médica 20, 194 (1 September 1934): 561-568, 589-590.

[114] Stepan, The Hour of Eugenics.

[115] Carlos A. Bambarén, "Labor y Finalidades de la Liga Nacional de Higiene y Profilaxia Social," Anales de la Cruz Roja Peruana 4 (December 1934-January 1935): 9-11. The Anales de la Cruz Roja Peruana was the official journal of the Peruvian Red Cross, and it acknowledged the support of Dr. René Sand for its work throughout the 1930s, including

Despite its ambitious intentions, the League did not have a cadre of grassroots promoters of its own, and relied instead on the state's public health apparatus to deliver its message. Budgetary and manpower limitations made it difficult for the *Liga* to spread advice about "extrauterine puericulture" or eugenics beyond the city of Lima. Between 1876 and 1940 the population of that city alone grew more than fourfold, from 129,000 to 595,000, and that of the country as a whole grew over twofold, from 2.65 million to 6.2 million.[116] In contrast, there were only 17 Peruvian *maternólogas* in 1933. Furthermore, some eugenic prescriptions were too costly and strict to be politically palatable, especially for men. Emblematic of this extremism was the early anti-alcoholism campaign. In 1896 the Ministry of Justice, Religion and Education sponsored the formation of a special commission to tackle the issue of alcoholism. The commission included a group of distinguished physicians from the Faculty of Medicine, among them Leonidas Avendaño, Ernesto Odriozola, Francisco Gerardo Chávez, and Narciso Alayza.

The commission proposed a law creating a course for primary and secondary school students about the effects of alcohol. The bill also called for mandatory conferences about alcoholism in universities, parishes, police and military units, warships, hospitals, and prisons. It mandated that all people registering births, deaths and marriages be subject to a lecture about alcoholism. The bill forbade employers from paying wages in alcoholic beverages. It also forbade the presence of alcoholic beverages in theaters, circuses, churches, bullfighting arenas, and other public places. The initiative called for police surveillance of all businesses that served alcohol, and forbade them from

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its efforts to establish the eugenic *Liga Nacional de Higiene y Profilaxis Social*. On the founding of the Peruvian Red Cross in 1879, see Jorge Arias Schreiber Pezet, "Los Médicos Peruanos en la Guerra del Pacifíco," Acta Médica Peruana 2 (1979): 1-8.

[116] Contreras, "Sobre los Orígenes de la Explosión Demográfica en el Perú," 10.

covering their windows with paint or curtains, while reducing taxes for restaurants that did not serve alcohol. It also ordered businesses that sold alcohol to close on Saturdays at 6 pm and reopen only on Mondays at 9 am. The remaining days of the week such businesses were to stay open only until 11 pm, always barring entrance to minors, members of the police and the armed forces, women, clergy, and government workers. The bill even ordered the increase of taxes on alcohol imported to produce pharmaceutical compounds.

Supporters of this far-reaching piece of legislation claimed that alcohol made up a "deathly trinity" alonside syphilis and tuberculosis, causing the hereditary degeneration of the race and "damaging up to the fourth generation of alcoholics." They explicitly targeted males, noting the sad spectacle of men spending their wages on Saturday nights, instead of spending that time with their families. Proponents argued that alcohol "turns the popular masses into brutes, weakening their family values, already underdeveloped among our people, and thus leading to the nation's depopulation."[117] The bill was defeated in Congress in 1901. However, two decades later, President Augusto B. Leguía resuscitated two weakened portions of the same bill. One forbade the drinking of alcohol in brothels, as intoxicated customers might be less likely to demand a prostitute's health certificate. The other mandated the institution of a course in high schools about hygiene, contagious diseases, alcoholism and puericulture.[118] It is important to note that the legislation was enacted only with the support of a strong executive branch, consolidated

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[117] ACP: Catálogo de los expedientes del Congreso y de la Camara de Diputados, Libro 12, legajo 9, cuaderno 1: "Asuntos de interés general pendientes en comisiones: Principal de legislación, exp. 16: 'Represión del alcoholismo,' 1905."
[118] La Temperancia 8, 17 (20 May 1922): 41-42; ACP: Ley 4950: "Declarando obligatoria en los colegios y escuelas en general la enseñanza de la higiene, enfermedades infecto contagiosas, alcoholismo y puericultura," (16 February 1924).

during Leguía's rule. The reformers' early failure shows that eugenic arguments were only marginally persuasive for a Congress that had to balance business interests, public health, and male privileges.

Despite their limitations in changing the practice of public health, Peruvian eugenicists successfully promoted new biologically governed norms of reproductive behavior, such as the need for pre-nuptial health certificates for civil marriages. Civil marriage was universally instituted in Peru only in 1930, during the military government of Luis Sánchez Cerro.[119] In fact, civil marriage had been available since 1897, but it was only optional, and only non-Catholic couples could marry this way.[120] The National League of Hygiene and Social Prophylaxis began lobbying the lower chamber of Congress in favor of pre-nuptial health certificates in 1923, calling for their "absolute and generalized adoption."[121]

Peruvian eugenicists finally succeeded on this score in 1931. A few years earlier, in 1927, the First Panamerican Eugenics Conference met in Havana and endorsed eugenic marriage laws.[122] This endorsement was so influential that President Luis Sánchez Cerro added a few key provisions to the recently promulgated civil marriage law. In addition to birth certificates and proofs of domicile, couples would also have to present a medical certificate attesting to their good physical and mental health, as well as their "aptitude to

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[119] ACP: Decreto ley 6889: "Ley de Divorcio Absoluto y Matrimonio Civil Obligatorio" (4 October 1930).
[120] ACP: "Autorizando el Matrimonio Civil de las Personas que no Profesan la Religión Católica," (23 December 1897).
[121] "Sesión del 27 de Enero de la Comisión de Avendaño, Larrabure y León Garcia," Boletín de la Academia Nacional de Medicina (1922-1923): xiv. See also Carlos Pastor Padierna, "El Control Sanitario del Matrimonio," (Tesis de Grado, Facultad de Medicina de San Fernando, 1924).
[122] Rosa Medina "Eugenesia y Formas de Hacer Historia: Cuestiones para el Debate," Dynamis 24 (2004): 291-305.

contract marriage without endangering the offspring." Article 20 of the ammendment permitted third parties to put forward reasons why certain marriages should not take place in case of contagious, chronic, and hereditary diseases.[123]

Many in the medical community criticized the change as repressive, scientifically baseless, and unrealistic. Dr. Leonidas Klinge, for example, pointed out that disease had genetic and environmental causes, and that therefore blaming heredity for it was scientifically simplistic. Moreover, he argued that the country's medical personnel was too small to be up to the task of performing all the clinical and laboratory exams required for pre-nuptial health certificates.[124] The medical journal La Acción Médica complained that "two people who truly love each other will not stop having children because of their failure to get a certificate." Rather, they would prefer not to get married. Thus, the writer warned, the certificate's effect would be to discourage marriages, thus making it more difficult for children to be raised properly.[125]

Nonetheless, Peruvian eugenicists were able to persuade nurses and the association of physicians of the APRA political party of the virtues of the pre-nuptial health certificate. As the journal of Peru's Nursing Association put it, "Scientifically speaking, children's hygiene does not begin at conception or at birth, but when one chooses a husband or wife."[126] Likewise, the Secretary General of the Association of

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[123] ACP: Decreto ley 7282: "Ampliando las Disposiciones Relativas al Matrimonio Civil Obligatorio Estatuído por Decreto Ley 6889," (22 August 1931).
[124] Leonidas Klinge, "Algunas Consideraciones sobre la Eugenesia en el Perú," La Reforma Médica 20, 194 (1 September 1934): 581-588. See also Victor Manuel Sánchez Caballero, El Certificado Médico Prenupcial en el Perú (Tesis de Grado, Facultad de Medicina de San Fernando, 1941).
[125] "Profilaxis Social," La Acción Médica (9 March 1929): 12.
[126] Domingo Gómez Tejera, "Higiene Prenatal," La Enfermera Peruana 1, 2 (February 1934): 8-9.

APRA Party Physicians endorsed both eugenics and the use of pre-nuptial health certificates in his speech to the Association's first national meeting in 1946.[127] Thus, eugenics moved out of elite academic medicine and seeped into the discourse of broader circles of health workers. Many of these, from academic physicians to nurses to public health officers came to believe that little money and education made workingmen especially prone to habits like drinking and frequenting prostitutes. Once they contracted a venereal disease, they would spread it to their partners and future generations, who would be born weak and prone to degeneracy.[128]

The National League of Hygiene and Social Prophylaxis also succeeded in its campaign to regulate prostitution.[129] Peruvian physicians had long deemed prostitution a necessary evil, as they saw male sexuality as too ardent to withstand inactivity.[130] As

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[127] Eduardo Goicochea, "Editorial," Archivos Médicos 1, 2 (November-December 1946): 1-2. Founded by Victor Raúl Haya de la Torre in 1924, the American Popular Revolutionary Alliance, APRA, was, at the time, a left-of-center nationalist party. Throughout Peru's history, APRA has been the most important and popularly supported party in the country. On APRA's history, see Haya, El Antimperialismo y el APRA; Klaren, Formación de las Haciendas Azucareras; and Stein, Populism in Peru.

[128] Pedro Villanueva, "Estenosis del Orificio Uterino y Sifilis Conyugal," La Reforma Médica 2, 26-28 (30 September 1916): 99-100; Eduardo Pérez Araníbar, "El Problema Médico-Social de la Sífilis," (Tesis de Grado, Facultad de Medicina de San Fernando, 1927); José Nicanor Espinosa Palacios, "La Sifilis en las Clases Trabajadoras," (Tesis de Grado, Facultad de Medicina de San Fernando, 1936). See also "Mas Vale Prevenir que Curar," Educación Sanitaria 2, 13 (July-October 1942: 31-32) and "El Certificado Médico Pre-Nupcial," Educación Sanitaria 2, 14 (November-June 1942-1943): 5. Educación Sanitaria was the official public health bulletin published by Peru's Ministry of Public Health, Work and Social Assistance.

[129] Prostitution became a sizable urban phenomenon during the boom-bust cycle of guano production of the mid-nineteenth century. See Pablo Macera, "Sexo y Coloniaje," in Trabajos de Historia, vol. 3 (Lima: INC, 1977).

[130] José Gil Cárdenas, "El Matrimonio Civil," (Tesis de Grado, Facultad de Medicina de San Fernando, 1884); Manuel Guzmán Rodriguez, "Profilaxis de las Enfermedades Venéreas," (Tesis de Grado, Facultad de Medicina de San Fernando, 1905); Felipe Merkel, "Reglamentación de la Prostitución en Lima," (Tesis de Doctorado, Facultad de

Paulo Drinot concludes, physicians of the early twentieth century objected only to unregulated prostitution, that is, prostitution outside the bounds of brothels, by women not registered as prostitutes, and who did not subject themselves to regular physical exams to detect venereal diseases. For that reason, physicians supported the establishment of a red light district in Lima for the location of brothels.[131]

The idea of some form of state control of prostitution in Lima circulated at least since 1882. In July of 1910, the Office of Public Sanitation took the issue under its jurisdiction through the *Servicio Sanitario de la Prostitución* (Office for Prostitution Hygiene, SSP), which developed a set of guidelines for the practice of prostitution in Lima and Callao. The clinical underpinning was Dr. Paul Ehrlich's discovery of Salvarsan, also known as Preparation 606, in Germany in 1909.[132] Dr. Julio Egoaguirre, Minister of Economic Development, announced in 1911 that the National Academy of Medicine would conduct appropriate trials on Preparation 606 to be later distributed freely or at production cost in venereal disease clinics.[133] In addition, the SSP organized the medical corps of the police in May 1914, which began to register and subject prostitutes to weekly genital exams to detect venereal diseases. The identification cards

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Medicina de San Fernando, 1908);); Alfonso de las Casas, "La Delincuencia Infantil," (Tesis de Grado, Facultad de Medicina de San Fernando, 1913).

[131] Paulo Drinot, "Moralidad, Moda y Sexualidad: El Contexto Moral de la Creación del Barrio Rojo de Lima," in Scarlett O'Phelan and Margarita Zegarra (eds.), Mujeres, Familia y Sociedad en la Historia de América Latina, Siglos XVIII-XXI (Lima: CENDOC-Mujer, 2006).

[132] Thus named after the number of previously ineffective drugs that Ehrlich tested. Salvarsan's effectiveness against a specific pathogen, syphilis in this case, led to its being labeled the world's first "magic bullet" drug. See Allan Brandt, No Magic Bullet: A Social History of Venereal Disease in the United States since 1880 (New York: Oxford University Press, 1985).

[133] AGN: Archivo Histórico del Ministerio de Hacienda, Julio E. Egoaguirre, "Memoria del Ministerio de Fomento de 1911."

the SSP distributed contained the woman's photo, work establishment, and the exam results for the previous week. By December of 1915, 588 prostitutes were on the SSP's Lima and Callao registries; the number grew to 1,109 by 1918.[134]

Most academic physicians ridiculed the policing campaign. The strong-arm tactics of the police, they accused, made prostitutes fear medical men, and encouraged a flourishing business of fake registration identifications. More importantly, the campaign only dealt with prostitutes working in known brothels and did not affect out-of-brothel prostitutes at all. In addition to supporting the creation of free-treatment clinics, physicians were strong proponents of the use of condoms by all clients of prostitutes, especially members of the armed forces.[135] Still, the campaign continued and prostitutes were subjected to increasingly brutal police harassment in the name of public health. Then, in 1924, Congress legally classified the activities of out-of-brothel prostitutes as vagrancy, punishable by a jail term of 30 to 60 days and banishment from the city. The law's goal had been to stem "the tide of criminality that, alarmingly, robs society of its deserved tranquility."[136] Peru's harsh treatment of prostitutes was hardly unique in this period. Beginning in the second half of the nineteenth century, anti-vice campaigns in Europe, the United States, and Latin America also targeted prostitution as a threat to public health, good morals, and the safety of women, and attempted to regulate it.[137] What

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[134] AGN: Archivo Histórico del Ministerio de Hacienda, Juan Manuel García, "Memoria del Ministro de Fomento a la Legislatura Ordinaria de 1912." See also Victor Colina, "Contribución al Estudio de la Profilaxia de las Enfermedades Venéreas y de su Tratamiento Abortivo," (Tesis de Grado, Facultad de Medicina de San Fernando, 1917).
[135] Juan N. González, "La Prostitución Reglamentada en Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1918).
[136] ACP: Ley 4891: "Sobre la Vagancia," (18 January 1924).
[137] See Guy, Sex and Danger in Buenos Aires; Bliss, Compromised Positions; Philippa Levine, Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire

we witness in early twentieth-century Peru, then, is the adoption of a very common pattern of biologized coercive intervention in the lives of female sex workers.

The Peruvian anti-prostitution campaigns of the 1910s did not single out the male clients of prostitutes for monitoring. Focusing attention on the sexual lives of men was the most significant contribution to the prostitution regulation debate that the National League of Hygiene and Social Prophylaxis made in the 1920s. As Dr. Pando put it, "the problem is very complex: coquettishness, love of luxury, poverty, insufficient education, etc, are crucial factors in prostitution. But, it is men's selfish bachelorhood that is the ultimate cause of it."[138] In addition to supporting the establishment of venereal disease clinics, the *Liga* supported academic research on prostitutes' clients, both civilian and military, and launched an educational campaign using flyers and public speakers to educate men about their role in the production of healthy offspring. *Liga* supporters deemed married men the vanguard of healthy citizenship. They believed that married men's greatest interest was the preservation of the health of their family members. In contrast, they assumed that unmarried men lived with no one to care for, and thus willingly severed the ties between themselves and society. In their view, single men were tormented by their freedom, lived shorter and more disorderly lives than married men, and had unusual sleep and eating patterns, in addition to sexual habits that only prostitutes tolerated.[139]

(New York: Routledge, 2003); Brian Donovan, White Slave Crusades: Race, Gender, and Anti-Vice Activism, 1887-1917 (Urbana: University of Illinois Press, 2006).

[138] J.L, Pando Baura, "Editorial," La Acción Médica (29 June 1929): 8.

[139] Gerardo Alarco, "Programa General para la Lucha Antivenerea," Revista de la Sanidad Militar del Perú 1, 1-2 (January-June 1928): 56-61; Luis Arias Schreiber, "La Profilaxia de las Enfermdedades Venéreas en el Ejército," Revista de la Sanidad Militar del Peru 1, 3 (July-September 1928): 172- 195; Pedro Melgar Menéndez, "Profilaxia

In April of 1923 the city of Lima opened its first venereal disease clinic. Significantly, the official announcement of its establishment was made at a meeting of the National Academy of Medicine, which was by then one of the ideological hubs of the National League of Hygiene and Social Prophylaxis.[140] Then, on September 10th, 1926, President Leguía issued a special decree creating the *Liga Nacional Antivenérea* (National Antivenereal League, or LNA), just months after the country's first national conference on venereal diseases, to coordinate all initiatives for the regulation of prostitution and the control of sexually-transmitted infections. Medical experts and political appointees worked together in the LNA's Board of Directors, Board of Advisors and Executive Council, including several Ministers and Congressmen, the President of Peru's Supreme Court, delegates from the Faculty of Medicine, the Red Cross Society, the National League for Hygiene and Social Prophylaxis, the Sanitary Chiefs of the Army and Navy, the Director of Lima's venereal disease clinic, and even President Leguía himself.[141]

In August of 1929, Leguía once again reorganized venereal disease control efforts, by giving control over these activities to the newly created Hygiene and Social Prophylaxis Section of the Office of Public Sanitation (DSP). Even after Leguía's fall

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Social de las Enfermedades Venéreas," (Tesis de Grado, Facultad de Medicina de San Fernando, 1929); R. Angulo, "La Profilaxia Antivenérea entre Nosostros," Revista Médica Peruana 5, 58-59 (Octubre-Noviembre 1933): 1414-1424; J. Corrales Diaz, "Estadística y Profilaxia de las Enfermedades Venéreas en la Armada Peruana," (Tesis de Grado, Facultad de Medicina de San Fernando, 1934); Rafael Latorre, "El Preventivo Antivenéreo Civil en Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1944); Rosa Cáceres Silva, "Rol de la Enfermera en la Profilaxia de las Enfermedades Venéreas," Boletín del Enfermero de la Sanidad de Gobierno y Policía 1, 6 (September-October 1946): 15-19.

[140] "Sifilicomio," Boletín de la Academia Nacional de Medicina (1922-1923): 1-2.

[141] "Estatutos de la Liga Nacional Antivenérea," Boletín de la Dirección General de Salubridad Publica (1927): 213-215.

from power, this DSP section continued its work, establishing the National Museum of Antivenereal Prophylaxis in September 1932 in Lima's red light district, Huatica. The museum, located inside the venereal disease clinic of La Victoria, explicitly catered to boys of high school age, urging them to become acquainted with "the horrors caused by venereal contagion."[142]

Public health as a governmental function so grew in importance that General Oscar Benavides (President from 1933 to 1939) created the Ministry of Public Health, Work and Social Welfare in 1935. Its *Dirección General de Salubridad* (General Office of Sanitation, or DGS), was in charge of hospitals and health posts, including venereal disease clinics.[143] Within just six months in 1935, the DGS staged thirty lectures on the contagion of sexually transmitted infections. It also distributed flyers, screened the film "*El Azote de la Humanidad*" ("The Scourge of Humanity"), and made an itinerant exhibit out of the wax statues of the National Museum of Antivenereal Prophylaxis. The DGS praised the Ministry of Education for "all the forms of help" it provided transporting 2,460 students over 16 years of age to attend its functions. The DGS also reported reaching 1,820 workers, 900 male patients of venereal disease clinics, and 555 "young men" through its anti-venereal education campaign.[144]

In August of 1936, the Minister of Public Health, Work and Social Welfare, Dr. Fortunato Quesada, began preparations for the "National Antivenereal Day", after an

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[142] Enrique B. Rubin, "Discurso con Motivo de la Inauguración del Museo Nacional de Profilaxis Antivenérea," La Reforma Médica 18, 147 (15 September 1932): 226-228.
[143] César Lip, Oswaldo Lazo and Pedro Brito, El Trabajo Médico en el Perú (Lima: Organización Panamericana de la Salud, 1990).
[144] "La Lucha Anti-Venérea en Lima y Labor de los Puestos de Socorro," Boletín de la Dirección General de Salubridad 1, 3 (1935): 9.

intense campaign by the National League of Hygiene and Social Prophylaxis.[145] Organizing this special day on the 4th of September of 1938 required the participation of the Navy's cadets and students from the Faculty of Medicine. Dr. Carlos Bambarén, President of the National League of Hygiene and Social Prophylaxis, Dr. Victor Eguiguren, Chief Medical Officer of the anti-venereal disease campaign, and Dr. Guillermo Almenara, Minister of Public Health, spoke about the importance of pre-nuptial health certificates, the role of the state in fighting venereal diseases, and the promotion of moral and physical education as means to curb male lasciviousness. These lectures were broadcast by radio. Moreover, the film "The Scourge of Humanity" was screened at least six times, and the film "Let us Open Our Eyes" ("*Abramos los Ojos*") at least four times in different venues in Lima. In addition, the theatrical company of actor Angel Sebratti performed "The Deadly Kiss" ("*El Beso Mortal*"), a morality play written by the French playwright Gouredice at the Municipal Theater of Lima. Tickets for the play were free and available at the three male venereal disease clinics in Lima.[146]

"National Antivenereal Day" was meant to include both men and women. Its celebration shows that both the physicians from the National League of Hygiene and Social Prophylaxis and the Faculty of Medicine had acquired an important degree of political power by the late 1930s. To them, the reproductive potential of men was not to be squandered. In fact, because this reproductive potential had a tendency to waste away in single life, and to contaminate women and offspring, men's behavior had to be restrained through repetition, exhortation, and even intimidation. Of course, the *Liga*'s

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[145] Victor M. Pilares Polo Escalante, "La Profilaxis de la Sífilis en el Ejército," (Tesis de Grado, Facultad de Medicina de San Fernando, 1947).
[146] "Dia Antivenéreo," La Reforma Médica 24, 290 (1 September 1938): 672, 706.

anti-alcoholism campaigns, lobbying for pre-nuptial certificates, and anti-venereal disease initiatives implicated women too. Women were, after all, the domestic partners who suffered if men's wages were spent at the bar, the unwitting recipients of crippling diseases, and the potential mothers of degenerate children. To women, puericulturists offered concrete solutions in day care centers and milk distribution centers, as well as advice on the importance of appropriate clothing, nutritious food, physical exercise, and marriage.

The achievements and limitations of this gendered way of safeguarding the reproductive potential of the nation may say more about the proponents of these puericulture and eugenics interventions than about their target audiences. The ideas and actions of these physicians, however, are not trivial. They help us understand which projects were enacted and which ones failed in pursuit of the goal of a larger and healthier population. These initiatives are also part of the broader stories of Latin American pro-natalism and the diffusion of Social Medicine, to which we turn next.

Pro-Natalism and Social Medicine

As Lynn Payer and George Weisz have shown, comparing medical systems in different countries can highlight variations in the extent of the influence and in the execution of generally accepted medical ideas.[147] Their insights can be extended to the study of medical pro-natalism in Latin America, to argue for the existence of national demographic cultures determined by the historical experiences of local elites. The

[147] Lynn Payer, Medicine as Culture: Varieties of Treatment in the United States, England, West Germany and France (New York: Henry Holt, 1988); Weisz, Divide and Conquer.

medical preoccupation with the quantity and quality of Latin Americans starting in the nineteenth century is well documented, as is their belief in Catholic marriages as the best environment in which to raise children, and in mothers' strong role in determining the moral character of children.[148] Bliss's analysis of the "cult of masculinity" during the Mexican Revolution reminds us that men have been more important to the construction of Latin American pro-natalism than scholars previously thought.[149] My analysis of Peruvian eugenicists' efforts to contain the spread of syphilis and alcoholism among men shows the importance of men as both material providers and transmitters of undesirable genetic traits, and thus augments our understanding of the importance of men's roles in Latin America's pro-natalism. This is the context in which to read little Luisa Arróspide Bueno's 1933 accolade as the child with the best "vital traits": mother, father, and medical science were attributed responsibility for those traits.[150]

However, even though many Latin American countries accepted the importance of population growth and the importance of women's (and probably men's) reproductive potential, there remained important differences between pro-natalist national styles. The differences were strongly determined by the ways in which local elites dealt with the abundant racial and ethnic diversity within their young nations. By the 1910s, it was clear that these republics had taken various paths towards demographic growth. Argentina, for example, carried out wars of extermination against its own indigenous peoples, and

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[148] See Stepan, The Hour of Eugenics; Elizabeth Kuznesof and Robert Oppenheimer, "The Family and Society in Nineteenth-Century Latin America: A Historiographical Introduction," Journal of Family History 10 (1985): 215-234; and Donna Guy, White Slavery and Mothers Alive and Dead: The Troubled Meeting of Sex, Gender, Public Health and Progress in Latin America (Lincoln: University of Nebraska Press, 2000).
[149] See Bliss, Compromised Positions.
[150] See the anecdote that introduces this chapter.

almost wiped them out by the 1890s. Cuba, as much of the rest of the Caribbean, lost most of its indigenous population during the colonial period. Nonetheless, it had rich Afro-Cuban cultural and political traditions. Even then, however, the Cuban elite assumed that non-whites would disappear with the end of the slave trade, white immigration, and miscegenation. Of course, the rise of Chinese labor immigration threw these plans somewhat off course. Brazilian elites held similar hopes of whitening their nation via European immigration, but often complained of its insufficiency. Mexico's elites went from believing in the backwardness of Indians and the degeneracy of mixed races during the Díaz regime to a national cult of the mestizo racial identity after the Mexican Revolution.[151]

In Peru, colonial administrators posited the co-existence of distinct Spanish and indigenous cultures. Although miscegenation among indigenous peoples, Europeans, and Africans complicated this simple dichotomy, leading to a caste system with many fluid categories of race mixtures, the original binary definition continued to shape this system.[152] While the mestizo identity did not accrue any particular social benefits, and was more readily linked to character flaws such as immorality and laziness, a strong Europhile tradition developed in cities like Lima and Arequipa. The counterpart to this

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[151] Graham, The Idea of Race in Latin America; Skidmore, Black into White; Alexandra Stern, "From Mestizophilia to Biotypology: Racialization and Science in Mexico, 1920-1960," in Nancy Appelbaum, Anne McPherson and Karin Rosemblatt (eds.), Race and Nation in Modern Latin America (Chapel Hill: University of North Carolina Press, 2003).

[152] Africans were brought to Peru as slaves beginning in the sixteenth century, until the trade was abolished in 1854. Although they were not as numerous as they were in countries like Brazil and Colombia, Afro-Peruvians worked in a variety of occupations in agriculture and mining, in urban and rural settings, especially in the coast. See Frederick Bowser, The African Slave in Colonial Peru, 1524-1650 (Stanford: Stanford University Press, 1974); and Carlos Aguirre, Breve Historia de la Esclavitud en el Perú: Una Herida Que No Deja de Sangrar (Lima: Fondo Editorial del Congreso del Perú, 2005).

Europhilia was most pronounced in the southern Andes of Peru, and also in Bolivia, where it was the grand pre-Columbian past that local elites hailed as the core of Peruvian identity.[153]

Defeat in the War of the Pacific intensified the insecurities the Peruvian white elite harbored about indigenous culture as an untrustworthy yet numerically dominant element of the Peruvian nation.[154] Indeed, as Florencia Mallon has shown, indigenous peoples in Peru reacted in different ways to the Chilean invasion: some resisted in the name of the Republic of Peru, others sought compensation for Chilean attacks, others did nothing, and still others forged alliances with the Chileans against Peruvian hacienda owners. Even after the war, as the external threat lessened, indigenous civil uprisings and regional rebellions worried the white elite.[155] Not surprisingly, by the 1890s some among the elite were convinced of indigenous Peruvians' lack of patriotism and civic virtues.

These elite beliefs in their political distinctness from, and superiority to, the indigenous population received legal support in the Peruvian Penal Code of 1924, valid until 1991, which divided Peruvians into "civilized", "semi-civilized" and "savages", and meted out punishments that varied depending on the guilty party's degree of "civilization."[156] This attitude had a medical counterpart that described indigenous

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[153] de la Cadena, Indigenous Mestizos; Chambers, De Subditos a Ciudadanos.
[154] Flores Galindo traces these back at least to the Tupac Amaru II rebellion in the 1780s. See Alberto Flores Galindo, Buscando un Inca: Identidad y Utopía en los Andes (Lima: SUR, 1986).
[155] Florencia Mallon, Peasant and Nation: The Making of Postcolonial Mexico and Peru (Berkeley: University of California Press, 1995). See also Mark Thurner, From Two Republics to One Divided: Contradictions of Postcolonial Nationmaking in Andean Peru (Durham: Duke University Press, 1997).
[156] See Tamar Herzog, "Percibir el Otro: El Código Penal de 1924 y la División de los Peruanos en Personas 'Civilizadas', 'Semi-Civilizadas' y 'Salvajes'", in Johannes-

peoples as reluctant to embrace the advance of science and, in the case of indigenous women, as prone to experiencing pain and fear in animal-like ways.[157] However, Peruvian physicians also acknowledged the nation's reliance on indigenous labor in key economic and geo-political activities like agriculture, mining, and the military. Likewise, medical doctors recognized Peru's indigenous peoples as heirs of the mighty Inka Empire, and blamed the brutality of the Spanish conquest and colonial period for their contemporary prostration and poverty. Physicians encouraged the growth of the indigenous population of Peru as a matter of demographic justice. Population gains would, after all, aid the recovery of lost populations. Even so, indigenous demographic growth, physicians held, required institutions such as medicine, the military, and contract agricultural work to act as civilizing and disciplining forces to "redeem" and "rebuild" the Indian into a "utilizable building block of the nation."[158]

Thus, one distinctive aspect of Peruvian medical pro-natalism was to grant a specific role to indigenous demographic growth: Peru as a nation needed more inhabitants to take full advantage of the new opportunities provided by its participation as an exporter of raw materials in a transnational capitalist economic system. This was a particularly persuasive view during the years of economic growth between 1890 and 1930. Within this framework, Peru's indigenous peoples were called upon to serve not in

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Michael Scholz and Tamar Herzog (eds.), Observation and Communication: The Construction of Realities in the Hispanic World (Franfurt: Vittorio Klostermann, 1997).

[157] Daniel Laborería, "El Arte de Curar entre los Antiguos Peruanos," Anales de la Universidad Nacional Mayor de San Marcos 29 (1902): 59-263; "Vida Física de la Mujer," La Acción Médica (22 September 1928): 11; Lucio Castro Medina, "La Obstetricia en la Raza Indígena," Actualidad Médica Peruana 5, 2 (Junio 1939): 44-50.

[158] Carlos Enrique Paz Soldán, "La Medicina Militar y los Problemas Nacionales," (Tesis de Grado, Facultad de Medicina de San Fernando, 1910: 13, 14). See also Tudela, El Problema de la Población el el Perú; and Enrique León García, Las Razas en Lima (Tesis Doctoral, Facultad de Medicina de San Fernando, 1909).

cities but in rural areas: as agricultural and mining workers, as soldiers, and as colonizers of the farthest reaches of the country, civilized by whites, and politically subordinate to them.[159] The steps taken to protect the reproductive potential of Peruvians, such as corps of visiting social workers, milk distribution centers, laws for maternity leave, pre-nuptial health certificates, and venereal disease clinics were, before the 1940s, almost exclusively urban institutions.[160] Thus, Peru's pre-1940s medical writings and health policies reveal the institutionalization of a deeply racist national demographic culture.

The racist elitism of this culture is clear in its appropriation of Social Medicine concepts to promote the endurance of racial and cultural hierarchies in Peru. French hygienists had discussed the health of the public as a right and a direct concern of the government since the 1820s. German physician and legislator Rudolf Virchow synthesized this view in the 1840s when he argued that epidemics were as much social as biological events, and that their ravages could be prevented if populations acquired more political rights, if they were better educated, and were financially prosperous.

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[159] Gloria Gray, "Bolivar Odicio, El Cashibo Civilizador," Perú Indígena 4, 9 (April 1953): 146-155.

[160] There were, however, important improvements in the coverage of rural health in the 1940s during Manuel Prado's presidency (1939-1945). Most notably, in 1940 Peru conducted its first national census since 1876. In addition, led by Minister Constantino J. Carvallo, the Ministry of Public Health had a budget that more than tripled between 1940 and 1945. Carvallo estalished 25 of the 42 venereal disease clinics that existed in Peru by 1944, most of them outside of Lima, and made their services available to both men and women. Carvallo also re-launched the national corps of visiting social workers, and sponsored the medical study of indigenous communities in the Peruvian Amazon region. Under Carvallo's tenure as Minister, the number of physicians working for the state rose from 260 in 1939 to 600 in 1945, the number of hospitals and health centers in the country increased, and the Faculty of Medicine received a subsidy. See AGN: Chief of the General Office of Public Health Dr. Víctor Eguiguren, "Reporte del Servicio Nacional Antivenéreo," Boletín de la Dirección General de Salubridad Pública 1943 and 1944. See also Cueto, "Social Medicine and 'Leprosy.'"

Virchow's Social Medicine influenced his countryman Alfred Grotjahn in the early twentieth century in ways that had repercussions for Peru. Grotjahn's "Social Hygiene" explicitly declared the main problem of Social Medicine to be physical and social degeneration. As Rosen explained, Social Hygiene was both a descriptive and a normative science, concerned with "the conditions that affect the spread of hygienic culture among groups of individuals, and their descendants, living under the same spatial, temporal and social conditions."[161] In practice, Social Hygiene emphasized the collection of population statistics on morbidity and mortality, hygienic conditions of labor, nutrition, housing and clothing, and the protection of children. It also promoted the importance of a program of eugenics.

Within the first two decades of the twentieth century, Social Hygiene influenced public health practice in Germany, France, Belgium, and the United States. Dr. René Sand, social activist and Secretary General of the League of Red Cross Societies in 1921, became the strongest promoter of Social Hygiene in francophone Europe. Sand's research focus was on childhood, tuberculosis, and venereal disease, along with the medical problems of labor. In addition, Sand advocated the medico-anthropological study of physical and mental inequalities between social classes, the translation of these inequalities into distinct class-bound social pathologies, and the application of social prophylactic measures to palliate, cure and, prevent diseases of social origin.[162] Although Social Medicine as a preventive approach had been touted in the Peruvian *Academia Nacional de Medicina* since 1888, it was Sand's brand of interventionism that most

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[161] Rosen, From Medical Police to Social Medicine, 98.
[162] Sand, The Advance to Social Medicine. See also Lynne Healy, International Social Work: Professional Action in an Interdependent World (New York: Oxford University Press, 2001).

strongly influenced the Faculty of Medicine of Lima's pro-natalism through its various new specialties in the late nineteenth and early twentieth centuries: Social Medicine, Pediatrics, Obstetrics and Gynecology, Tropical Diseases, Urology, Dermatosyphilis, and even Psychiatry.[163] These physicians successfully demanded a place as population policy-makers in the early twentieth century. Writing about such a policy for Peru, Social Hygiene Professor Carlos Enrique Paz Soldán maintained that physicians put in charge of public hygiene could do much for endogenous growth and immigration promotion. To accomplish this, in his view, social hygienists had to go "from sanitary police officers to technical cadres of the state […] their skills being those of hygienists, educators, economists and legislators."[164]

From its founding in 1923, the Peruvian eugenic League for Hygiene and Social Prophylaxis also embraced Sand's approach to Social Hygiene. The crucial difference was that the Peruvian eugenicists stressed less the physical and mental inequalities that might exist between people of different social classes, and more those between white and indigenous Peruvians. This paternalistic and authoritarian appropriation of Social Medicine was most discernable in physicians' calls to conduct anthropological research into Andean and Amazonian peoples in the 1930s, and in their claims that their cultures (their languages, in particular) acted as a barrier to indigenous Peruvians' intellectual

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[163] Peru's most renowned psychiatrist, Honorio Delgado, popularized the notion of neurasthenia in medical circles as a neurologically debilitating disease that threatened the mental hygiene of the Peruvian race. See Honorio Delgado, La Psiquiatría y la Higiene Mental en el Perú (Lima: Facultad de Ciencias Médicas, 1919); and Enrique Galli, "Semblanza de Honorio Delgado: Humanismo y Psicopatología," Revista Médica Herediana 11, 4 (2000): 130-135. On neurasthenia more broadly, see Marijke Gijswijt-Hofstra and Roy Porter (eds.) Cultures of Neurasthenia from Beard to the First World War (Amsterdam: Rodopi, 2001).

[164] Carlos Enrique Paz Soldán, "La Función de la Higiene Pública en una Política de Población," La Acción Médica (5 October 1929): 3.

development.[165] Most importantly, far from supporting greater political rights, education, economic prosperity, and public health services throughout the country, as Virchow did for Germany, Peruvian physicians before 1940 seemed only interested in their ability to use Social Medicine to "civilize" non-white Peruvians and turn them into effective "human capital" to increase the wealth of the state.[166]

The physicians from the Faculty of Medicine were very important in the formation of a national demographic culture between 1895 and 1940. This culture stressed the importance of increasing the country's population, but focused on the welfare of the largest cities, especially Lima, and showed little regard for the health of people in rural areas and for indigenous Peruvians. Because these medical elites ultimately wished to engineer a new, larger, and healthier Peru through the management of men's and women's fertility, it is not surprising that they tended to reproduce reductionist stereotypes about women as potential mothers in need of protection and men as potential fathers in need of tough guidance. Yet we know that there was more to women's and men's lives than acting as potential parents. Throughout this period, Peruvian women and men met for fun, economic convenience, and paid sex in bars and on the street, and they

[165] "Medicina y Antropología," Actualidad Médica Peruana 2, 2 (1936): 1-2; Actualidad Médica Peruana 1, 11 (1936): 617-619; "La Unificación del Idioma como Medida de Higiene Mental en el Perú," Actualidad Médica Peruana 4, 9 (January 1939): 310; "La Influencia del Bilingüismo en la Mentalidad del Pueblo Peruano,"Actualidad Médica Peruana 6, 5 (September 1940): 131-133; Maxime Kuczynski Godard, La Vida en la Amazonía Peruana: Observaciones de un Médico (Lima: UNMSM, 1944).
[166] "Un Significado Ejemplo de los Progresos de la Higiene Rural," Anales de la Cruz Roja Peruana, 2 (September-October 1934): 19-21; José B. Jiménez Camacho, "El Ejercicio de la Profesión Médica en Provincias: Obstetricia Rural en la Sierra del Peru," Actualidad Médica Peruana 6, 3 (July 1940): 74-79.

formed domestic alliances with each other without the mediation of health certificates.[167] New problems arose for these men and women when they inadvertently became parents, as we shall see in the next chapter.

[167] Nestor P. Roldán, "El Peligro Venéreo y su Profilaxia en el Ejército," (Tesis de Grado, Facultad de Medicina de San Fernando, 1914); Pedro Vega Gamarra, "Contribución al Estudio de la Mortalidad Infantil en Huaraz," (Tesis de Grado, Facultad de Medicina de San Fernando, 1929); Juan Herón Frisancho, "Mortalidad Infantil y Movimiento Demográfico en la Ciudad de Puno," (Tesis de Grado, Facultad de Medicina de San Fernando, 1938); José Alejandro Ruiz, Evolución Demográfica de Chiclayo (Tesis de Grado, Facultad de Medicina de San Fernando, 1938); Victor Villavicencio, La Vida Sexual del Indígena Peruano (Lima: Barrantes Castro, 1942).

Chapter Three

Accusation and Abortion, 1890s-1940s

This chapter analyzes the state of medical knowledge about abortion between the late nineteenth and early twentieth centuries, as well as how this led (or failed to lead) to accusations against people for causing miscarriages and performing abortions.[1] What did physicians know about abortion? Under what circumstances did they translate that knowledge into legal accusations? How were these accusations leveled? What arguments strengthened or weakened the accusations? These are the questions for this chapter. I make two related arguments. First, despite the fact that physicians witnessed many instances of pregnancy loss, they rarely instigated criminal accusations of abortion. Second, even when physicians and state authorities advanced such charges, several obstacles stood in the way of a conviction. Among these obstacles was the legal precept that "honorable women" who had abortions deserved forgiveness and reformation rather than punishment. In addition, judiciary records of abortion investigations reveal that women relied on a variety of strategies to derail criminal investigations and protect themselves from prosecution, from withholding the truth from physicians to accusing others of causing their miscarriages. An analysis of these records allows a privileged view of how Peruvians dealt with uninvited medical and state scrutiny into their sexual and reproductive lives.

Although this chapter is substantially concerned with the phenomenon of abortion, it is also a bridge between chapters two, on medical pro-natalism in the late

[1] When I use the term "abortion", I refer only to induced abortions, not to spontaneous miscarriages.

nineteenth century, and four, on the family planning initiatives of the second half of the twentieth century. The Peruvian medical establishment already considered pregnancy losses from abortion an important cause of demographic stagnation in the late eighteenth century.[2] By the mid-twentieth century, this establishment also construed unsafe illegal abortions as a cause of maternal mortality that suggested the need to improve the medical care of women and to popularize family planning.[3] Indeed, by the 1960s physicians throughout Latin America and elsewhere warned of the grave risks women ran when attempting to end a pregnancy through an unsafe illegal abortion. Whether women were coerced into getting an abortion or whether they sought one out, the 1960s and 1970s medical literature tended to portray women as victims, either of their own misguided actions, or of unskilled or dishonest abortion providers.[4]

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[2] See chater two.

[3] López Cornejo, "Las Realidades de la Asistencia del Parto en el Perú"; Antonio Quintanilla Paulet, "Algunos Problemas Médicos en Relación con el Subdesarrollo Económico del Perú," (Tesis de Grado, Facultad de Medicina de San Fernando, 1956); Glicerio Arroyo Posadas, "Infancia y Pro-biofilaxis (Dos Mil Niños y su Destino Socio Vital en 'El Montón,'" (Tesis de Grado, Facultad de Medicina de San Fernando, 1957); José Burgos Amaya, "La Procreación Consciente en Nuestro País y el Ritmo de la Esterilidad y de la Fecundidad en la Mujer," (Tesis de Grado, Facultad de Medicina de San Fernando, 1957); Mariano Bedoya Hevia, "Social Problems of Abortion: Illegal Abortion," in C. Wood and W.A.W. Walters (eds.), Proceedings of the 5th World Congress of Gynaecology and Obstetrics, Sydney, Australia, September 1967 (London, Butterworths: 1967).

[4] Edris Rice-Wray, "The Provoked Abortion – A Major Public Health Problem," American Journal of Public Health 54, 2 (1964): 313- 321; Ofelia Mendoza, "Population Growth and Family Planning in Latin America," Journal of Sex Research 1, 2 (1965): 161-170; Rolando Armijo and Tegualda Monreal, "The Problem of Induced Abortion in Chile," Milbank Memorial Fund Quarterly 43, 4 (1965): 263-280; Santiago Gaslonde Sainz, "Abortion Research in Latin America," Studies in Family Planning 7, 8 (1976): 211-217; "Abortion - Cost of Illegality," People IPPF 3, 3 (1976): 28; Benjamin Viel, The Demographic Explosion: The Latin American Experience (New York: Irvington, 1976); Irene Figa-Talamanca, "Health and Economic Consequences of Illegal Abortions: Preliminary Findings from an International Study," in Gerald Zatuchni, John Sciarra, and J. Joseph Speidel (eds.) Pregnancy Termination (Hagerstown, MD: Harper and Row,

Contemporary medical practitioners and the popular press have rarely deviated from the above portrayal.[5] Yet, this "women are victims" message is problematic, as it buries much of the social complexity of abortion. Without challenging the importance of the status of victimhood, nor denying the magnitude of abortion as a public health problem in Latin America, social scientists have opened up new ways in which to think about abortion in the region. Some of this literature challenges the one-dimensional portrayal of abortion seekers and attempts to understand the reasons why women choose to abort. Among these are a dislike of mechanical contraceptive devices, and fear of the effects of a new child on a woman's body, on a family's income, or on the relationship with one's spouse.[6]

Other scholars have focused on the culturally specific value of pregnancies and fetuses, as well as the interpersonal dynamics that lead women to desire to end a

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1979); Hugo Corvalan, "The Abortion Epidemic," in Malcolm Potts and Pouru Bhiwandiwala (eds.), Birth Control: An International Assessment (Lancaster: MTP, 1979).

[5] Crane, "The Transnational Politics of Abortion"; Susheela Singh and Deirdre Wulf, An Overview of Clandestine Abortion in Latin America (New York: Alan Guttmacher Institute, 1996); Eileen Yam, Ingrid Dries-Daffner, and Sandra García, "Abortion Opinion Research in Latin America and the Caribbean: A Review of the Literature," Studies in Family Planning 37, 4 (2006): 225-240. See also James Brooke, "High Rate of South American Abortion Ills Seen," New York Times (23 November 1993): C5; and "Abortion Rights in Latin America," New York Times (6 January 2006): A20.

[6] Esther Andradi and Ana María Portugal, Ser Mujer en el Perú (Lima: Mujer y Autonomía, 1978); Michele Shedlin and Paula Hollerbach, "Modern and Traditional Fertility Regulation in a Mexican Community: The Process of Decision Making," Studies in Family Planning 12, 6-7 (1978): 278-196; John Tomaro, "Tendencias y Prácticas del Aborto en los Seis Estados del Norte de México," Estudios de Población (ACEP Colombia) 4, 7-11 (1980): 61-84; Karen Rodriguez and Jennifer Strickler, "Clandestine Abortion in Latin America: Provider Perspectives," Women and Health 28, 3 (1999): 59-76; María Mercedes Lafaurie, Daniel Grossman, Erika Troncoso, Deborah Billings, Susana Chávez, "Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and Peru: A Qualitative Study," Reproductive Health Matters13, 26 (2005): 75-83.

pregnancy. As several of these scholars have shown, ending a pregnancy is not always "a matter of desperation," nor the result of a cool resource-allocation calculus.[7] Rather, there are cultural norms that sanction positively the use of abortion to preserve personal or familial welfare.[8] In other cases, fetuses are not thought of as complete beings of this world, but rather as spiritual entities with certain powers over worldly matters.[9] Their transit towards this world is not something over which people have full control. Therefore, pregnancy loss arouses few feelings of grief and rarely elicits punishment for parents or birth attendants.

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[7] Demetria Martínez, "Abortion in Latin America is a Matter of Desperation," Conscience 11, 1 (1990): 18.

[8] Brigitte Jordan, "Two Studies in Medical Anthropology: The Self-Diagnosis of Early Pregnancy," (PhD diss., University of California Irvine, 1975: 50-51); Sainz, "Contraception in Three Chibcha Communities." For a broader, though somewhat dated, review by a Freud-inspired psychiatrist, see George Devereux, A Study of Abortion in Primitive Societies: A Typological, Distributional, and Dynamic Analysis of the Prevention of Birth in 400 Preindustrial Societies (London: T. Yoseloff, 1960).

[9] Hermilio Valdizán, Historia de la Medicina Peruana (Lima: Instituto Nacional de Cultura, 2005 [1939]); W.E. Carter, "Trial Marriage in the Andes?" in Ralph Bolton and Enrique Mayer (eds.) Andean Kinship and Marriage (Washington, DC: American Anthropological Association, 1977); Morgan, "Imagining the Unborn." The reciprocity between our world and the world of spirits in which the unborn dwell is a common theme in Andean cosmology, particularly as this conversation between the worlds applies to healing. See for example Chambi et al. Así Nomás Nos Curamos; and Grimaldo Rengifo Vasquez, "Hacemos Así, Así: Aprendizaje o Empatía en los Andes," in La Regeneracion de Saberes en los Andes (Lima: PRATEC, 1998). The issue of the transitional status of fetuses is also discussed in Rosalind Petchesky, "Fetal Images: The Power of Visual Culture in the Politics of Reproduction," Feminist Studies 13, 2 (1987): 263-292; Linda Layne, "Motherhood Lost: Cultural Dimensions of Miscarriage and Stillbirth in America," Women & Health 16, 3-4 (1990): 69-98; Rosanne Cecil (ed.) The Anthropology of Pregnancy Loss: Comparative Studies in Miscarriage, Stillbirth and Neonatal Death (Oxford: Berg, 1996); Leslie Reagan, "From Hazard to Blessing to Tragedy: Representations of Miscarriage in Twentieth-Century America," Feminist Studies 29, 2 (2003): 357-380; Jürgen Habermas, The Future of Human Nature (Cambridge: Polity, 2003); Annemarie Jutel, "What's in a Name? Death before Birth," Perspectives in Biology and Medicine 49, 3 (2006): 425-434.

Historians of Latin America have also dealt with abortion. C.A. Rabell and Alfredo López portray it as a common pre-Columbian practice. María de los Angeles Rodríguez, Londa Schiebinger, and Mary Ann Mahony discuss abortion as a reaction to political disenfranchisement by colonized or enslaved subjects. Maria Emma Mannarelli, Dora Barrancos, and María Soledad Zárate present abortion as a privilege that physicians sought to monopolize in the late nineteenth century. Cindy Forster, Heidi Tinsman, Martha Few, and Brodwyn Fischer analyze abortion in the context of how material conditions such as land tenure patterns, urban poverty, and violence against women affected women's actions regarding unwanted pregnancies.[10] Most of this literature however, deals with abortion only indirectly, with book-length monographs on abortion still rare.[11]

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[10] C.A. Rabell and C.S. Assadourian, "Self-Regulating Mechanism of the Population in a Pre-Columbian Society: The Case of the Inca Empire," Proceedings of the International Population Conference, Mexico 1977, Volume 3 (International Union for the Scientific Study of Population: Mexico, 1977, 25-42); Alfredo López Austin, Cuerpo Humano e Ideología: Las Concepciones de los Antiguos Nahuas, Tomo 1 (Mexico: UNAM, 1980: 344); María de los Angeles Rodríguez and Thomas Calvo, "Sobre la Práctica del Aborto en el Occidente de México: Documentos Coloniales (Siglos XVI-XVII)," Trace 10 (1986): 32-38; Maria Emma Mannarelli, Pecados Públicos: La Ilegitimidad en Lima, Siglo XVII (Lima: Flora Tristan, 1993); Cindy Forster, "Violent and Violated Women: Justice and Gender in Rural Guatemala, 1936-1956," Journal of Women's History 11, 3 (1999): 55-77; Heidi Tinsman, "Good Wives and Unfaithful Men: Gender Negotiations and Sexual Conflicts in the Chilean Agrarian Reform, 1964–1973," Hispanic American Historical Review 81, 3-4 (2001): 587-619; Few, Women Who Live Evil Lives; Brodwyn Fischer, "Quase Pretos de Tão Pobres? Race and Social Discrimination in Rio de Janeiro's Twentieth-Century Criminal Courts," Latin American Research Review 39, 1 (2004): 31-59; Londa Schiebinger, "Feminist History of Colonial Science," Hypatia 19, 1 (2004): 233-254; Dora Barrancos, "Problematic Modernity: Gender, Sexuality, and Reproduction in Twentieth-Century Argentina," Journal of Women's History 18, 2 (2006): 123–150; Zárate, Dar a Luz en Chile, Siglo XIX; Mary Ann Mahony, "Creativity under Constraint: Enslaved Afro-Brazilian Families in Brazil's Cacao Area, 1870-1890," Journal of Social History 41, 3 (2008): 633-666.

[11] Note Caulfield's silence on this subject in her excellent review of the Latin American gender historiography in "The History of Gender in the Historiography of Latin

Very few historical studies of abortion in Latin America have focused on criminal accusations. These studies take place in the late nineteenth century, in social contexts that sharply distinguished the privileges and duties of men and women, and which, in addition, witnessed an increasing professionalization of physicians. In countries such as Mexico and Argentina, motherhood within marriage was deemed a woman's greatest responsibility and her main conduit to social respectability. These were, in fact, criteria to include and exclude a woman from the category of "honorable woman." Abortions implied a rejection of these values, and criminologists, physicians, and clerics attempted to find the reasons that led to such "unnatural" acts. The identification of maternity with womanhood was so strong that these experts doubted that women who had abortions or killed their newborns could have been acting consciously or freely. An important consequence of these debates was the consideration of mitigating circumstances when trying a woman for an abortion or infanticide. The laws and the courts were more lenient towards women who committed these crimes to hide the fact that they had had sex outside of marriage. These acts might have been rash and cruel, but they took place because the pressure to protect their honor temporarily occluded women's "natural"

America." Contrast this with the abundance of literature on abortion in the United States, which includes J.C. Mohr, Abortion in America: The Origin and Evolution of National Policy, 1800-1900 (New York: Oxford University Press, 1978); Pauline Bart, "Seizing the Means of Reproduction: An Illegal Feminist Abortion Collective – How and Why It Worked," in Helen Roberts (ed.), Women, Health and Reproduction (London: Routledge & Kegan Paul, 1981); Kristin Luker, Abortion and the Politics of Motherhood (Berkeley: University of California Press, 1984); Rickie Solinger, The Abortionist: A Woman Against the Law (Berkeley: University of California Press, 1996); Reagan, When Abortion Was a Crime; and Johanna Schoen, Choice and Coercion: Birth Control, Sterilization and Abortion in Public Health and Welfare (Chapel Hill: University of North Carolina, 2005).

maternal instincts.[12] As I will show, Peruvian laws and medical experts' opinions also reflected this kind of gendered definition of honor and supported leniency for "honorable" women who had abortions or committed infanticide.

This chapter deals with two aspects in addition to the role of honor, domestic violence and lay forms of knowledge about the body, that have a bearing on abortion and that the existing historiography of abortion in Latin America does not address. Historians of medicine have recently begun to explore the role of lay knowledge about the body in the healing and beautification practices of early modern Europe, including Spain.[13] Healing practices in Spanish colonies during this period partook of this tradition, and reveal a high degree of individual participation in self-diagnosis and self-procurement of means to obtain relief from ailments, including unwanted pregnancies.[14] In addition, the combination of European, native American, and African forms of knowledge yielded complex and diverse approaches to diagnostics and therapeutics in the Americas that

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[12] Kristin Ruggiero, "'Not guilty': Abortion and Infanticide in Nineteenth-Century Argentina," in Carlos Aguirre and Robert Buffington (eds.), Reconstructing Criminality in Latin America (Wilmington: Scholarly Resources, 2000); Beatriz Urías Horcasitas, "Eugenesia y Aborto en México (1920-1940)," Debate Feminista 14, 27 (2003): 305-323; Elisa Speckman, "Morir en Manos de una Mujer: Homicidas e Infanticidas en el Porfiriato," in Felipe Castro and Marcela Terrazas (eds.), Disidencia y Disidentes en la Historia de México (Mexico: UNAM, 2003). On the different sources and forms of male and female honor in Latin America, see Stevens, "Marianismo"; and Chambers, De Subditos a Ciudadanos.

[13] Elaine Leong, "Making Medicines in the Early Modern Household," Bulletin of the History of Medicine 82 (2008): 145-168; Montserrat Cabré, "Women or Healers? Household Practices and the Categories of Health Care in Late Medieval Iberia," Bulletin of the History of Medicine 82 (2008): 18-51; Alisha Rankin, "Duchess, Heal Thyself: Elisabeth of Rochlitz and the Patient's Perspective in Early Modern Germany," Bulletin of the History of Medicine 82 (2008): 109-144.

[14] Few, Women Who Live Evil Lives; Marianne Samayoa, "More than Quacks: Seeking Medical Care in Late Colonial New Spain," Social History of Medicine 19, 1 (2006): 1-18.

allowed sufferers' understandings of their own afflictions to play important roles in ending them.[15]

This medical pluralism is still an important feature of the practice of medicine in Latin America today.[16] Realizing this, contemporary epidemiologists have begun to support approaches to disease prevention that take into consideration the importance of lay knowledge of health and disease.[17] Underlying epidemiological approaches such as "community-based research partnerships" is the understanding that lay people commonly draw on many different aspects of their lives and environment to construct bodily "truths," that they share these "truths" with others, and that uncertainties are powerful determinants for the development of new forms of lay bodily knowledge. Often, this lay knowledge points to experts' blind spots or directly challenges established scientific knowledge and promotes the development of new ways to heal or prevent health problems.[18] Other times, however, lay knowledge interferes with effective treatment.[19]

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[15] Sowell, "Contending Medical Ideologies"; Palmer, From Popular Medicine.
[16] See for example Scheper-Hughes's discussion of "nervos" in Death Without Weeping; and Crandon-Malamud, From the Fat of Our Souls.
[17] Melissa Leach and James Fairhead, "Manners of Contestation: 'Citizen Science' and 'Indigenous Knowledge' in West Africa and the Caribbean," International Social Science Journal 54, 173 (2002): 299-311. See also Jennie Popay and Gareth Williams, "Public Health Research and Lay Knowledge," Social Science and Medicine 42, 5 (1996): 759-768; Meredith Minkler, "Community-Based Research Partnerships: Challenges and Opportunities," Journal of Urban Health 82, 2 (Supplement 2, 2005): ii3-ii12.
[18] On the social construction of these bodily "truths", see Polanyi, Personal Knowledge; Françoise Loux, "Popular Culture and Knowledge of the Body: Infancy and the Medical Anthropologist," in Roy Porter and Andrew Wear (eds.), Problems and Methods in the History of Medicine (London: Croom Helm, 1987); Phil Brown, "Popular Epidemiology and Toxic Waste Contamination: Lay and Professional Ways of Knowing," Journal of Health and Social Behavior 33 (1992): 267-281; Tola Olu Pearce, "Lay Medical Knowledge in an African Context," in Shirley Lindenbaum and Margaret Lock (eds.), Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life (Berkeley: University of California Press, 1993); Emily Martin, Flexible Bodies: The

This chapter also addresses the issue of men's domestic violence against women, in the form of physical assaults that, deliberately or not, resulted in miscarriages. Historians have studied the social origins of this kind of violence well in Spanish America. Iberian domination emphasized norms like strict monogamy and Catholic observance during the colonial period, as well as a sharp demarcation of spheres of action for men and women, with men securing the public sphere and demanding primacy in the domestic one, and women acting as the moral compasses of families while depending on fathers, husbands, and brothers to secure livelihoods and political rights.[20] Abiding by these tenets constituted the basis of a gendered code of honor that was not only socially widespread but also durable. Historians such as Chambers and Borchart de Moreno, for example, show that both the wealthy and the poor negotiated versions of honor based on the theme that men's and women's respectability ought to be judged following different criteria, and that these honor codes survived more or less unchanged through the upheaval of the collapse of Spanish rule.[21]

Some of the more consistently upheld values concerned behavior in the domestic sphere. Women were supposed to be submissive towards the adult men in their households, and to refrain from sexual activity except with their husbands. Conversely,

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Role of Immunity in American Culture from the Days of Polio to the Age of AIDS (Boston: Beacon, 1994); Epstein, Impure Science.

[19] María Luisa Vázquez, Mario Mosquera, Axel Kroeger, "People's Concepts on Diarrhea and Dehydration in Nicaragua: The Difficulty of the Intercultural Dialogue," Revista Brasileira de Saúde Materno-Infantil, Recife 2, 3 (2002): 223-237.

[20] Stern, The Secret History of Gender; Ward Stavig, Amor y Violencia Sexual: Valores Indígenas en la Sociedad Colonial (Lima: IEP, 1996); Lyman Johnson and Sonya Lipsett-Rivera (eds.), The Faces of Honor: Sex, Shame and Violence in Colonial Latin America (Albuquerque: University of New Mexico Press, 1998).

[21] Chambers, De Súdbitos a Ciudadanos; Christiana Borchart de Moreno, "Words and Wounds: Gender Relations, Violence, and the State in Late Colonial and Early Republican Ecuador," Colonial Latin American Review 13, 1 (2004): 129-144.

men ought to jealously guard the sexual exclusivity of their wives, and that of their daughters until marriage. The mere appearance of a sexual transgression or an overt act of disobedience by women could result in socially accepted violent outbursts from men.[22] The picture the historiography paints is one in which domestic violence was an endemic and tolerated aspect of social life in Latin America.

While recognizing this uneven gender playing field, some historians have identified ways in which women contested men's violence, insults, and dishonorable behavior.[23] Institutions such as criminal courts and marriage annulment ecclesiastic courts provided outlets for women to ventilate their grievances with men and find legal support,

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[22] Soledad González and Pilar Iracheta, "La Violencia en la Vida de las Mujeres Campesinas: El Distrito de Tenango, 1880-1910," in Carmen Ramos (ed.), Presencia y Transparencia: La Mujer en la Historia de México (México: El Colegio de México, 1992); Martha Moscoso, "'Los Consejos del Diablo…': Maltrato, Adulterio y Divorcio en el Ecuador (1860-1920)," Arenal, Revista de Historia de las Mujeres 1, 2 (1994): 209-222; Tanja Christiansen, Disobedience, Slander, Seduction, and Assault: Women and Men in Cajamarca, Peru, 1862-1900 (Austin: University of Texas Press, 2004); Lisette Griselda Rivera Reynaldos, "Crímenes Pasionales y Relaciones de Género en México, 1880-1910," Mundo Nuevo, Nuevos Mundos 6 (2006): 1-11. Different accounts indicate that this is an unfortunate trait that still characterizes relations between men and women in Latin America and that continues to protect abusive men. See for example Matthew Gutmann, The Meanings of Macho: Being a Man in Mexico City (Berkeley: University of California, 1996); Maureen Larkin, "Global Aspects of Health and Health Policy in Third World Countries," in Ray Kiely and Phil Marfleet (eds.) Globalisation and the Third World (London: Routledge, 1998); Norma Fuller, Masculinidades: Cambios y Permanencias (Lima: Pontificia Universidad Católica del Perú, 2002); César Chelala, "A Hidden Epidemic: Gender Violence," Américas 55, 4 (2003): 55; Nancy Palomino, Miguel Ramos, Rocío Valverde and Ernesto Vásquez, Entre el Placer y la Obligación: Derechos Sexuales y Derechos Reproductivos de Mujeres y Varones de Huamanga y Lima (Lima: Universidad Peruana Cayetano Heredia, 2003); María Elva Echenique, "La Casa y la Domesticidad como Metáforas de la Opresión Social: El Testimonio de Domitila Barrios," Revista Iberoamericana 70, 206 (2004): 275-283.

[23] Sarah Chambers, "Los Ritos de la Resistencia: Estrategias de las Peruanas para Defenderse de la Violencia Doméstica, 1780-1850," in Luzelena Gutiérrez de Velasco (ed.), Género y Cultura en América Latina (México: El Colegio de México, 2003: 217-238); Laura Gotkowitz, "Trading Insults: Honor, Violence, and the Gendered Culture of Commerce in Cochabamba, Bolivia, 1870s-1950s," Hispanic American Historical Review 83, 1 (2003): 83-118.

including, as we shall see, cases of domestic violence that resulted in miscarriage. If skillfully conducted on the woman's behalf, a trial or an annulment proceeding could provide a modicum of social vindication by portraying men as violent, negligent, diseased, poor, and powerless to assert themselves in their relations with women.

Discussing the manifestations of these two phenomena, lay knowledge of the body and domestic violence, along with the medico-legal context in which abortion accusations were made can help us better connect abortion to social life in early-twentieth century Peru. In the next section I will analyze how medical discourses and legal provisions made pregnancy loss a matter of national interest.

Medico-Legal Knowledge and Debates about Abortion

Throughout the nineteenth and early twentieth centuries, Peru's medical profession deemed pregnancy loss a social, medical, and legal problem with difficult solutions and grave consequences for population growth, for the prestige of the profession, and for the stability of the family. However, the professional community of physicians did not participate actively in the debates that led to the earliest legal stipulations about abortion in the 1830s. This was because, as explained in the previous chapter, the Faculty of Medicine of Lima, the core organization of the profession, was in the midst of a curricular and organizational overhaul that concluded only in the late 1850s. However, physicians became increasingly important to these debates towards the late nineteenth century. What kind of legal environment framed abortion in this period? How did physicians first enter this field? What did they actually know about the inducement of abortions?

For approximately two years, between 1836 and July of 1838, the territories of Peru and Bolivia formed a geopolitical unit led by General Andrés de Santa Cruz.[24] The Peru-Bolivia Federation disbanded in civil war in 1838, therefore the 1836 Penal Code had a brief lifespan. Nonetheless, it was the first Penal Code of Peru's Republican period, and the first to make abortion a crime in the country. The 1836 law classified abortion as a homicide, consistent with the Catholic idea that male fetuses over forty days and females over eighty days had souls and were, therefore, persons.[25] The 1836 law did not concern itself with earlier pregnancy losses, which implicitly allowed them.

According to the 1836 Penal Code, knowingly assaulting or giving food or drink to a pregnant woman to make her miscarry was considered an abortion. Successful attempts were more severely punished than unsuccessful ones (four to eight years in jail, as opposed to two to four years, respectively). Importantly, a woman's consent lessened the punishment, cutting the jail time in half. The law was relatively lenient to all women. They were deemed criminals only if they succeeded in terminating their pregnancies. Even then, the penalty for them was not jail time, but rather internment in a moral reform institution for a period between one and two years.[26] Moreover, a woman might not be interned at all if a judge determined that she was "single, or a non-corrupt widow, and honorable," whose only motive had been to cover up her having sex outside of

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[24] On the Peruvian-Bolivian Confederation project, see Cristóbal Aljovín, Caudillos y Constituciones: Perú 1821-1845 (Lima: Fondo de Cultura Económica, 2000).
[25] The soul entering the body was what defined an "animated fetus." This Catholic thesis exists at least since the eleventh century. See James Coriden, "Church Law and Abortion," The Jurist 33 (1973): 184-198.
[26] On how these institutions strived to re-integrate female delinquents into society, see María Soledad Zárate, "Vicious Women, Virtuous Women: The Female Delinquent and the Santiago de Chile Correctional House, 1860-1900,"in Ricardo Salvatore and Carlos Aguirre (eds.), The Birth of the Penitentiary in Latin America: Essays on Criminology, Prison Reform and Social Control, 1830-1940 (Austin: University of Texas Press, 1996).

marriage.[27] Physicians, surgeons, pharmacists, and midwives who provided abortions were treated more harshly. The law barred these specialists from practice if found guilty of providing abortions. Still, they were spared any jail time. In other words, the only people the 1836 law punished with incarceration were unlicensed abortion providers and those who physically assaulted women known to be pregnant.

Peru's next Penal Code, promulgated in 1862, emerged in a context of increased governmental stability, largely due to the wealth generated by the export of guano and the consolidation of the Faculty of Medicine of Lima as the main professional organization in the country.[28] The new Code legislated the question of abortion in greater detail than the previous one, and introduced two important changes.[29] First, women who obtained abortions could end up in jail for up to two years. Still, like the 1836 law, the 1862 law was lenient towards "women of good repute" who sought only to cover up their extra-marital sexuality. The second important change was the harsh punishment doled out to physicians, surgeons, midwives, and pharmacists "who abuse[d] their art" by performing abortions. The jail terms for these practitioners could be as long as five years, longer than the punishment for potions manufacturers and assailants who caused miscarriages.

This turning of abortion into a more serious offense in 1862 was consistent with changes elsewhere, including in the United States and England, where medical professionals lobbied in favor of the criminalization of abortion in the second half of the

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[27] Código Penal del Estado Sud Peruano 1836, Libro III, Título 1, Capítulo 1, artículos 516 and 517. For legal commentary on this Code, see Javier Aljovín Swayne, "El Aborto Terapeutico," (Tesis de Bachiller en Derecho y Ciencias Políticas, Pontificia Universidad Católica del Perú, 1957).
[28] On Peru's mid-nineteenth century guano wealth, see chapter one.
[29] Código Penal del Perú 1862, Libro 2, Sección 7, Título 3, artículos 243-245.

nineteenth century, particularly when performed by non-physicians.[30] However, it is not possible to determine the extent to which Peruvian legislators' and physicians' likely knowledge of these changes influenced the 1862 Penal Code. This is because the *Archivo del Congreso* does not keep a record of the debates that led to the Penal Code modifications. The severity of the penalties in 1862 extended to infanticide, which had not been previously regulated.[31] Women found guilty of this crime could receive jail sentences of up to five years. The sentences for people who assisted them varied between four and twelve years' imprisonment.[32]

Physicians first began to write about abortion in the early 1890s. The earliest pertinent work is that of clinicians working in the city of Lima and appears in the form of medical theses.[33] These theses discussed obstetric cases in detail, and reached conclusions inductively. Cáceres, for example, argued that most pregnancy loss cases he treated were spontaneous and not induced. A complex and common pathology affected by genetics, the environment, and a woman's temperament, pregnancy loss occurred most frequently to women whose bodies were weakened by repeated sexual activity, such as prostitutes.[34] Gavidia too argued that pregnancy losses were common and unintended, the result of a

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[30] J.C. Mohr, Abortion in America; Barbara Brookes, Abortion in England, 1900-1967 (London: Croom Helm, 1988).
[31] Código Penal del Perú 1862, Libro 2, Sección 7, Título 2, artículo 242.
[32] Prison (*prisión*) terms were different from jail (*cárcel*) terms, even though time served as inmates might be similar. Prison terms carried, in addition to the time served, the suspension of civil rights during imprisonment and for up to seven years after release from prison, as well as a probation period of up to five years, depending on good behavior. Jail terms carried the suspension of civil rights during confinement and a probation period of up to two and a half years.
[33] I located 218 medical theses on obstetrics and gynecology written between 1890 and 1976 at the historical archive of the Faculty of Medicine of San Marcos University in Lima.
[34] Ismael Cáceres, "Patogenia y Etiología del Aborto," (Tesis de Grado, Facultad de Medicina de San Fernando, 1891).

woman's body's weak grip on the growing fetus. Physical traumas and diseases further debilitated the body's ability to hold on to the fetus, and led to its premature expulsion.[35] Syphilis was among the most dreaded diseases, because of its link to stillbirths, premature births, and the birth of weak and low-weight infants, which in turn affected the quality and quantity of the country's population.[36] Basadre criticized the use of corsets, which prevented proper oxygenation of the body and could cause miscarriages. He urged women to remember that "lack of air leads to the weakness of important organs" needed to nurture a fetus and give birth, and that children born under these circumstances would be "incapable of fulfilling their duties to the fatherland."[37]

There was little for physicians to do for women hospitalized after miscarrying, beyond curettage and bed rest. Parisian gynecologist Joseph Récamier had introduced the curette to scrape off infected tissues in the uterus around 1850.[38] However, the procedure did not become safe for obstetric use until the development of analgesics (to reduce the pain of dilating the cervix) and Lister's invention of antisepsis in the 1860s.[39] Peruvian gynecologists embraced Récamier's device and publicized the dilation and curettage procedure enthusiastically in the late nineteenth century, celebrating it as a radical step

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[35] Agustín Gavidia, "El Aborto como Accidente Espontáneo o Patológico en el Curso del Embarazo, (Tesis de Grado, Facultad de Medicina de San Fernando, 1904).
[36] Guzmán Rodriguez, "Profilaxis de las Enfermedades Venéreas"; Pedro Villanueva, "Estenosis del Orificio Uterino y Sifilis Conyugal," La Reforma Médica 2, 26-28 (30 September 1916): 99-100.
[37] Eduardo Basadre, "Ligeras Consideraciones sobre el Uso Prematuro y el Abuso del Corsé," (Tesis de Grado, Facultad de Medicina de San Fernando, 1907: 4).
[38] Joseph Récamier, "Memoire sur les Productions Fibreuses et Fongueses Intra-Uterines," cited in H.A.M. Brölmann, F.P.H.L.J. Dijkhuizen and B.W.J. Mol, "The Clinical Importance of the Microcurettage," Reviews in Gynaecological Practice 4 (2004): 58–64.
[39] David, "Abortion in Europe, 1920-91"; de Brouwere, "The Comparative Study of Maternal Mortality."

forward in surgical therapy, thanks to its ease and low cost.[40] Molina touted its potential to revitalize the uterus by arguing that the dilation and curettage procedure "fertilized barren fields; thanks to the scraping technique many marriages that had lost all hope for offspring have fulfilled their ambitions."[41] Physicians such as Beraún went further, indicating that anesthesia was not always necessary for the dilation and curettage to succeed, as the uterus, in his view, was not a very sensitive organ. Perhaps unwittingly revealing that diverse groups of women had abortions, Beraún bragged that he had carried out the procedure on "delicate whites, nervous and excitable blacks, and resigned and apathetic Indians" in just fifteen minutes and without the help of an assistant.[42]

These early medical treatises on pregnancy loss reveal the importance of French puericulture on Peruvian medicine in two ways.[43] First, pregnancy loss was defined as a kind of pathology characterized by a female body's inability to hold on to and nourish a growing fetus until ready. Instead of treating instances of pregnancy loss as deliberate, physicians tended to consider these losses as unintended, and adopted leading French puericulturist Adolphe Pinard's penchant for metaphorically linking pregnancy loss to

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[40] Pedro Galup, "Exéresis Parcial del Utero (Curetaje)," (Tesis de Grado, Facultad de Medicina de San Fernando, 1892); Wenceslao Molina, "El Curetaje Uterino," (Tesis de Doctorado, Facultad de Medicina de San Fernando, 1896); A.A. Beraún, "Curetaje Uterino y sus Aplicaciones Terapeuticas," (Tesis de Grado, Facultad de Medicina de San Fernando, 1906). Mexican gynecologists also celebrated the procedure. See A. López Hermosa, "Sobre la Raspa Uterina en Ginecología y Obstetricia," Memorias del Segundo Congreso Panamericano, México 16-19 de Noviembre de 1896, Volumen 2 (México: Hoeck & Hamilton, 1898: 262-266).

[41] Molina, "El Curetaje Uterino," 39.

[42] Beraún, "Curetaje Uterino y sus Aplicaciones Terapeuticas," 15.

[43] For a synthesis of these puericultural ideas as they were adopted in Peru, see Paz Soldán, La Protección a la Infancia en el Perú; and Ricardo L. Cornejo, "Algunas Consideraciones i Observaciones de Orden Etiológico sobre el Aborto Espontáneo Habitual o Reincidente de los Primeros Meses," (Tesis de Grado, Facultad de Medicina de San Fernando, 1931). On puericulture and its founder, the Paris physician Adolphe Pinard, see chapter two.

failed agricultural production: stillbirths and the prematurely born became unripened fruits, curettes became fertilizers, and childless women's uteri became barren fields. Second, physicians believed that weakness was a crucial reason for the female body's inability to protect the fetus. Diseases such as syphilis, tuberculosis and malaria, mental strain, and bodily exertion through excessive physical work and sexual activity purportedly caused this weakness. Thus, Peruvian physicians, like their French colleagues, began to promote the avoidance of weakness-inducing factors in women's lives as a matter of national interest, since population growth was at stake. I will return to the notion of physical strain later, as some women invoked it as the reason why they miscarried.

By the 1910s there was a decisive shift in the methodology and tone of medical investigations of abortion, determined by the specialization of physicians and their awareness of the importance of population growth to national politics. The Chair in Gynecology and Obstetrics at the Faculty of Medicine of Lima (also known as the San Fernando Faculty of Medicine) was established in 1895.[44] Soon, gynecologists began to leverage the topic of pregnancy loss to gain political notoriety and power. Their new works emphasized the collection of hospital statistics, and no longer just the presentation of clinical cases. Likewise, medical texts from this period strongly condemned abortion providers and infanticides, and made policy recommendations to prevent further population losses that included, not surprisingly, more medical oversight of pregnancies.

The new generation of specialists focused also on the city of Lima. In 1917, for example, Dr. Leoncio Chiri became the first to attempt a statistic of pregnancy losses in

[44] Ugarte Taboada, "Historia de los Servicios de Emergencia de Lima y Callao."

the country. He based his calculations on the medical histories collected at the *Maternidad de Lima*, the Santa Ana Hospital, the Bellavista Maternity Hospital in Callao, and the San Juan de Dios Hospital, also in Callao. Chiri found that an average of 34 miscarriages occurred every year between 1908 and 1916 in these hospitals. In every single case, the reason that led to the miscarriage was listed as unknown, but Chiri hypothesized that syphilis was an aggravating factor.[45] Around the time Chiri wrote his thesis, Dr. J.M. Barandiarán began to work on his, using also the medical records of the *Maternidad de Lima* for the year 1920. According to these records, there were 206 cases of miscarriage, stillbirth, and infant death occurring less than five days after birth. Barandiarán did not disaggregate these instances. Consistent with the prevailing medical view of fetal and perinatal death as mere causes of population stagnation, Barandiarán was content to compare the children "lost" in these ways with the 1,539 children that lived long enough to leave the *Maternidad de Lima*, and to pin the losses on the mothers' physical exhaustion.[46] Like Barandiarán, Dr. Humberto Portillo also concentrated on the records of the *Maternidad de Lima* and added to his study those of the Bellavista Maternity Hospital, to compare the rates of stillbirth at the two main maternity hospitals in Lima and Callao. According to his estimate, there were 17,092 live births and 1,197 stillbirths at the *Maternidad de Lima* between 1914 and 1922, as well as 3,004 live births and 111 stillbirths between 1914 and 1923 at the Bellavista Maternity Hospital.[47]

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[45] Leoncio P. Chiri, "Consideraciones sobre la Sífilis y el Embarazo entre Nosotros," (Tesis de Grado, Facultad de Medicina de San Fernando, 1917).
[46] Barandiarán, "Descanso y Protección de la Mujer Embarazada."
[47] Humberto Portillo B., "El Problema de la Natimortalidad en Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1925).

All of these researchers complained that their work had been hindered by the incompleteness of the available medical histories, and urged a more careful keeping of medical records. It is possible that poor record keeping was responsible for their failure to identify the specific causes that led to the pregnancy losses they attempted to count. Portillo's thesis, for example, does not indicate how he determined the difference between stillbirth and infanticide, yet there were concerns that infanticide could be confused with stillbirth, and that the former was even more common than abortion.[48] The feature that defined a newborn was whether the child had ever breathed air. It was a standard adopted from Napoleonic France, one that likely predated 1811.[49] The standard was based on the notion that, although fetuses grew and developed in the womb, they were still dependent on a woman's body for nourishment and thus not separate from that body. This changed the moment infants were born and were able to breathe on their own. Although infants were still unable to fend for themselves, the air in their lungs and their ability to expel it through crying was a turning point in their achieving personhood status, medically speaking. The distinction had legal implications as well, according to the 1862 Penal Code: killing a breathing infant was considered infanticide, a severely punishable crime, whereas the death of a newborn that had not breathed was considered a stillbirth, a tragic accident.[50]

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[48] Avendaño and Fernandez-Davila, La Despoblación; Herón Frisancho, "Mortalidad Infantil y Movimiento Demográfico en la Ciudad de Puno".

[49] Michael Obladen, "History of Surfactant up to 1980," Biology of the Neonate 87 (2005): 308-316.

[50] Statistics about infanticides during this period were as difficult to gather as those about miscarriages and stillbirths. This was due to both poorly made histories, and to the inherent difficulties of forensic analysis. Only two researchers attempted systematic studies. See Francisco Changanaquí E., "Algunos Casos de Infanticidio en Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1916); and Alejandro Mercado B.,

The suspicion that abortion and infanticide occurred often led well-known physicians to suggest legal changes. Dr. Leonidas Avendaño, Professor of Legal Medicine at the Faculty of Medicine of Lima, supported mandatory public registration of all pregnancies and the liberalization of paternity lawsuits.[51] Earlier, Avendaño had made a proposal to the Fifth Latin American Medical Congress of 1913 to mitigate the guilt of "women of good repute" who killed their newborns "at birth or immediately after" so they would not be humiliated when it became generally known that they had conceived outside the bounds of marriage.[52] Leniency for women of good repute was necessary, according to Avendaño, because "society is not kind to dishonored women," that is, women whose pregnancies resulted from extramarital sex. Knowledge of this imminent social shunning "overexcites her nervous system to the maximum, as do the natural processes of giving birth and the efforts she makes to extinguish her own birthing pains," leading an otherwise "exemplary woman" to kill a newborn.[53]

Avendaño was not the only one to support leniency for women who committed infanticide. In 1915, led by *Diputado* for Lima Víctor Maúrtua, the Peruvian Congress began work to upgrade the 1862 Penal Code. Maúrtua himself introduced an infanticide bill that exempted women from responsibility if they acted within what he called the "puerperal period", that is, the period that immediately followed a birth. Maúrtua

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"Contribución al Estudio del Infanticidio en Lima" (Tesis de Grado, Facultad de Medicina de San Fernando, 1921).

[51] Avendaño and Fernandez-Davila, La Despoblación.

[52] The Fifth Latin American Medical Congress met in the city of Lima. See Anales de la Facultad de Medicina de la Universidad de San Marcos, 1913: 106.

[53] Leonidas Avendaño, "Ponencia ante la Primera Conferencia Nacional del Niño Peruano de 1922," Anales de la Facultad de Medicina de la Universidad de San Marcos 5, 2 (July-August 1922): 109. Note the similarities with the Argentinian case discussed by Ruggiero, Modernity in the Flesh.

suggested that the strain of labor left women temporarily physically and mentally unable to care for an infant and made it more likely for some to commit "unnatural" acts.[54] Maúrtua's proposal was different from Avendaño's in that it did not make a woman's "good repute" a prerequisite to benefit from the law.

Congress's work on a new Penal Code began in 1915. It continued after the election of Augusto B. Leguía as President in 1919, and concluded in 1924. The new Penal Code stipulated jail penalties for women who caused their own miscarriages (up to four years), for abortion providers who had the woman's consent (up to four years, and up to six if the woman died as a result of the intervention), for providers who acted without a woman's consent (up to ten years), and for those who caused a woman to miscarry unintentionally through an assault (up to two years).[55] In addition, the Code adopted a modified version of Víctor Maúrtua's infanticide bill. Women who killed their newborns during birth or "under the influence of the puerperal state" could be jailed for up to three years.[56] Unfortunately, the Code did not specify the duration of the "puerperal state", a loophole that could in theory open the door to gross abuses.

An important change introduced in the 1924 Penal Code was the legalization of therapeutic abortion, which was defined as an abortion carried out by a physician with a woman's consent, "if there is no other way to save the mother's life or avoid a permanent and grave injury."[57] Unfortunately, the *Archivo del Congreso* did not record the debates of the Congressional commission that crafted the 1924 Penal Code, and that led to the

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[54] ACP: Víctor Maúrtua, "Proyecto de Ley sobre el Infanticidio, Artículos 129 y 130," 1916.
[55] Código Penal del Perú 1924, Libro 2, Sección 1, Título 2, artículos 159-164.
[56] Código Penal del Perú 1924, Libro 2, Sección 1, artículo 155.
[57] Código Penal del Perú 1924, Libro 2, Sección 1, artículo 163.

legalization of therapeutic abortion. However, this legal change was in keeping with changes in penal law in other countries.[58] Moreover, as previously argued, medical research on the frequency of miscarriages, stillbirths, and infant deaths in the 1910s suffered because of the incompleteness of records showing the cause of death. Physicians were aware of their colleagues' practice of omitting this data when they had induced an abortion, as will be shown in the next section. It is possible that these researchers thought the legalization of therapeutic abortion would encourage a more complete and honest recording of clinical histories. In addition, as shown above, physicians considered dilation and curettage a safe, inexpensive, and fast procedure. Allowing this to be an alternative for women might bolster physicians' prestige and incomes, and would also dissuade women from attempting other, presumably more dangerous, ways to end a pregnancy.

These possibilities notwithstanding, there was little debate in Peruvian medical circles about the need for physician-controlled therapeutic abortion before 1924, nor advocacy by physicians to secure the privilege. This makes it difficult to determine how desirable the monopoly of therapeutic abortion was for Peruvian physicians. In fact, some medical doctors did not celebrate the legalization of therapeutic abortion because, they feared, it could lead to greater popular demand for abortion services. As Professor of Legal Medicine Fernández Dávila put it,

> "long past are the times when an abortion was the result of the desperation of honest women following a moment of weakness. […] Today, women of all social classes ask us directly and almost daily for abortions, giving banal and untrue

[58] Between 1916 and 1923, for example, Argentina, Uruguay and Chile legalized therapeutic abortions when a pregnancy endangered a woman's life.

> justifications, with the same equanimity and assertiveness with which they demand remedies for common discomforts. Our refusal irritates them; it makes them hold us in contempt and mistrust us […] The carefree procreators will always find someone to get rid of the seedling we respected, because these days criminal abortions are a lucrative industry and its practitioners are legion."[59]

It is clear, then, that some physicians worried about two potential consequences of the legalization of therapeutic abortion. One was an increase in the demand for abortions that would overwhelm the capacity of medical professionals to provide these services, and thus encourage the growth of a profitable industry in which the participation of non-physicians would be inevitable. The other was the strengthening of a carefree attitude regarding procreation, as safe abortions could separate sex from pregnancy, and encourage men and women to see each other erotically, and not as long-term partners in a Catholic marriage.

Faced with a presumed potential explosion in the demand for abortions, a few professionals thought it important to document and denounce cases of illegal abortion.[60] Daniel Fosalba y Muro analyzed 2,831 clinical histories of women hospitalized after miscarrying at the Arzobispo Loayza Hospital and the Bellavista Maternity Hospital between 1923 and 1928. He found that approximately 3.3 percent of these women had complied with the criteria specified for the performance of a therapeutic abortion by a physician (to save the mother's life or avoid a permanent and grave injury). An additional

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[59] Guillermo Fernández Dávila, El Delito de Aborto (Lima: Lux, 1926: 22).
[60] Daniel A. Fosalba y Muro, "La Excusa Absolutoria del Aborto Científico," (Tesis de Grado, Facultad de Medicina de San Fernando, 1929); Juan M. Escudero Villar, "Contribución al Estudio del Aborto," (Tesis de Grado, Facultad de Medicina de San Fernando, 1930); Carlos Enrique Paz Soldán, "Editorial," La Reforma Médica 19, 165 (15 Junio 1933): 197-198.

13.84 percent miscarried due to complications arising from malaria, 9.56 percent miscarried due to some form of physical trauma, 8.06 percent miscarried due to syphilis, and only 1.16 percent miscarried due to abortions performed illegally. Significantly, Fosalba y Muro classified the causes of most miscarriages as unknown, due to the incompleteness of medical records.[61]

The same incompleteness of medical records beleaguered Fosalba y Muro's colleague, Dr. Juan Escudero. His analysis of clinical histories at the Arzobispo Loayza Hospital between 1925 and 1929 identified 1,174 cases of miscarriage. Yet, he was able to find complete records for only 83 patients. Of these, 27 women had spontaneous miscarriages; 9 were therapeutic abortions; 17 miscarried due to accidents, 24 due to various pathologies, and 6 due to physical trauma. Like Fosalba y Muro, Escudero suspected that the missing records hid a significant number of criminally induced abortions, but he went no further with his suspicions. However, Escudero was sympathetic to the reasons that drove women to seek abortions, including the fear of not being able to work, or of being dishonored by an out-of-wedlock pregnancy.[62] In such cases, Escudero noted, women's partners played a role in helping them get abortions. Conversely, pregnancies resulting from the violent acts of partners who cheated on them

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[61] Fosalba y Muro, "La Excusa Absolutoria," np.

[62] Several other physicians emphathized with the economic argument that led women to seek abortions. See Ernesto Tello Morales, "Causas de Muerte Materna en la Maternidad de Lima, 1947-1952," (Tesis de Grado, Facultad de Medicina de San Fernando, 1953); Antonio Amorín V., "Causas de la Mortalidad Fetal y la Neonatal en el Callao," (Tesis de Grado, Facultad de Medicina de San Fernando, 1953); Carlos Alberto Quintana Flores, "Contribución al Estudio del Problema Social y Médico Legal del Aborto: Estudio Estadístico de la Ciudad de Pisco," (Tesis de Grado, Facultad de Medicina de San Fernando, 1955).

and consumed drugs and alcohol were "repugnant" to women, and also led them to seek abortion services, albeit on their own.[63]

Some years later, Dr. Carlos Olascoaga admitted that physicians seldom documented their suspicions regarding induced abortions, much less bothered to alert the police, when women were not forthcoming about the reasons for their hospitalization.[64] This helps explain, to some extent, the dearth of complete clinical histories that troubled researchers such as Fosalba y Muro and Escudero. Further, Escudero's compassion toward women who sought abortion reveals reasons why physicians would not bother making accusations, even when they could. Without minimizing the demographic and ethical hazards posed by abortion, some physicians favored greater knowledge and not repression as a long-term solution. As Professor of Obstetrics Alejandro Busalleu put it in his inaugural lecture,

> "there are socially caused problems the future physician will face every day. One above all must be decidedly remedied: criminal abortions. Their frequency threatens our population and undermines our society's concepts of morality. This is a medical, social, moral, and even philosophical problem of such complexity that its solution will elude the mere enforcement of the [Penal] Code. Only understanding the factors that play a role in it will we be able to solve this problem."[65]

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[63] Escudero Villar, "Contribución al Estudio del Aborto," 3.
[64] Carlos Olascoaga Mar, "Estudio Médico Social del Problema Materno-Infantil en la Ciudad de Tacna," (Tesis de Grado, Facultad de Medicina de San Fernando, 1961).
[65] Alejandro Busalleu. "Lección Inaugural del Curso de Obstetricia," Anales de la Facultad de Medicina de la Universidad de San Marcos 21, 2, (2do Semestre 1938): 225-236, 231. It is interesting to note that US gynecologist Frederick Taussig had published an influential book on abortion just two years earlier, one that emphasized the role that

The call for greater understanding of the social causes of abortion led some physicians to chastise Peruvians for their low rates of marriage. Marriage, these physicians believed, encouraged couples to stay together and raise children properly. Failure to marry encouraged men to abandon their homes, making it more likely for women to commit abortions or become prostitutes.[66] Others believed that a lack of sexual education made it difficult for young women to use their sexuality in a proper manner. For this, the Catholic Church's "deep-rooted inquisitorial prejudices" and its "false and archaic ideas about modesty" deserved part of the blame.[67] Also to blame were women's desires to be the equals of men, which led the former to abandon their homes in search of work, and put them at the mercy of sexual predators.[68] Manuel Salcedo, Director of the Ministry of Health's Department of Maternal and Child Protection, blamed both children's work and working women for "deforming the character" of new generations,

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physicians could play in preventing abortions by understanding the reasons why women sought out those interventions in the first place. Still, it is not easy to determine how influential such treatise was among Peruvian physicians. See Frederick Taussig, Abortion, Spontaneous and Induced: Medical and Social Aspects (St. Louis, Missouri: Mosby, 1936).

[66] Samuel Gajardo, "Las Deficiencias del Hogar como Factor de Delincencia de Menores," La Acción Médica (2 November 1929): 1-2, 15; Frisancho, "Mortalidad Infantil y Movimiento Demográfico en la Ciudad de Puno." The extended Catholic family, with a male breadwinner and a female moral compass, was an ideal extended throughout Latin America. See Kuznesof and Oppenheimer, "The Family and Society in Nineteenth-Century Latin America"; Peter Beattie, "The House, the Street, and the Barracks: Reform and Honorable Masculine Social Space in Brazil, 1864-1945," Hispanic American Historical Review 76, 3 (1996): 439-473; Findlay, Imposing Decency; Rosemblatt, Gendered Compromises.

[67] "Aspectos Sociales de la Educación Sexual," La Acción Médica (9 November 1929): 3. See also "El Papel Preponderante de la Madre en la Educación Sexual de sus Hijos," La Acción Médica (16 November 1929): 10-11.

[68] Jorge Avendaño, "¿Hay Jerarquía en la Sociedad Conyugal?" Nuestros Hijos 3, 14 (December 1955): 7-8; Helio Castellon, "¿Está Masculinizándose la Mujer que Trabaja?" Ñusta: Revista Peruana Femenina 1, 5 (Noviembre 1957): 7-9-75.

rendering them more likely to commit crimes.[69] Salcedo's corollary was an exhortation to jumpstart the civic education of men and women to understand their "natural" roles within a patriarchal family structure, a proposal that gathered steam among prominent Peruvian female and Catholic intellectuals and even in Congress.[70]

Of course, not all physicians were as keen to learn why people sought abortions, or to delve into the intricate links between familial anomie and delinquency. Professionals who only sought punishment for seekers and providers of abortion aimed their vitriol at midwives, traditional birth attendants, pharmacists, and some of their own colleagues, accusing them of practicing abortions liberally as a way to make a living.[71] Dr. Leonidas Avendaño, for example, reserved special contempt for the "ignorant women responsible for the horrible scenes seen in dark alleys and tenements, dirty and nauseating dives both, starring a rustic patient, resisting all hygienic practices, and a stupid woman who does not hesitate to sacrifice a life or two for a few cents snatched from the naïve

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[69] Manuel Salcedo F., "Infancia Abandonada en Peligro y Peligrosa," Boletín del Departamento de Protección Materno Infantil 4, 15-16 (1944): 11-32, 13.

[70] Elvira García y García, La Mujer y el Hogar (Lima: Miranda, 1946); Froilán Villamón Haltenhof, "El Derecho de Nacer y la Conservación de la Especie," Revista Peruana de Obstetricia 3, 1 (1955): 7-26; Irene Silva de Santolalla, Intentando la Solución de ¡El Gran Problema! (Lima: Salas, 1957); Irene Silva de Santolalla, "La Eugenesia," Ñusta: Revista Peruana Femenina 1, 9 (March 1958): 36, 42. See also Humberto Velásquez Pitta, "La Ginecología en los Servicios Médicos de la UNMSM," Boletín de los Servicios Médicos de la Universidad Nacional Mayor de San Marcos 6, 11 (November 1952): 5-7, for an amusing, if rather sexist, take on how female university graduates' "intellectual and corporal work" and their "exaggerated sexual lives" exacerbated their pathologies, risking their future maternal potential. In addition, the Peruvian Congress passed a law to teach "family skills" to male and, especially, female elementary school students in 1957. See ACP, Ley 12818: "Creando la 'Hora de Educación Familiar' en los Centros Docentes que se Indican," (15 Marzo 1957).

[71] Pedro Valle Medina, "Contribución al Estudio del Problema Social y Médico-Legal del Aborto en el Callao," (Tesis de Grado, Facultad de Medicina de San Fernando, 1946).

family."[72] Dr. Luis Vargas Prada, Director of the General Office of Sanitation (in charge of all public health matters in Peru) sent a cautionary memorandum to all hospital directors in April of 1933, in which he stated that "[a]bortions induced by unqualified personnel and without therapeutic goals are criminal practices that become more common every day, posing grave risks to pregnant women and society as a whole."[73]

Professor of Social Medicine Carlos Enrique Paz Soldán applauded Vargas Prada's official position. He accused "physicians and midwives without scruples, as well as ignorant *curanderas* who live and profit, immorally, exploiting people's naïveté and disgrace" of being the culprits behind a supposed rising tide of abortion. With quixotic enthusiasm, Paz Soldán began a campaign to drag illegal abortion practitioners out in the open. Since he could not count on his colleagues to provide all the help he needed, he called on health workers in general to feed him tips "every time hospitals admit cases in which you suspect abortive maneuvers without therapeutic aim. We will investigate confidentially and make the appropriate accusation at the Public Defender's Office."[74] I could not find any evidence that Paz Soldán ever made a single accusation, much less one leading to an arrest or trial, at least in Lima, where he began his campaign.[75] Paz Soldán's, however, was not the last attempt to flush out illegal abortion providers. President José Luis Bustamante y Rivero established medical oversight committees in

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[72] Cited by Vidal, Historia de la Obstetricia y Ginecología en el Perú, 49. Though undated in Amat y León's text, Avendaño most likely made this statement while he was a Professor of Legal Medicine at the Faculty of Medicine of Lima between 1919 and 1930.
[73] Luis Vargas Prada, Director General de Salubridad, "Circular No. 7 a los Médicos Directores de Hospitales," (10 April 1933), cited in La Reforma Médica 19, 165 (15 Junio 1933): 197.
[74] Carlos Enrique Paz Soldán, "Editorial," La Reforma Médica 19, 165 (15 June 1933): 198.
[75] However, the Penal Archive of Lima lost the records between the years of 1933 and 1938. Thus, it is possible that some of Paz Soldán's accusations have been lost.

Peru's major hospitals in 1946.[76] One of the functions of these committees was to denounce the illegal practice of abortion by physicians. However, there is also no evidence in Peruvian archives that any of these committees ever initiated a criminal abortion accusation. Much later, this failure became one of the reasons for the implementation of the 1997 Sanitary Law, which criminalized the failure to report suspected cases of abortion to police authorities.[77]

Physicians began to weigh in more explicitly on the nation's rates of maternal mortality in the 1940s, a shift in Peruvian medical practice that had two important consequences.[78] First, new research called attention to the fact that puerperal infections acquired in hospitals and health centers caused as many, if not more, maternal deaths than complications related to induced illegal abortions. Landaburú, for example, found that 10 out of the 94 parturient women who died at the *Maternidad de Lima* in 1945, died as a result of puerperal infections and 13 as a result of abortion-related complications.[79] By 1950, puerperal infections at the same hospital were responsible for twice as many maternal mortalities as were abortion-related complications (22 and 11, respectively, out

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[76] José Luis Bustamante y Rivero, "Decreto Presidencial 24 Mayo 1946," cited in "Regulacion de la Fecundidad," mimeographed document, 1979 (Centro de Documentación de la Mujer Peruana, CENDOC-Mujer).
[77] See Rousseau, "The Politics of Reproductive Health in Peru."
[78] López Cornejo, "Las Realidades de la Asistencia del Parto en el Perú"; David U. Barreto P., "Problema Materno-Infantil en Iquitos," (Tesis de Grado, Facultad de Medicina de San Fernando, 1945); Juan E. Landaburú Soubise, "Contribución al Estudio de la Mortalidad Materna," (Tesis de Grado, Facultad de Medicina de San Fernando, 1946); Jesús Untiveros Morales, "La Frecuencia de los Abortos en Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1946); César Frías Ocampo, "Causas de Internamiento y de Muerte en la Maternidad de Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1951); Alejandro Neyra Mosquera, "El Problema Médico Legal y Médico Social del Aborto en el Perú," (Tesis de Grado, Facultad de Medicina de San Fernando, 1951); Quintana Flores, "Estudio Estadístico de la Ciudad de Pisco."
[79] Landaburú, "Contribución al Estudio de la Mortalidad Materna," 42, 100.

of a total of 59 fatalities).[80] Second, the new research showed that abortion-related complications required surgery more often than any other obstetric complication. Landaburú found that 55 percent of all 5,887 surgical interventions on women between 1925 and 1945 at the *Maternidad de Lima* were dilation and curettage procedures to heal a woman after a botched abortion.[81] Similarly, according to Frías, the majority (44 percent) of all 1,470 surgeries at the *Maternidad de Lima* in 1950 were dilation and curettages following induced illegal abortions.[82]

The demand for dilation and curettage created pressures on hospital surgical services, not only for anesthetics and antibiotics, but also for blood. A blood bank was established at the *Maternidad de Lima*, the largest maternity hospital in Peru, in 1949.[83] The supply of antibiotics became more efficient throughout several Peruvian hospitals and health centers in the early 1950s, thanks to two related developments.[84] First, the Second World War increased the prices of commodities Peru produced and exported, and President Manuel Prado y Ugarteche allocated some of the income generated to improve the country's medical services.[85] Constantino Carvallo, Peru's longest-serving Minister of Health, administered these resources between 1939 and 1945 to improve the country's

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[80] Frías, "Causas de Internamiento y de Muerte en la Maternidad de Lima," 33-34.
[81] Landaburú, "Contribución al Estudio de la Mortalidad Materna," 173. Vaginal tears were the next most common intervention, making up 25 percent of all surgeries.
[82] Frías, "Causas de Internamiento y de Muerte en la Maternidad de Lima," 11. Vaginal tears were the next most common intervention, making up 19 percent of all surgeries.
[83] Tello Morales, "Causas de Muerte Materna en la Maternidad de Lima, 1947-1952."
[84] On the introduction of antibiotics in Peru, see Instituto Nacional de Planificación, "Plan Nacional de Desarrollo Económico y Social del Perú, 1962-1971." On the worldwide diffusion of antibiotics, see Robert Bud, Penicillin: Triumph and Tragedy (Oxford: Oxford University Press, 2007).
[85] On the Prado presidency, see Dennis Gilbert, La Oligarquía Peruana: Historia de Tres Familias (Lima: Horizonte, 1982); and Felipe Portocarrero, El Imperio Prado, 1890-1970 (Lima: CIUP, 1995).

health infrastructure. Second, US President Franklin Delano Roosevelt had embraced a "Good Neighbor Policy" towards Latin America.[86] As part of this new foreign policy, the US funded what became known as the Inter-American Cooperative Service for Public Health (SCISP, after its initials in Spanish). The SCISP in Peru worked on a variety of health projects, including malaria control, water sanitation, obstetric care, training of health personnel, and the management of health centers. The SCISP was also involved in setting up distribution chains of medications, including antibiotics and sulpha drugs, to some of the poorest regions of rural Peru.[87]

In sum, in the first five decades of the twentieth century, the medical profession participated in national debates about pregnancy loss in a variety of ways. Some physicians, following Hipólito Unanue, treated instances of miscarriage and abortion as causes of demographic stagnation.[88] For other physicians, deliberate pregnancy losses became opportunities for physicians to make moral judgments about Peruvians. Sometimes these judgments were somewhat benign, for example when they revealed physicians' sympathy for the plight of sexually scorned women, or that of women and men concerned with the employment opportunities a new child would foreclose. Other

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[86] On the Good Neighbor Policy, see Fredrick Pike, FDR's Good Neighbor Policy: Sixty Years of Generally Gentle Chaos (Austin: University of Texas Press, 1995).

[87] Established in 1942, the SCISP operated in several Latin American countries as a dependency of local health ministries. Most SCISP employees were local health workers, but a few, especially the top decision-makers, were highly trained US technical experts paid by the US government. On the health care assistance Peru received from the US, see Jonathan B. Bingham, Shirt-Sleeve Diplomacy: Point 4 in Action (New York: J. Day Co., 1954: 19); Alfredo Lynch C., "Una Experiencia Medico-Social en el Departamento de Ica," (Tesis de Doctorado, Facultad de Medicina de Lima, 1955); and Marcos Cueto, The Value of Health: A History of the Pan American Health Organization (Rochester: University of Rochester Press, 2007).

[88] See chapter one for a discussion of Hipólito Unanue's views on medicine and demographic growth.

times, these judgments were harsh, especially when physicians sought to distinguish themselves from the non-physicians who also provided abortions without the legal protection that the 1924 Penal Code afforded to therapeutic abortions. It is important to place these harsh judgments in the context of the professionalization of Peruvian medicine in the early twentieth century.[89] Attempting to assert their power, medical professionals attacked potential competitors, such as midwives and folk healers, who also provided abortions.

This jurisdictional competition and physicians' texts indicate that abortion was a widespread means to avoid having children in Peru in this period, one used by women of different income and racial groups. Yet, by the late 1940s, the trend towards preventive medicine, exemplified by Peru's SCISP, helped raise the awareness of public health professionals regarding maternal mortality. Abortion was still an important medical topic, but increasingly only as a contributor to maternal mortality and morbidity rates. An important question concerns the translation of these fifty years of medico-legal debates into medical practices of reporting the abundant suspected criminal abortion activities.

Why Were Abortions So Rarely Investigated as Crimes?

Despite physicians' rhetoric about the threat abortion posed to the family, the profession, and the nation, their contribution to bringing abortion seekers and providers to justice was minimal between the 1890s and the 1940s. I came to this conclusion after reviewing all available criminal records at two Peruvian archives, the *Archivo General de la Nación* (AGN, in Lima, the country's largest historical archive), and the *Archivo*

[89] See Cueto, Excelencia Científica en la Periferia.

Regional de la Libertad (ARL, in Trujillo).[90] I found that only two cases out of 1,496 in the first archive, and five cases out of 540 in the second, dealt with suspicious miscarriages or abortions. Of these seven, only one began because of a physician's action. In this section, I account for this small number of cases, and argue that sympathy for hospitalized women and concerns for their own careers were important reasons for which physicians left out their suspicions about abortion from medical histories and did not report them to the police. The fact that these omissions were within the law protected their inaction. In addition, hospitalized women's refusal to confirm physicians' suspicions of induced abortions through a confession made it difficult for physicians to make these accusations. In fact, some women's accounts of their miscarriages fit medical explanatory schemes well, which also provided some protection from prosecution.

Above, I aluded to some of the reasons why physicians left their suspicions of induced illegal abortion out of the clinical histories they recorded. Namely, sympathy towards women who wished to keep their out-of-wedlock pregnancies secret and towards those who could not afford another child financially might have prevailed upon physicians' duty to denounce crime. Of course, making criminal accusations also required additional work, which busy physicians might have been glad to avoid. In addition, self-interest also made physicians reluctant to make criminal accusations when they suspected

[90] The AGN has 1496 unindexed transcripts of criminal records from 1895 until 1919, all of which correspond to the *departamento* of Lima. There are more criminal record transcripts for Lima at the *Archivo Penal*, but the transcripts between 1920 and 1937 have been lost or misplaced, and I found no abortion cases at the Archivo Penal between 1938 and 1949, the period covered by this chapter. The ARL has 540 unindexed transcripts of criminal records between 1895 and 1944, all of which correspond to the *departamento* of La Libertad.

an abortion had occurred. This was particularly clear when physicians dealt with an upper-class clientele keen on not making their private affairs public.

Dr. Montoya, for example, described the case of Mrs. "N.N.", a well-off 37-year-old married woman of Lima, who did not have any children, "despite her not taking contraceptive precautions."[91] Her husband had left on a seven month-long trip and, shortly after his return, a kerosene stove exploded in their home. Shaken, Mrs. N fell and noticed she was bleeding from her genitals. The doctor who admitted her found "symptoms of an induced abortion" when he examined a clot that came out of Mrs. N that resembled ground meat.[92] Mrs. N's husband took this as evidence that she had cheated on him while he was away, and demanded a divorce. However, Mrs. N's personal physician, R. Colareta, had a colleague run pathology tests on the clot. Upon closer inspection, the diagnosis was amended: the clot was now pronounced a uterine cyst. By then, however, the husband was upset and the wife resentful. This medical mistake had so damaged this marriage that Montoya feared a civil lawsuit against his colleague was imminent, and used this experience as a cautionary tale for other physicians to diagnose abortions as such only with the utmost care.[93]

Out of concern for their own careers, physicians to the wealthy were careful not to identify their clients by name, and to go to great lengths to protect them from scandal. This helped ensure the ongoing patronage of these clients. Dr. Ismael Cáceres, for example, discussed the abortion of Mrs. "C.G. de G" in 1891. A white, upper-class

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[91] José Julio Montoya M. "Estudio Médico Legal sobre un Caso de Pseudo-Embarazo y Pseudo-Aborto," (Tesis de Grado, Facultad de Medicina de San Fernando, 1941: 3).
[92] Montoya, "Estudio Médico Legal," 4.
[93] Indeed, Peru's 1936 Civil Code, article 1136 estipulated that "Anyone who by his acts, carelessness or imprudence, causes a damage to another, is obligated to indemnify it." In this case, the misdiagnosis could be interpreted as careless and damaging to the marriage.

married woman of 22 from Lima, Mrs. G had been married at 15. She had heard that sodium silicate could produce a miscarriage when taken in repeated doses. Mrs. G engineered her own abortion by having a servant purchase a large amount of the chemical. She instructed her servant to tell the pharmacist that sodium silicate was intended to help cure a sudden rheumatic pain on the small toe of her right foot. Mrs. G took the drug for two days and finally overdosed on it, experiencing pain and bleeding. Dr. Cáceres, her personal physician, was summoned to the scene. He prescribed sulphuric lemonades and a laudanum enema to prevent an abortion. Nevertheless, the attempt succeeded.[94] Tellingly, Cáceres did not include Mrs. G's confession in her medical history, nor did he report her to the police. In fact, Cáceres did not even name his wealthy client. However, he named five other women whom he suspected of inducing their own miscarriages: Fidela Reyes, a seamstress, Cecilia Barreto, a washer woman, Escolástica Zárate, a cook, Maria Elena Enríquez, also a cook, and Rosalía Vázquez, a street peddler. From their occupations (indeed, from the very fact that they worked for a living), we can infer that these women were not as wealthy as Mrs. G, and thus were unable to buy the discretion of a personal physician.

However, even women such as these five could protect themselves from criminal accusations by not revealing much about the circumstances that led to their miscarriages. This is exactly what one of the women Cáceres named did. To the latter's frustration, all Fidela Reyes admitted was to feeling ill for ten days before going to the hospital. On the eleventh day, she told Cáceres that she had miscarried the night before and that she felt

[94] Cáceres, "Patogenia y Etiología del Aborto," Observación VI.

less pain since then.[95] It was difficult to obtain these confessions. Physicians such as Marcelino Castellares and Jesús Untiveros remembered obtaining confessions about abortion as small personal triumphs that could help them better diagnose future instances of pregnancy loss, or write more thorough clinical histories.[96] Significantly, neither mentioned bringing criminals to the attention of the police as a goal of getting such confessions. Untiveros bombastically stated that, "I have had to rectify most of the clinical histories in Wing Nine of the *Maternidad* [*de Lima*] after earning the trust of the aborting woman (which is indispensable). I have thus been able to extract declarations about the real cause [of the miscarriage]. But to get such results, one must invest so much patience, be so tenacious, and use so many persuasive means!"[97] Still, just as often, as Dr. Cabrera generously admitted, "women fooled us easily during the interview."[98]

Part of the ease with which physicians were fooled had to do with the common belief in the medical profession that "almost all women know effective contraceptives and abortifacients"[99]: from potions based on rye and celery, to "personal hygiene

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[95] Cáceres, "Patogenia y Etiología del Aborto," Observación I. The refusal to reveal details of their abortions could be rather dramatic. Even after being confronted by the police and physicians at the *Maternidad de Lima* about her aborted fetus, for example, domestic worker Rosa Rosales Sánchez refused to say anything about what happened or even who the father was. See El Comercio (10 March 1954): 6. On police efforts to get truthful accounts about miscarriages from women, see also Leslie Reagan, "'About to Meet Her Maker': Women, Doctors, Dying Declarations, and the State's Investigation of Abortion, Chicago, 1867-1940," Journal of American History 77, 4 (1991): 1240-1264.
[96] Marcelino Castellares Z., "Abortos Espontáneos y Abortos Provocados," Actualidad Médica Peruana 1, 6 (1935): 366-370, 366; Untiveros Morales, "Frecuencia de los Abortos en Lima," 13.
[97] Untiveros Morales, "Frecuencia de los Abortos en Lima," 13.
[98] Francisco Cabrera Castro, "Ensayo de Clasificación de la Etiología del Aborto," (Tesis de Grado, Facultad de Medicina de San Fernando, 1931: 44).
[99] Escudero Villar, "Contribución al Estudio del Aborto," 81.

products."[100] Women also used quinine as an abortifacient, though they claimed to use it to relieve themselves of malarial symptoms.[101] P.M., a 30-year-old *mestiza* from Huaraz, for example, with five live births and a previous miscarriage, diagnosed herself with malaria and procured quinine on her own. At the Santa Ana hospital in Lima, Dr. Beraún performed a dilation and curettage on her, after he found signs of an abortion. He concluded that P.M. had miscarried deliberately, but was not able to make P.M. confirm his suspicions.[102] Of course, these tactics did not always work. The pregnant woman who asked Dr. Gavidia for quinine tablets in his practice at the Bellavista Maternity Hospital did not have symptoms of malaria but, and this is what gave Gavidia pause, she had five children and a previous "suspicious" miscarriage.[103]

The use of plant-derived substances to affect fertility has an even older history than the use of quinine in the Andean region. Polo de Ondegardo, a Spanish chronicler of the Conquest period, refers to the use of herbs to induce sterility, such as the *mallunhua*. Hermilio Valdizán's survey in the early twentieth century identified 28 different plant-based abortifacients and 9 other plant-based substances to increase the likelihood of conceiving.[104] Antúnez de Mayolo indicates that traveling naturalists such as the German Alexander von Humboldt and the French Alcide d'Orbigny had noted the use of Andean

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[100] Escudero Villar, "Contribución al Estudio del Aborto," 3.
[101] We now know that quinine can act as an emmenagogue only when taken in large quantities that make it very toxic. See Andrew Dannenberg, Sally Dorfman, and Jamie Johnson, "Use of Quinine for Self-Induced Abortion," Southern Medical Journal 76, 7 (1983): 846-849; R. McGready, "The Effects of Quinine and Chloroquine Antimalarial Treatments in the First Trimester of Pregnancy," Transactions of the Royal Society of Tropical Medicine and Hygiene 96, 2 (2002): 180-184.
[102] Beraún, "Curetaje Uterino," 45.
[103] Gavidia, "Aborto como Accidente," 70.
[104] Hermilio Valdizán and Angel Maldonado, La Medicina Popular Peruana, Volumen 1 (Lima: Torres Aguirre, 1922: 343).

plants to induce abortion in the nineteenth century. Antúnez de Mayolo also reproduced the list of healing plants that physician Manuel Antonio Osores tested in Chota, in the northern Andes, in 1850. Some of these, like the *misquichilca* and the *panisara* were used "to empty the uterus." Antúnez de Mayolo added his own compilation of substances used, allegedly from time immemorial, to bring about menstruation.[105] Other scholars have since compiled their own lists of Andean abortifacients.[106]

We cannot be certain of the manner in which people learned about these substances. However, it is likely word of mouth played a role. A 1929 survey indicated that Lima pharmacies commonly sold about 165 plant-derived compounds that did not exist in the official contemporary pharmacopoeia. Most of these were native plants that pharmacists carried because customers asked for them and pharmacists were able to purchase from small traders. The majority of these plants were classified as energizing tonics and diuretics; others had anesthetic effects; a few were antidotes for poisons. Still, a good number appear to have functions pharmacists ignored or were unwilling to divulge, and that people yet knew well enough to request. Although somewhat discomforted by this gap between expert and popular knowledge, officers from the Office of Public Sanitation seemed keen to maintain pharmacists' access to these mysterious compounds. State regulators feared that, should pharmacists only be allowed to sell products well known to science, users would be more likely to circumvent the formal

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[105] Santiago Antúnez de Mayolo, Cuadernos de Medicina Popular Peruana 1 (1977): 5.
[106] Carter, "Trial Marriage in the Andes?"; Elois Ann Berlin, "Aspects of Fertility Regulation Among the Aguaruna Jivaro of Peru," in Lucile Newman (ed.), Women's Medicine: A Cross-Cultural Study of Indigenous Fertility Regulation (New Brunswick: Rutgers University Press, 1985); and Millones and Pratt, Amor Brujo.

system, of which the pharmacy was part, and get their desired compounds from non-medically-trained healers.[107]

Social commentary about the presumed extensive local knowledge of emmenagogues in early twentieth-century Peru extended beyond medical circles. Juan José Calle, a state attorney for Peru's Supreme Court wrote of the "many people who, without being medical doctors, are in the business of manufacturing abortifacient medicines and potions, selling them under names that disguise their true purposes, even though they hint as to the effects they will cause."[108] In all likelihood, Calle was not only referring to plant-based potions, but also to patent medicines advertised openly by pharmacies. These included *Agua del Socorro*, which promised to cure "irregularities" in a woman's period and return her to "health, wellness and vigor"; and *Cardui*, "the woman's tonic," which promised to fix period delays.[109]

Despite being discussed fairly often by others, emmenagogue potions were rarely mentioned by women hospitalized after miscarrying, with exceptions such as a Mrs. G. Instead, when physicians pushed women to explain what brought them to the hospital, women often blamed sudden and traumatic external events, such as falls, brusque movements, or emotional distress. Gavidia, for example, reported miscarriages due to moving a heavy sewing machine, and to falling from a chair while sitting on it.[110] Two of

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[107] "De la Vida Farmaceutica," La Acción Médica (23 March 1929): 12. On the role of pharmacies in the distribution of informal substances, see Anne Digby, "Self Medication and the Trade in Medicine within a Multi-Ethnic Context: A Case Study of South African from the Mid-Nineteenth to Mid-Twentieth Centuries," Social History of Medicine 18, 3 (2005): 439-457.
[108] Juan José Calle, Anotaciones y Concordancias al Código Penal (Lima: Congreso del Perú: 1924: 138).
[109] La Prensa (31 August 1916): 3; and La Prensa (3 February 1920): 6.
[110] Gavidia, "Aborto como Accidente," 70.

the seven miscarriages Molina treated with dilation and curettage were due to falls, according to the patients.[111] A. E., whom Beraún treated with a dilation and curettage, miscarried after she "got mad at her family."[112] Escolástica Zárate explained that her miscarriage was due to her having to lift heavy objects as part of her work as a cook. Maria Elena Enríquez claimed that her first pregnancy ended when she fell down a flight of stairs the day before her admittance to the hospital. Rosalía Vázquez said in her interview that she miscarried when she lunged to catch her baby as he was about to fall off a chair. Despite bleeding, she refused to go to the hospital for four more days. Another of her seven pregnancies ended when she watched in shock as her husband was "brutally struck." That time, the fetus was expelled after seventeen days in the hospital. Mrs. Vázquez disposed of it quietly during the night, without any investigation by medical staff.[113]

According to the puericultural tradition that dominated contemporary Peruvian obstetrics, sudden and traumatic external events, pathological, physical or mental in nature, could weaken the female body, even to the extent of making it lose its hold on the growing fetus. This is probably why some women could blame falls, physical effort, and emotional distress for their miscarriages without physicians second-guessing them. As late as 1946, physicians classified falls, physical effort, long trips, and "strong emotions" as causes of spontaneous miscarriages.[114] The fact that different women in a fifty-year

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[111] Molina, "El Curetaje Uterino," np.
[112] Beraún, "Curetaje Uterino," 45.
[113] Cáceres, "Patogenia y Etiología del Aborto," Observación III, IV, and V.
[114] Untiveros Morales, "Frecuencia de los Abortos en Lima," 47. However, within just a few years, falls were no longer deemed so innocent, and began to be listed alongside oxytocic drugs, uterine irrigation and the introduction of solid bodies in the uterus, as the

time span explained their miscarriages in similar ways is important. It suggests the existence of a kind of lay knowledge about the body that linked sudden and traumatic external events to pregnancy loss, a knowledge that some women could strategically use to end their own pregnancies, even though this put them at risk of physical harm.[115] The convergence between this kind of lay knowledge and puericultural ideas was beneficial for women who did not wish to confess to having an abortion, and for physicians who wanted to avoid the attention a criminal investigation would bring. Women who did not wish to explain the circumstances of their miscarriages in detail made some physicians uneasy. But how could the latter, when faced with the resolute silence of women, prove conclusively that something like a fall was more than a terrible accident?

The desire to protect their careers, the sympathy they felt for some women, and the ease with which they could be tricked or denied information, made physicians unlikely to accuse women of the crime of abortion. This unwillingness prevailed despite the fact that medical doctors often witnessed signs of abortions, and performed life-saving interventions on women following botched attempts. In addition, not reporting suspected abortions was criminalized only in 1997. Therefore, the silence of physicians was legal, if controversial, during the period studied. Considering all these obstacles to

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most common methods for the inducement of illegal abortions. See Neyra Mosquera, "El Problema Médico Legal y Médico Social del Aborto en el Perú," 45.

[115] Mexican scholars have also documented the belief that physical exhaustion causes abortions, as well as the technique of lifting heavy weights to induce a miscarriage. See María Eugenia del Valle Prieto, "Parto y Aborto en Algunas 'Ciudades Perdidas' de México," Anales de Antropología (México) 17, 2 (1980): 197-222. "Bad belly" syndrome among Jamaican women is another example of this type of lay bodily knowledge that can be used to mask a deliberate abortion. See E.J. Sobo, "Abortion Traditions in Rural Jamaica," Social Science and Medicine 42, 4 (1996): 495-508.

making effective criminal accusations of abortion, it is not surprising that so few of them exist. The fate of those few is the subject of the next section.

Investigating Pregnancy Loss Accusations

As indicated in the previous section, a review of all 2,036 available criminal records at the *Archivo General de la Nación* in Lima and the *Archivo Regional de La Libertad* in Trujillo yielded only seven cases of abortion. Of these, only one resulted in a conviction. In the previous section I discussed the reasons that made accusations unlikely. In this section I will show that, once abortion investigations began, they faced different kinds of difficulties that made assigning criminal responsibility problematic.

The professional discretion of medical and legal experts was the first of these difficulties. Their power to influence the application of the law could and did lead to cases against presumed criminals being dropped. Dr. Enrique Blondet, for example, alerted the Trujillo police after getting Angélica Luz Fernandes, a 14-year-old domestic worker, to confess why she had been hospitalized. Ms. Fernandes told Dr. Blondet that, while coming back from her employers' house to her mother's one day in June of 1920, she felt pain, miscarried on the side of a road outside Trujillo, and left the fetus there.[116] Of all criminal cases reviewed, this is the only one that began with the intervention of a physician. Acting on Blondet's tip, the police found the body of Ms. Fernandes's fetus, which led to Ms. Fernandes being charged with the crime of infanticide. However, following an examination of the remains, Dr. Blondet determined that the six-month-old

[116] ARL: "Declaración de Angélica Luz Fernandes," (26 June 1920). In Causas criminales, grupo 1050 (1940): Contra Angélica Luz Fernandes por infanticidio. (Hereafter "Fernandes Case").

female fetus, despite having taken a breath of air, "was not properly developed and would have died anyway."[117] It was largely based on this report that the state attorney of Trujillo cleared Ms. Fernandes of any wrongdoing.

A similar case is that of Rosa Huamán de Wong, a 19-year-old homemaker from Trujillo, who accused birth attendant Rosa Valderrama of hoodwinking her out of some money in January of 1940. The investigation went on for over a year, and revealed that Mrs. Huamán had paid Mrs. Valderrama for an abortifacient potion, at which point the latter was accused of practicing medicine illegally.[118] In the end, however, the state attorney of Trujillo acquitted Mrs. Valderrama. For the illegal practice of medicine to be punishable, he wrote, the culprit must "habitually devote herself to the art of curing." Yet in this case, the state attorney believed that Mrs. Valderrama's activities were "a frequent and socially accepted fact among poor people, who have no resources to seek professional assistance when pregnant or about to give birth." Ms. Valderrama, the state attorney ended, "does not treat diseases unknown to her, nor does she treat people unknown to her." He, therefore, dropped all charges.[119]

Like the previous case, this one too highlights the power experts had to influence the application of the law, by disregarding standards (such as breathing on one's own as a sign of independent life), as Dr. Blondet did, or by downplaying the deleteriousness of illegal activities, as the state attorney did in the Huamán case. The Huamán decisión, in addition, harbors a normative elitist assumption about the role of traditional healers such

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[117] ARL: "Informe del Fiscal," (7 July 1920), Fernandes Case.
[118] ARL: Causas criminales, Grupo 1 (1940): "Rosa Huamán de Wong contra Rosa Valderrama Alvarez del Villar por ejercicio illegal de la medicina." (Hereafter "Huamán Case").
[119] ARL: "Informe final del fiscal," (13 January 1941), Huamán Case.

as birth attendants and *curanderos* in society. According to the state attorney, traditional healers steered clear of "diseases unknown" and "people unknown" to them, and their actions were "frequent and socially accepted" among those "who have no resources to seek professional assistance." The acquittal reveals an elitist view that separates "the poor" and their healers from the rest of society. As historians Pablo Piccato and Julia Rodríguez have shown for Mexico and Argentina, respectively, this normalization of the poor as different from the rest of society, with their own pathologies and their own criminal tendencies, was directly correlated with the growing influence of scientific Positivism in governmental institutions, a process also underway in Peru in the early twentieth century.[120] Ironically, in this case, such marginalization and contempt for the poor also protected abortion providers such as Mrs. Valderrama.

A second kind of obstacle to the assigning of criminal responsibility in abortion cases concerns the difficulties investigators had gathering evidence. The accusations against Eudosia Mendoza and Felícita Rebaza for abortion, for example, were weakened because the remains of their allegedly aborted fetuses never turned up.[121] Compounding the lack of evidence was the small number of investigators. Justice of the Peace Gabriel Lira, who accused Mendoza in 1901 in the small town of San Damián, in central Peru, did not even have a staff to conduct an investigation. He was forced to deputize two local farmers, Marcos Chulán and Dolores Hinojosa, and a silversmith, Manuel Martinez, to

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[120] Pablo Piccato, City of Suspects: Crime in Mexico City, 1900-1931 (Durham: Duke University Press, 2001); Rodríguez, Civilizing Argentina.
[121] AGN: Causas criminales, Legajo 14 (1901): "Oficio contra Eudosia Mendoza por aborto," (hereafter "Mendoza Case"); and ARL: Causas criminales, Grupo 7, (1940): "Contra Manuel Díaz Vera en agravio de Felícita Rebaza Valderrama por aborto," (hereafter "Rebaza Case").

assist him.[122] Other times, there were no witnesses to corroborate complainants' accounts. This is what happened to Filomena Ramón, who accused her husband, Ismael Ramón, of beating her to the point of making her miscarry in 1904, in the town of San Pedro de Coayllo, in Peru's south central coast.[123] Doña Maximina de la Vega, a local birth attendant, arrived in time only to see the dead fetus, but no one actually witnessed the assault.[124] Even if there were witnesses, sometimes investigators were not able to maximize their value as accusers. Celia Jara, a 25-year-old homemaker, for example, was accused by "several witnesses" of retaining the services of a skilled male Bolivian abortionist in June of 1940.[125] In a display of unorthodox investigative skills, the police did not indicate the number or the names of the witnesses, nor how they figured out the man was Bolivian or an abortionist. The same witnesses could not offer any help locating the mysterious Bolivian, and the state attorney had to withdraw the accusation against Celia Jara.[126]

These cases highlight the budgetary and technical competence constraints faced by the Peruvian judiciary throughout the period studied. Judging from the kinds of criminals found in Lima's prisons in this period, more state resources were devoted to the apprehension of thieves and murderers than to that of abortionists. In the absence of funds and trained personnel, gathering criminal evidence of abortions would have been

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[122] AGN: "Oficio contra Eudosia Mendoza por aborto," Mendoza Case.
[123] AGN: "Declaración de Filomena Ramón," (13 August 1904), in Sección Causas criminales, Juzgado de Primera Instancia de Cañete, Legajo 28 (1903-1904), Número 55: "Contra Ismael Ramón por maltrato." (Hereafter "Ramón Case").
[124] AGN: "Declaración de Maximina de la Vega," (13 Agosto 1904), Ramón Case.
[125] ARL: Grupo 8 (1940): "Contra Celia Jara Sanchez y un Boliviano desconocido por su propio aborto en agravio de la misma Jara Sanchez," (13 June 1940). (Hereafter "Jara Case.") La Encalada was a sugar cane plantation. On the plantations of northern Peru in this period, see Klaren, Formación de las Haciendas Azucareras.
[126] ARL: "Informe final del fiscal," (3 February 1941), Jara Case.

difficult.[127] Moreover, the case against Eudosia Mendoza reveals that the very meaning of "criminal evidence" was contested. After Ms. Mendoza's miscarriage, her father, Anselmo Mendoza, 54, came home to find her lying in bed. He declared that he kept this incident secret because "no one was guilty", since "the creature had been born dead" because of "the strain of lifting a heavy thing." Moreover, Mr. Mendoza buried the fetus immediately in a field because "the creature had not been baptized."[128] Mr. Mendoza's actions illustrate another documented belief in rural areas of Andean countries: that the unbaptized dead may become dangerous and vengeful spirits. If they are not buried rapidly, they pose a particular threat against the woman who expelled them from her womb, and against her living children. The aggressiveness of the unbaptized unborn is unabated until their burial ends their liminal status as beings that belong neither to this world nor to the world of spirits.[129] Rather than being an attempt to hide criminal evidence from investigators, Mr. Mendoza's quiet and quick burial of the unbaptized fetus might have been motivated by his concern to shield his daughter from future harm.

In other cases, evidence was not forthcoming because witnesses protected women who sought abortions. Rosa Huamán de Wong, for example, met Rosa Valderrama, who gave her an abortifacient potion through her neighbor Rosa Vaquedano.[130] The three

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[127] Carlos Aguirre, The Criminals of Lima and their Worlds: The Prison Experience, 1850-1935 (Durham: Duke University Press, 2005).
[128] AGN: "Declaración de Don Anselmo Mendoza al Juez de Paz Gabriel Lira," (23 November 1900), Mendoza Case.
[129] Tristan Platt, "El Feto Agresivo: Parto, Formación de la Persona y Mito-Historia en los Andes," Estudios Atacameños 22 (2002): 127-155. On the spiritual liminality of fetuses in the Andes, see also Morgan, "Imagining the Unborn." For a theoretical overview of the social recognition of the beginnings of personhood, see Wendy James, "Placing the Unborn: On the Social Recognition of New Life," Anthropology & Medicine 7, 2 (2000): 169-189.
[130] ARL: "Declaración de testigo Rosa Vaquedano," (4 January 1940), Huamán Case.

women arranged a meeting in a store managed by Vicente Wong, Mrs. Huamán's husband. When interviewed, Mr. Wong identified Ms. Valderrama as a skilled healer (*curandera*), and confirmed that the latter had received payments and clothing items for a ritual "for the good of my wife."[131] Both the Jara and Huamán cases show that abortions, in addition to being crimes, were also complex local dramas, in which people from the neighborhood were privy to details about a person's intimate affairs. This knowledge could lead to an accusation that state authorities recognized as credible enough to begin an investigation (the Jara case).[132] Other times, rather than attracting state attention, social networks of neighbors and spouses provided quiet introductions, money and support for women who sought abortions (the Huamán case).

Men and women were able to articulate explanations for pregnancy losses that made them appear as accidental or guiltless. This too made assigning criminal responsibility difficult in abortion cases. Women invoked the link between physical stress and miscarriage often, as did hospitalized women in the previous section. Eudosia Mendoza, for example, said that she miscarried because she moved a heavy barley bag to prevent her cow from getting to it.[133] Angélica Fernandes explained that her miscarriage was the result of a fall from a donkey and of her working "on things that forced me to strain myself" at her employers' house.[134] Similarly, after police investigators accused

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[131] ARL: "Manifestación de Vicente Wong," (11 January 1940), Huamán Case.
[132] For a similar case of neighborhood networks operating against privacy, see Rachel Fuchs and Leslie Page Moch, "Invisible Cultures: Poor Women's Networks and Reproductive Strategies in Nineteenth-Century Paris," in Susan Greenhalgh (ed.), Situating Fertility: Anthropology and Demographic Inquiry (Cambridge: Cambridge University Press, 1995).
[133] AGN: "Declaración de Eudosia Mendoza al Juez de Paz Gabriel Lira," (22 November 1900), Mendoza Case.
[134] ARL: "Declaración de Angélica Luz Fernandes," (26 June 1920), Fernandes Case.

Rosa Huamán of consuming an abortifacient potion, she remembered that, just before consuming the alleged potion, she had had a bad fall "that shook the creature inside me," after which she had had "an unstoppable flow of blood."[135]

Even men resorted to strain as an explanation for miscarriage. Manuel Díaz, a 33-year-old peddler accused of causing his wife Felícita Rebaza's miscarriage through a beating, suggested that the beating had had nothing to do with the miscarriage. In his defense, he offered two alternative and not mutually exclusive explanations. First, he claimed that Mrs. Rebaza had made too much effort carrying a pail full of water to play with her neighbors. Second, Mr. Díaz told investigators that Mrs. Rebaza had grown frustrated because she had not been able to eat pork around the time of her miscarriage, despite craving it.[136] Ismael Ramón, another husband accused of causing his wife's miscarriage through a beating, cast doubt on the charge by arguing that the birth had been difficult, and that his wife, Filomena Ramón, miscarried because birth attendant Maximina de la Vega arrived too late to be of any help.[137]

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[135] ARL: "Manifestación de Rosa Huamán," (17 April 1940), Huamán Case.
[136] ARL: "Declaración de Manuel Díaz Vera," (15 May 1940), Rebaza Case. Historians and anthropologists have documented the widespread belief in the significance of cravings during pregnany in Spanish Latin America. According to it, the satisfaction of a woman's food cravings during pregnancy is considered important to maintain her health, to keep the being growing inside her satisfied and not provoke its possible angry flare-ups, to avoid the development of stigmatizing birthmarks on the newborn, and to avoid miscarriages. See Valdizán and Maldonado, Medicina Popular Peruana, Vol. 1, 343; Carmen Flores Cisneros, "Saber Popular y Prácticas de Embarazo, Parto y Puerperio en Yahuío, Sierra Norte de Oaxaca," Perinatología y Reproducción Humana 17 (2003): 36-52; Zuanilda Mendoza González, "'¿Dónde Quedó el Arbol de las Placentas?' Transformaciones en el Saber acerca del Embarazo/Parto/Puerperio de Dos Generaciones de Triquis Migrantes a la Ciudad de México," Salud Colectiva, La Plata 1, 2 (2005): 225-236.
[137] AGN: "Declaración de Ismael Ramón," (13 August 1904), Ramón Case.

Mr. Díaz's testimony is indicative of the high regard in which the knowledge of a traditional birth attendant could be held. Birth attendants also wielded their specialized knowledge as a weapon to deflect accusations. Mrs. Rosa Valderrama, a 50-year old widow with three sons and a primary education, examined Mrs. Rosa Huamán and concluded the latter was not pregnant: "her period was just suspended, her stomach aches made it evident."[138] Ms. Valderrama based this assessment on her alleged thirty years of experience as a birth attendant. She had then given Mrs. Huamán a *culantrillo* potion, "brewed to regularize a woman's menstrual period," over several days.[139] She had not demanded payment, as that would have cheapened the value of her work, but rather "a gift" of money as a show of respect from Mrs. Huamán's family.[140]

A final factor complicating the investigation of criminal abortions were the complex interpersonal relations that existed between husbands and wives. Some of these interpersonal relations reveal explosive degrees of socially tolerated jealousy and desire for women's obedience on the part of men, consistent with the ample historiography on Latin American domestic violence discussed earlier. Filomena Ramón, for example, accused her husband Ismael Ramón of beating her savagely, to the point of making her miscarry. According to Mrs. Ramón, Mr. Ramón, upon noticing a bruise on her arm, turned to her saying, "someone hit you like I don't. Who was it?" Her husband, Mrs. Ramón implied, was convinced that, to cause such a bruise, another man must have put his hands on his wife's body. The beating followed Mrs. Ramón's refusal to name the

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[138] ARL: "Manifestación de Rosa Valderrama," (8 January 1940), Huamán Case.
[139] ARL: "Manifestación de Rosa Valderrama," (3 January 1940), Huamán Case.
[140] ARL: "Declaración de testigo Rosa Vaquedano," (4 January 1940), Huamán Case. On the practice of honoring birth attendants through gifts rather than payment, see Vargas and Naccarato, Allá, las Antiguas Abuelas Eran Parteras; Tula Sáenz, Partos y Parteras en la Cuenca del Rio Marcará (Huaraz: Asociación Urpichallay, 2000).

real or imagined lover.[141] Although he contested having caused the miscarriage, Ismael Ramón did not deny the beating nor his motives.[142] Likewise, Felícita Rebaza accused her husband, Manuel Díaz Vera, of beating her to the point of miscarrying. Mrs. Rebaza had been playing with her neighbors in Trujillo, throwing water at each other as part of the carnival celebrations that last throughout the whole summer in Peru's hot coastal cities. When Mr. Díaz arrived, drunk and belligerent, he ordered Mrs. Rebaza back in the house immediately. When she refused, he got mad at her disobedience and beat her.[143] Manuel Díaz, before the police, did not deny he had been drunk or nasty, and stated that he "shoved her to stop her from playing with water."[144]

At times, these complex interpersonal relations manifested themselves as wars of words between spouses, with the judiciary as their stage, one that was ultimately ignorant of the deep causes of these conflicts, and powerless to come to a decision regarding guilt. When the police began inquiring after Celia Jara's suspicious miscarriage, her husband, José Armas Herrera, volunteered that he had recently contracted gonorrhea from Mrs. Jara, and that he had sought treatment at a local public clinic.[145] Mrs. Jara denied having a venereal disease, and instead accused Armas of beating her to the point of making her miscarry.[146] The state attorney ordered medical exams, which showed that both Jara and Armas had gonorrhea, but could not find evidence of an abortion nor determine who

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[141] AGN: "Declaración de Filomena Ramón," (13 August 1904), Ramón Case.
[142] AGN, "Declaración de Ismael Ramón," (13 August 1904), Ramón Case.
[143] ARL: "Preventiva de Felícita Rebaza," (20 May 1940); and "Testimonio de Fidencio Moreno, witness," (20 May 1940), Rebaza Case.
[144] ARL: "Declaracion de Manuel Díaz Vera," (15 May 1940), Rebaza Case.
[145] ARL: "Declaración de José Armas Herrera," (3 July 1940), Jara Case.
[146] ARL: "Declaración de Celia Jara," (3 July 1940), Jara Case.

infected whom.[147] Stumped by uncorroborated mutual accusations, the state attorney withdrew the accusation against Celia Jara.

The only case that led to a conviction also reveals how complex interpersonal relations were between quarreling spouses. In February of 1901, just outside of Salaverry, in Peru's northern coast, José Aguilar, a 20-year-old carpenter, beat his wife, Julia Izquierdo, stopping only when three of her female friends held him back. As a result of her injuries, said the medical report, Mrs. Izquierdo miscarried.[148] "I have had illicit relations with my aggressor," admitted Mrs. Izquierdo, "and we have had many children, including the one he made me abort."[149] The miscarriage worsened Mr. Aguilar's criminal responsibility for the assault, and justice was swift. By January of 1902, Mr. Aguilar indicated he had been in jail for almost one year.[150] Shortly after, Mrs. Izquierdo wrote to the judge begging for mercy for her husband. The lesions he inflicted "have not resulted in any long-lasting problem," she said, and "he has always been good to me […] He was simply not himself that time because of the effects of alcohol […] One year in jail is enough to punish him."[151]

Given the nature of the assault, the presence of witnesses and the medical report to substantiate the miscarriage, Aguilar could have served the 16 to 24 months of jail time his crime deserved, according to the 1862 Penal Code. It is unclear whether Mrs. Izquierdo's plea helped her husband. However, this case makes it plain that there was

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[147] ARL: "Informe final del fiscal," (3 February 1941), Jara Case.
[148] ARL: "Parte medico," (12 February 1901) in Causas criminales, grupo 963 (1901): Doña Julia Paula Izquierdo contra José Aguilar Alache por maltratos. (Hereafter "Izquierdo Case").
[149] ARL: "Declaración de Julia Paula Izquierdo," (16 February 1901), Izquierdo Case.
[150] ARL: "Comparece José Aguilar Alache," (9 January 1902), Izquierdo Case.
[151] ARL: "Carta de Julia Paula Izquierdo," (9 January 1902), Izquierdo Case.

often more going on in the domestic realm than the abuse and asymmetrical power relations illustrated by the three previous cases of Mrs. Rebaza, Mrs. Jara, and Mrs. Ramón. Only the endurance of other ties (economic interdependence, mutual affection) can explain the paradox of an official conviction being challenged by the victim of a beating who also had to subject herself to the embarrassment of publicly admitting to having "illicit relations" with her aggressor.

To summarize, then, the analysis of these cases confirms previous historiography that shows a certain amount of legal latitude in the application of penalties against those accused of the crime of abortion. Scholars like Ruggiero and Urías Horcasitas, for example, have discussed how courts often showed mercy towards "honorable women" accused of committing abortions and infanticides. My analysis of the Peruvian cases indicates that the mercy of the court was not the only way in which an abortion accusation could be weakened. Professional discretion in the interpretation of the law, lack of physical evidence or witnesses, the protection provided by an abortion seeker's social network, credible alternative explanations for a miscarriage, the costs involved in conducting an investigation, and the difficulties parsing mutual recriminations between spouses, made the application of criminal laws messier than the Penal Code could anticipate.

These cases also reveal the diverse origins of abortion accusations. Physicians who treated hospitalized women were one source, but not the only one. The inquiries of local authorities also led to accusations, as did the rumors and gossip of neighbors, women's complaints about their husbands' abusive behavior, and even women's disatisfaction, as consumers, with the quality of the abortifacients they bought. Finally,

these cases showcase the limited investigative capacity of Peruvian law enforcement and judicial institutions in the early twentieth century, exemplified by their inability to reach witnesses and find evidence. This hampered the judiciary's power to sustain cases.

However, the investigative shortcomings did not dissuade women from making accusations or from responding to their husbands'. As Gotkowitz has argued, courts were public fora where social identities were formed and contested.[152] What we witness in these transcripts are not simply women's attempts to obtain specific outcomes (a conviction for an abusive husband, for example), but, more broadly, women strategically seeking a day in court to negotiate for more power and status relative to their partners. Court accusations were apt vehicles to accomplish this, although other aspects of marital strife were probably too complex for any court to sort out perfectly. This can explain why some women, like Mrs. Izquierdo, ultimately chose to return home to their husbands, give them second chances, and even forgive them.

Conclusion

There is much more to abortion than the victimization of women. For instance, physicians working in hospitals acted, formally, as gatekeepers and information providers for the state. But, as I have shown, they did not report everything they suspected about abortion to the authorities. Their silence was the result of both compassion and a self-interested desire to avoid legal and financial problems. Although some physicians sought out punishment for abortion, especially after the legalization of therapeutic abortion,

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[152] Gotkowitz, "Trading Insults"; see also Laura Lewis, "Colonialism and Its Contradictions: Indians, Blacks, and Social Power in Sixteenth and Seventeenth Century Mexico," Journal of Historical Sociology 9, 4 (1996): 410-431.

others were more interested in the prevention of abortion through learning more about the phenomenon, than in serving as agents of punishment. Peruvian physicians, influenced by French puericulture, treated pregnancy as a complex and delicate phenomenon that could be negatively affected by pathologies, the environment, and a person's disposition. The medical histories and the court cases reviewed indicate that lay people also articulated explanations for pregnancy losses based on this relationship between physical strain and miscarriage. The convergence between these forms of lay and expert knowledge is another reason for the paucity of abortion accusations.

Women accused of having abortions rarely admitted having done so, out of fear of punishment, or because they honestly did not try to end their pregnancies on purpose. Those who ended up in the hospital, as we have seen, rarely confessed their intention to provoke an abortion. Instead, they lied, fell back on lay theories about the body, or they simply did not say a thing. There is a form of power at work here, a subaltern kind of power that denies access to the "truth" or at least to a confession. Authority figures like physicians may have made demands on women who had abortions, but they were thwarted in practice almost all the time. As much as physicians' irregular recording of medical histories, these women's tactics are reasons why there are no accurate numbers on abortion or infanticide in the early twentieth century, and even today.

Some of the criminal cases presented here have a clear gender violence component. However, even when the pregnancy losses occurred as a result of violence of men against women, abortion was not the main lesion women complained about. Instead, they focused on the abuse they suffered at the hands of their male partners. Taking the latter as a departure point, we may argue that women's accusations about abortion were

means for them to limit patriarchal authority in everyday life. As Steve Stern has shown, physical punishment by husbands of wives who challenged their authority within the family was common throughout Latin America.[153] The public demonstration of bodily signs such as bruises and lost pregnancies would strongly play in a woman's favor were she able to reach authorities such as the police or physicians. After all, men were supposed to dominate their families hegemonically and not coercively. Resorting to physical abuse was a dishonorable sign of male incompetence to maintain order and control in his relations with women. Men, for their part, could also articulate explanations for women's miscarriages that exonerated the men from the crime of causing a miscarriage, even if they did not deny other charges that women brought against them, including battery.

Women demonstrated a high level of agency when procuring abortions for themselves. They relied on their social networks, which included their lovers, to obtain abortifacients such as quinine and plant-based potions. Women also produced the dangerous circumstances that could lead to a miscarriage, such as falling down on purpose. Even when they found themselves recovering in a hospital bed, women resisted the attempts of medical authorities to produce a narrative of the events that caused their miscarriages. As stated earlier, there is power in denying information to authority figures. But there is also a darker side to this story. In a time and place in which access to contraceptives was severely limited, abortion was one of the few means Peruvians could use to prevent births. Yet, many women who obtained abortions or caused their own miscarriages wound up endangering their own lives in the process. In that sense, it is fair

[153] Stern, Secret History of Gender.

to speak of abortion as a bio-social phenomenon that is both important in itself as an everyday practice, and as a sign of grotesque ongoing gendered injustices.

Chapter Four

The Institutionalization of Birth Control in Peru I:

Transnational Discourses and Local Actions, 1930s-1974

Though some early twentieth century Peruvian physicians had begun to pay attention to the economic and health difficulties posed by having many children, the technical and organizational implementation of birth control services did not become feasible until the 1960s. This chapter deals with the slow but radical shift that led to the cheap and massive provision of such services for the first time in the country. Between the 1930s and the 1960s, medical institutions began to embrace the value of smaller families and more limited demographic growth. In a way, changes in Peru were only a reflection of broader transnational processes that reduced mortality rates in the so-called Third World and resulted in the invention of new contraceptives. These phenomena were necessary for the shift to occur, and have been well analyzed by different scholars.[1] At the same time, these transnational events do not sufficiently explain the diverse ways in which historical actors adapted to the social forces that favored birth control.

As I will show, the active participation of health workers and demographers was necessary for the diffusion of contraceptive ideas and services in Peru. Throughout Latin America, this diffusion exacerbated nationalistic, scientific and social tensions, and

[1] See for example Finkle and McIntosh, "The New Politics of Population"; Paul Basch, Textbook of International Health (New York: Oxford University Press, 1999); Abel, Health, Hygiene and Sanitation in Latin America c. 1870 to 1950; Julio Frenk, José Bobadilla, Jaime Sepúlveda, Malaquías López Cervantes, "Health Transition in Middle-Income Countries: New Challenges for Health Care" Health Policy and Planning 4, 1 (1989): 29-39; Abdel Omran, "The Epidemiologic Transition: A Theory of the Epidemiology of Population Change," Milbank Memorial Fund Quarterly 49 (1971): 509-538.

ultimately contributed to a significant drop in the birth rate in Peru and several other countries.[2] The Peruvian case can help us better answer questions like what was the scientific and social status of birth control technologies in the early- to mid-twentieth century? How did foreign birth control organizations promote themselves? How were their overtures interpreted locally? How did the actions of local birth control advocates fit within the broader political life of the nation?[3] These questions connect the local and transnational medico-political events that, together, popularized birth control globally in the second half of the twentieth century.

I will also show that early birth control researchers and advocates in Peru converged around specific problems such as high maternal mortality (brought on by the physical toll of multiparousness with short inter-parity intervals, the unavailability of medical services, and unsafe abortive practices), the financial stress of families who could not afford to care for a large number of offspring, and the social problems of unemployment and criminality that underplanned population growth exacerbated. The

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[2] See for example J. Oscar Alers, "Population and Development in a Peruvian Community," Journal of Inter-American Studies 7, 4 (1965): 423-448; Adrienne Germain, "Women at Mexico: Beyond Family Planning Acceptors," Family Planning Perspectives 7, 5 (1975): 235-238; Joana Maria Pedro, "A Experiência com Contraceptivos no Brasil: Uma Questão de Geração," Revista Brasileira de História (São Paulo) 23, 45 (2003): 239-260; Karina Felitti, "El Debate Médico sobre Anticoncepción en Buenos Aires en los Años Sesenta del Siglo XX," Dynamis 27 (2007): 333-357; Victoria Langland, "Birth Control Pills and Molotov Cocktails: Reading Sex and Revolution in 1968 Brazil," in Gilbert Joseph and Daniela Spenser (eds.), In From the Cold: Latin America's New Encounter with the Cold War (Durham: Duke University Press, 2008).

[3] There is little historical work in this field for Latin America, which includes Délcio da Fonseca Sobrinho, Estado e Populaçao: Uma História do Planejamiento Familiar no Brasil (Rio de Janeiro: Rosa dos Tempos, 1993); Pieper, "From Contested Duties to Disputed Rights"; and Briggs, Reproducing Empire. For that matter, the historiography of birth control outside industrialized nations is scant. One of the few monographs dealing with Africa, for example, is Klausen, Race, Maternity and the Politics of Birth Control in South Africa. For India, see Hodges, Reproductive Health in India.

explicit purpose of the Peruvian birth control proponents was to shield women from the physical harm posed by certain pregnancies, and to protect families from poverty, tightly bound, in their view, to having too many children.

Population limitation organizations, mainly from the United States, and transnational agencies such as the United Nations funded, trained, and created spaces for these actors to network regionally. Local advocates and foreign donors agreed that family planning acceptance required deep shifts in mentality by policy makers and the public, especially the poor, regarding the link between contraception, individual health, and national development. Despite the gains they made, birth control institutions in Peru faced everyday challenges related to persuading people of the value of contraception, and were vulnerable to political avatars. This fragility became evident with the downfall of the *Asociación Peruana de Protección Familiar*, a grantee of the International Planned Parenthood Federation, in 1974.

The chapter first presents the medical status of contraception in early twentieth-century Peru. It then introduces the political and scientific changes that permitted the establishment of birth control initiatives in Peru. Finally, it analyzes the activities of Peruvian birth control advocates and researchers, and their links with local and international actors.

Contraception before the 1960s

Cheap and effective contraceptive technologies were in short supply in early twentieth century Peru. Physicians rarely discussed their availability or relevance to

people's lives.[4] Abortion was the only commonly used means to end pregnancies. Its popularity encouraged ample public condemnation as well as ineffective repression.[5] Only a handful of strident activists publicly favored the use of involuntary sterilization for people deemed feeble-minded, gathering little public support.[6] One of them, Carlos Enrique Paz Soldán, Professor of Social Hygiene at San Marcos University, even defended Adolf Hitler's July 1933 sterilization law against epileptics, the blind, the deaf, the physically deformed, and alcoholics, all the while despising how the Soviet Union had liberalized access to voluntary abortion and sterilization for all its citizens.[7] Yet, Paz Soldán also spoke against sterilizing women simply because they had "too many children", and against voluntary birth control.[8]

Physicians reported the use of pessaries and condoms (as contraceptives and not just as means to prevent sexually-transmitted infections) as early as the 1880s among women and men in Lima.[9] Condoms, made of silk or rubber, were controversial as birth control technologies. On the one hand, they were well known by the male public as a

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[4] See for example Fernando Robinson, "Algunas Observaciones acerca de Nuestro Problema Racial," (Tesis de Grado, Facultad de Medicina de San Fernando, 1936, 58).
[5] See chapter three.
[6] Pastor Padierna, "El Control Sanitario del Matrimonio"; Luis Cademártori, "La Asistencia Médico-Social del Niño en el Callao," (Tesis de Grado, Facultad de Medicina de San Fernando, 1928); Fosalba, "Ideas Generales sobre la Herencia"; Roberto Mac-Lean y Estenos, "La Eugenesia en América," Revista Mexicana de Sociología 13, 3 (1951): 359-387.
[7] Carlos Enrique Paz Soldán, "El Problema de la Esterilización," La Reforma Médica 20, 189 (1933): 364; Carlos Enrique Paz Soldán, "Editorial," La Reforma Médica 19, 165 (15 Junio 1933): 197-198.
[8] Carlos Enrique Paz Soldán, "La Decadencia de la Maternidad," La Reforma Médica 20, 194 (1 September 1934): 561-568, 589-590.
[9] Mariano Ostolaza, "Estudio del Chancro," (Tesis de Grado, Facultad de Medicina de San Fernando, 1889); and Mariano M. López, "Diagnóstico de los Flujos Utero-Vaginales en las Enfermedades Venéreas," (Tesis de Grado, Facultad de Medicina de San Fernando, 1891).

form of protection against venereal diseases.[10] Physicians who cared for military personnel, for example, acknowledged that soldiers and sailors on leave frequented brothels as a form of recreation, and complained when the armed forces stopped providing these men with condoms, since treating infections such as syphilis required a painful course of arsenotherapy.[11] Its association with prostitution made the condom distasteful as a contraceptive by monogamous couples. Some Peruvian psychiatrists even classified "coitus condomatus" by married couples as a sexual perversion, along with homosexuality, necrophilia, and bestiality, one that was especially harmful to women, since the deposit of sperm allegedly played a role in the health of the uterus.[12]

Nevertheless, Limenians actively used condoms to restrict the number of children they had by the early 1920s, vexing San Marcos University professors of Legal Medicine Leonidas Avendaño and Guillermo Fernández Dávila. These experts blamed condom-wearing men for the country's inability to increase its population; they called married couples who used condoms "refined egotists" who put pleasure ahead of the national interest; and they condemned the women who demonstrated the proper utilization of condoms in advertisements for their sheer cheek.[13] The ubiquity of condom selling in pharmacies and even "by certain individuals in the main and busiest streets of the capital"

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[10] Colina, "Contribución al Estudio de la Profilaxia de las Enfermedades Venéreas."
[11] Corrales Diaz, "Estadística y Profilaxia de las Enfermedades Venéreas en la Armada Peruana"; Pilares, "La Profilaxis de la Sífilis en el Ejército." See also Brandt, No Magic Bullet.
[12] Celso Bambarén, "Algunas Consideraciones sobre las Perversiones Sexuales y la Delincuencia," (Tesis de Grado, Facultad de Medicina de San Fernando, 1946: 21). On the supposed role of sperm in women's health, see Anonymous, "Have Spermatozoa Functions or Effects Other than Fertilization?" Journal of the American Medical Association 77, 1 (1921): 42-43.
[13] Avendaño y Fernández Davila, La Despoblación, 27.

eventually led to a conservative backlash.[14] In April of 1940, the Directorship of Public Health, a part of the Ministry of Public Health, Work, and Social Welfare, passed Directorial Resolution 920, which indicated that the sale of condoms in the streets of Lima had reached "alarming proportions," with hawkers offering their wares to passers-by "without regard to their sex, age, and social condition." "[A]n affront to morality and respectability," street sales of condoms were thus forbidden. Furthermore, the Resolution instructed police to confiscate condoms sold in this manner and deliver them to the nearest public venereal disease clinic, where the condoms would be destroyed.[15]

In the early 1950s, the government of General Manuel Odría (1948-1956) ratcheted up the anti-condom offensive. Article 203 of the Customs Code banned the import of condoms, but failed to enforce it effectively. In addition, the Regulations for the Army Medical Corps during Peacetime stipulated that the mention of condoms as means to prevent sexually-transmitted infections in the training courses for recruits and officers of the Peruvian Army must end, ostensibly because of the recognition of the condom's double function as a prophylactic and a contraceptive. Making virtue out of necessity, in 1950, the Army Medical Corps emphasized the intellectual and physical vigor that accompanied sexual abstinence, and edited out the parts of educational movies that contained information about condoms.[16]

Despite the crackdown, sales of condoms in pharmacies continued during the 1950s, aided by advertisements in pharmaceutical journals. Between 1954 and 1958,

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[14] Burgos Amaya, "La Procreación Consciente en Nuestro País," 52.
[15] "La Venta de Preservativos en la Vía Pública," Boletín de la Dirección General de Salubridad Publica (1940): 75.
[16] "Directivas para la Profilaxia y Tratamiento del Paludismo y de las Enfermedades Venéreas en el Ejército," Revista de la Sanidad Militar del Perú, 27, 75 (April-June 1954): 51-60.

Droguería Kahan, S.A. (DROKASA) sold brand name condoms such as Sultán, Tuxedo, Romeo, Convoy, Silver Tex, and Koin Pack, wholesale and retail.[17] DROKASA imported these goods from Killashun, Inc. of the United States, the export division of the Akwell Corporation of Akron, Ohio. DROKASA also advertised and sold rubber cervical caps. However, in 1958, the government of Manuel Prado y Ugarteche (1956-1962) banned them when it forbade the importing, local manufacturing, advertising, and selling of all mechanical contraceptives "that do not prevent diseases." The policy aimed "to protect the birth rate [*la natalidad*], foundation of our human capital, as well as to defend good morals." Hypocritically, the policy did not target the male use of condoms as contraceptives, only the birth control devices women used, blaming such devices for causing a "possible predisposition to cancer" in women.[18]

This official pro-natalism was an important sign of continuity between Odría's military regime and Prado's civilian one.[19] During his eight years in power, General Odría decreased taxes for military personnel who had large families, increased the salaries of public health personnel and teachers with many children, and made being married and having a large progeny pre-requisites for those seeking to buy homes in the newly created housing projects of Risso, in Lima.[20]

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[17] The Revista Farmaceutica Peruana (RFP) was the official journal of the Peruvian Federation of Pharmacies. See for example RFP 23, 275 (March 1955): 6; RFP 24, 277 (May 1955): 13; and RFP 25, 289 (May 1956): 22.
[18] "Resolución Suprema 93-DGS (Ministerio de Salud Publica y Asistencia Social)," Diario El Peruano (7 August 1958): 1.
[19] On the Prado presidency, see Gilbert, La Oligarquía Peruana; and Portocarrero, El Imperio Prado.
[20] ACP: Decreto Ley 11298: "Estableciendo que las Remuneraciones Denominadas 'Racionamiento', 'Asistente', 'Remuneración por Tiempo de Servicios' y 'Gratificación por Familia Numerosa', que se Abonan a los Miembros de los Institutos Armados, Están Comprendidas en la Exoneración del Impuesto a los Sueldos que Estatuye el Decreto Ley

Official pro-natalism aside, the idea of voluntarily limiting the size of one's family grew during the 1930s recession and after, especially in cities.[21] Large progenies, it seemed, were not conducive to financial stability or domestic harmony. In rural areas, large numbers of children began to be associated with material scarcity.[22] Saturnino Huillca, one of the most senior leaders of Peru's peasant movement, for example, spoke of his ten sons and daughters as adding to his and his wife's "sorrow and suffering."[23] But it was especially in cities where many offspring were particularly punishing to some families. Social scientists who analyzed the relationship between large families and urban poverty took note of how children were hired out as domestic workers by their own parents, the ways in which poverty led to children's criminality, the crowded housing and unhygienic conditions of urban slums, and even how the nutritiousness of breast milk diminished after numerous pregnancies.[24]

11213," (10 March 1950); Ley 12175: "Crédito Suplementario a la Partida 77 del Pliego de Salud Pública del Presupuesto de 1954, Destinada a Abonar las Bonificaciones del 25% sobre los Primeros 400 Soles de Sueldo, y por Familia Numerosa y Tiempo de Servicios," (27 December 1954); Ley 12280: "Crédito Suplementario a la Partida 28 del Pliego de Educación Pública del Presupuesto de 1954, Destinado al Pago de la Bonificación a los Maestros por Familia Numerosa," (31 March 1955); Venancio Ayala Villanueva, "Estudio Médico Social del Agrupamiento Hipólito Unánue o Risso," (Tesis de Grado, Facultad de Medicina de San Fernando, 1956). My paternal grandfather, a married police officer with three children, was allowed to buy an apartment in this new district in the 1950s, and I still live in it.

[21] On the social and economic effects of the 1930s depression, see Denis Sulmont, El Movimiento Obrero en el Perú, 1900-1956 (Lima: PUC, 1975); and Rosemary Thorp and Geoffrey Bertram, Peru 1890-1977: Crecimiento y Políticas en una Economía Abierta (Lima: Mosca Azul, 1985).

[22] Jose Jiménez Camacho, "El Ejercicio de la Profesión Médica en Provincias: Obstetricia Rural en la Sierra del Peru,"Actualidad Médica Peruana 6, 3 (Julio 1940): 74-79.

[23] Hugo Neira, Huillca: Habla un Campesino Peruano (Lima: Peisa, 1974: 10-11).

[24] "Origenes, Desarrollo y Finalidades de la Cruz Roja: A los Pueblos de América," Anales de la Cruz Roja Peruana 31 (August 1934): 35-44; Elio Flores S., "El Hogar Infantil y su Rendimiento de Bien Médico Social," (Tesis de Grado, Facultad de Medicina de San Fernando, 1936); Ricardo Luna Vegas, Factores Etiológicos de la

It is important to note that the medical profession was becoming institutionally stronger in Peru by the mid-1930s. General Oscar Benavides (1933-1939) created the Ministry of Public Health, Work, and Social Welfare, thus giving health care an official place within the executive.[25] The subsequent administrations of Manuel Prado (1939-1945), José Luis Bustamante y Rivero (1945-1948), Manuel Odría (1948-1956), and Manuel Prado (1956-1962, his second term) worked to increase the number of hospitals and medical students. Between 1940 and 1960, the number of hospitals grew from 100 to 207. In addition, Peru added 213 health centers and 177 rural health posts in that twenty-year span. The number of medical students also increased, from approximately 680 in 1940 to 2,045 in 1956. That year there were 479 physicians practicing in the country.[26]

It was also during the 1940s that the influence of United States medicine began to displace the French model. Preventive medicine as practiced and promoted by training and research centers like Johns Hopkins and Harvard held special sway for a new generation of medical students. These students were as eager to complete specialty courses in Baltimore and Boston as half a century earlier they had been to do so in Paris. In 1942, the United States funded what became known as the Inter-American Cooperative Service for Public Health (SCISP, after its initials in Spanish). Working from within the Ministry of Public Health, the SCISP provided public health training and funds for Peruvian health officers to deal with problems like malaria, water sanitation, and obstetric

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Peligrosidad en los Menores (Lima: La Cotera, 1940); Manuel Salcedo F., "Discurso de Transmisión de Cargo en la Sociedad Peruana de Pediatría," Boletín del Departamento de Protección Materno Infantil 4, 15-16 (July-December 1944): 11-32; Antonieta Linares Lizárraga, "Contribución al Estudio Médico Social de la Madre Lactante," (Tesis de Grado, Facultad de Medicina de San Fernando, 1947).

[25] ACP: Ley 8124: "Ministerio de Salud Pública, Trabajo y Prevision Social," (5 October 1935).

[26] Bustios Romaní, "Historia de la Educación Médica, Segunda Parte."

care.[27] The popularity of preventive medicine was on the rise not only in Peru. Sponsored by the Pan-American Health Organization (PAHO), the First Panamerican Congress on Medical Education (Lima, May 1951) emphasized the importance of understanding how social dynamics affected the course of health problems. Laboratories and hospital wards were no longer, the Congress's organizers claimed, the only places where to learn to become physicians. Two subsequent PAHO conferences on medical education (Viña del Mar, Chile, 1955, and Tehuacán, Mexico, 1956) underscored the importance of community health, holistic approaches to health (encompassing prevention, curing and rehabilitation), and the integration of biological, psychological, and social aspects of healing.[28] This new orientation in Peruvian medicine contributed to the greater notice physicians took of the links between high fertility and biological problems like the nutritiousness of breast milk, and social ones, such as children's delinquency, in the 1940s and 1950s.

The revamping of the National Office of Statistics in 1937 also permitted the production of new knowledge about the effects of population growth. Between the national censuses of 1876 and 1940, Peru's population grew from 2.6 to seven million inhabitants.[29] Cities like Lima grew the most, particularly as a result of internal migrations from rural areas.[30] Some, like demographer Alberto Arca Parró, organizer of the 1940 census, celebrated this growth and the migrations because they believed that Peru's cities, with some careful planning, could harness the vigor of the new workforce

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[27] See Bingham, Shirt-Sleeve Diplomacy, 19); and Fee, Disease and Discovery.
[28] On the Pan-American Health Organization, see Cueto, El Valor de la Salud.
[29] Instituto Nacional de Estadística e Informática (INEI), "Historia de los Censos en el Perú," (online document accessed 19 February 2007).
[30] Carlos Aramburú, Migración Interna en el Perú (Lima: INANDEP, 1981).

and enter a stage of rapid industrialization.[31] Others were not so optimistic. Several public health experts connected the growth of urban slums to higher crime rates, and the increasing rates of maternal mortality in Lima to the fact that the hospitals simply could not care well for the growing population.[32] The first estimates of maternal mortality rates in Lima emerged in this context. The rate for the period between 1947 and 1952 was approximately 446 deaths per 100,000 births at the *Maternidad de Lima* hospital, then the most technically advanced health care institution in Peru.[33]

Aware of the newly available demographic data, even hardened opponents of the regulation of family sizes began to change their minds. Dr. Carlos Enrique Paz Soldán, for example, still believed that Peru required a larger population, but he pondered also how migration from the interior to the coastal cities would strain urban services in education, housing, health, and food procurement.[34] Paz Soldán even came to describe Lima as "an impressive battlefield where death is winning."[35] Referring to the establishment of the International Planned Parenthood Federation in 1952 in Bombay,

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[31] Alberto Arca Parró, "Census of Peru, 1940," Geographical Review 32, 1 (1942): 1-20; Alberto Arca Parró, El Medio Geográfico y la Población del Perú (Lima: Torres Aguirre, 1945).

[32] Valle Medina, "Problema Social y Médico-Legal del Aborto en el Callao"; Untiveros Morales, "La Frecuencia de los Abortos en Lima"; Augusto Monge Raguz, "El Avecindamiento Humano en el Cerro San Cosme," (Tesis de Grado, Facultad de Medicina de San Fernando, 1954); Enrique Altuna del Valle, "Una Concentración Sub-Urbana Peligrosa para la Sanidad de Lima," (Tesis de Grado, Facultad de Medicina de San Fernando, 1955); Arroyo Posadas, "Infancia y Pro-Biofilaxis."

[33] Tello Morales, "Causas de Muerte Materna en la Maternidad de Lima." The total number of women who gave birth at the *Maternidad de Lima* in this period was 101,859. National maternal mortality rates are only available from 1980. In that year, Peru's maternal mortality rate was 318 per 100,000 births. See http://www.unfpa.org.pe (accessed 2 November 2007).

[34] Carlos Enrique Paz Soldán, "El Magno Problema," La Crónica (5 May 1949): 10.

[35] Carlos Enrique Paz Soldán, La Demogenia Peruana y Sus Problemas Medico Sociales (Lima: Instituto de Medicina Social, 1950: 179).

Paz Soldán claimed to understand why Indian leaders Jawahardal Nehru and Rama Rau supported Margaret Sanger's advocacy of birth control in their "desperately poor nation." Yet he was puzzled by the use of birth control in wealthier countries like the United States. Turning to Peru, Paz Soldán found some support for birth control in the Bible, of all places: "How can one condemn [birth control] outright without first paying heed to the clamor of the Book of Ecclesiastes: 'I turned and saw the injustices committed under the sun, the tears of the innocents without solace; those who cannot defend themselves from the violence of others, shunned from all relief. And I envied the dead more than the living. *And I held as fortunate not this nor that one, but the unborn, who have not seen the evils committed under the sun'*?"[36]

Paz Soldán's comments suggest that physicians and social scientists were beginning to tone down their criticism of families' willingness to limit the number of children they had. As Quintanilla put it in 1956, low agricultural productivity, industrial inefficiency, "and perhaps a high birth rate" negatively affected families' ability to feed their children well, which in turn caused malnutrition and disease.[37] Quintanilla was skeptical that a reduced birth rate alone could sustain Peru's long-term economic welfare. Nonetheless, he favored a slow reduction of birth rates over time, but only through the use of the calendar method of birth control, and only for couples who could not provide for numerous children. José Burgos argued along similar lines when he wrote in 1957 that "We should all agree that couples with enough financial means should have as many children as they can, as well as agree that those who do not have such means should limit

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[36] Carlos Enrique Paz Soldán, "¿Será Mejor que No Nazcan?" La Reforma Médica 39, 577 (Marzo-Abril 1953): 39-40, p. 40. Emphasis in the original.
[37] Quintanilla Paulet, "Problemas Médicos," 90.

their offspring; with just three or four children they will accomplish their human mission."[38] Likewise, Burgos was among the first to promote an interparity interval (of three years), in the interest of maternal health. During this period, birth control ought to be practiced through the calendar method, since condoms, coitus interruptus, and vaginal douching were, in his view, less effective, more risky, and less satisfying.[39] The possibility of regulating family sizes through the calendar method had generated enthusiasm among Peruvian physicians. A 1934 editorial in La Reforma Médica called it "the most transcendental biological and socio-economic discovery of the century."[40] However, few physicians took up seriously the idea of teaching or otherwise disseminating the method to the lay public. In fact, my review of 225 periodicals at Peru's National Library indicates that, by 1960, the only instructions on the calendar method appeared not on medical or even popular journals, but in the back pages of women's erotica serials.[41]

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[38] Burgos Amaya, "La Procreación Consciente en Nuestro País," 14-15.

[39] The calendar method of birth control was based on Ogino's and Knaus's near simultaneous findings about the infertility periods in women's menstrual cycles in the mid-1930s. This research was the basis for a method that relies on the identification of segments in the menstrual cycle during which a pregnancy is unlikely to occur. Kyusaku Ogino, The Conception Period of Women (Harrisburg: Medical Arts Publishing Company, 1934); and Frederik Muller, El Metodo Ogino-Knaus (Buenos Aires: Editorial Central, 1960). Hermann Knaus's research was published in German as Die Periodische Fruchtbarkeit des Weibes (Vienna: Maudrich, 1935).

[40] "El Inquietante Problema de la Prole a Voluntad: El Metodo de Ogino y la Eugenesia," La Reforma Médica 20, 181 (15 February 1934): 111-112.

[41] Los Amores de Lidia by Catalina Ivanoff (Lima: Propsa, 1960) was one of these women's erotica titles, and it includes a "Manual for Using the Rhythm Method by Married Couples" on page 124. In contrast, not one medical publication before 1960 provided instructions for the rhythm method, even though a few medical theses in the 1940s and 1950s supported its use. See Untiveros Morales, "Frecuencia de los Abortos en Lima"; Quintanilla Paulet, "Problemas Médicos en Relación con el Subdesarrollo"; Burgos Amaya, "La Procreación Consciente en Nuestro País."

To summarize, the salience of poverty in urban areas led health experts to soften their stance on fertility regulation between the 1930s and 1950s. Poverty, in their view, caused criminality and ill health, and exacerbated problems such as induced abortions. This indicates a growing recognition of the negative consequences of fast population growth for the nation and for individuals. This awareness fit well with the interests of population limitation institutions, which will be analyzed in the next section. At the same time, we must not lose sight of Peru's particularities. It is important to place the Peruvian experts' attitude changes in the context of the fiscal austerity regime of Manuel Prado in the late 1950s, caused in part by the economic recession that followed the Korean War. His predecessor's administration, General Odría's, favored laissez-faire economic policies, including the reduction of taxes on exports and the authorization of foreign entities to have rights over mineral and oil resources. This benefited export-oriented landholders, who became Odría's strongest allies. As far as his social policies went, Odría combined paternalistic populist gestures with strong-armed repression of dissent. New internal security legislation even made it legal to persecute, imprison, and harass regime opponents. Odría also attempted to recruit political followers among the urban poor, a group increasingly made up of recent migrants from rural areas. The infrastructure-building boom in urban areas ended abruptly with a recession in 1957. President Prado dealt with this crisis by reducing public spending, freezing salary and wage increases, and raising the price of basic foodstuffs, which especially affected the less wealthy urban dwellers.[42] Having several dependents would have been especially difficult for this group of Peruvians.

[42] Baltazar Caravedo, Burguesía e Industria en el Perú, 1933-1945 (Lima: IEP, 1976);

The increasingly visible material squalor in urban areas in the 1950s notwithstanding, physicians and public health experts did not stop reflecting on the need to populate other parts of Peru, particularly the Amazon region.[43] This suggests that, for an important group of Peruvian intellectuals, the country's pressing problem was not overpopulation but rather a combination of poorly planned distribution of the existing population and the physical toll that short interparity intervals took on women. This determined physicians' reluctance to aggressively curtail population growth. As the experts pondered these medical and demographic problems, population experts in the United States and the United Nations also debated the challenges that population growth in the so-called Third World posed on a global scale.

Transnational Knowledge about Population, 1940-1964

Following the conduction of the Peruvian census of 1940, its organizer, Alberto Arca Parró, represented Peru at the first Interamerican Demographic Congress of Mexico in 1943. During this meeting, he proposed that a continent-wide census be conducted in the Americas in 1950. The delegates endorsed the idea unanimously. A follow-up conference was held in Washington D.C. in 1947 to develop the standard protocols to be followed for such census. In January of 1948, Peruvian President José Luis Bustamante y Rivero created the Executive Commission for the Inventory of the Economic Potential of

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Baltazar Caravedo, Desarrollo Desigual y Lucha Política en el Perú, 1948-1956: La Burguesía Arequipeña y el Estado Peruano (Lima: IEP, 1978); Piedad Pareja, Aprismo y Sindicalismo en el Perú (Lima: Rikchay, 1980); Gonzalo Portocarrero, De Bustamante a Odría: El Fracaso del Frente Democrático Nacional, 1945-1950 (Lima: Mosca Azul, 1983).

[43] Carlos Aramburú, Eduardo Bedoya and Jorge Recharte, Colonización en la Amazonía (Lima: Centro de Investigación y Población Amazónica, 1982); Cueto, "Social Medicine and 'Leprosy' in the Peruvian Amazon."

the Nation, to implement the decisions made at the Washington meeting.[44] All this preparation, however, came to naught with General Manuel Odría's coup d'état in 1948. Odría was inclined to limit the participation of government in the promotion of economic development. He believed that direct foreign investments could perform this task more efficiently and, not surprisingly, curtailed the government's economic planning activities.[45] One important consequence was the cancellation of the projected 1950 census.

Ironically, the scuttling of the Peruvian census occurred as demographic research acquired greater importance in the United States.[46] Endowed by the Milbank Memorial Fund in 1936, the Princeton University Office of Population Research (OPR) began a series of investigations into the European population, partly at the request of the League of Nations' Economic Bureau, which wanted the research to serve as background for post-war planning.[47] Later, with the Cold War about to set in, the US Department of State asked the OPR to extend its studies to Asia.[48]

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[44] ACP: "Mensaje del Presidente Constitucional del Perú, Dr. José Luis Bustamante y Rivero, ante el Congreso Nacional," mimeographed document (28 July 1948).
[45] Jorge Rodriguez Beruff, Los Militares y el Poder: Un Ensayo sobre la Doctrina Militar en el Peru, 1948-1968 (Lima: Mosca Azul, 1983); John Sheahan, La Economia Peruana desde 1950: Buscando una Sociedad Mejor (Lima: IEP, 2001).
[46] Clyde Kiser, "The Work of the Milbank Memorial Fund in Population since 1928," Milbank Memorial Fund Quarterly 49, 4, Part 2 (1971): 15-66.
[47] Frank Notestein, Irene Taeuber, Dudley Kirk, Ansley Coale, and Clyde Kiser, The Future Population of Europe and the Soviet Union: Population Projections 1940-1970 (Geneva: League of Nations, 1944); W.E. Moore, Economic Demography of Eastern and Southern Europe (Geneva: League of Nations, 1945; Dudley Kirk, Europe's Population in the Interwar Years (Geneva: League of Nations, 1946); and Frank Lorimer, The Population of the Soviet Union: History and Prospects (Geneva: League of Nations, 1946).
[48] Kingsley Davis, The Population of India and Pakistan (Princeton: Princeton University Press, 1951); and Irene Taeuber, The Population of Japan (Princeton: Princeton University Press, 1958).

The United States was not the only party interested in demographic research. The 1945 charter of the United Nations called for the establishment of a Population Commission within the UN's Economic and Social Council. Frank Notestein, a demographer at the Milbank Memorial Fund who later headed the Princeton OPR, became the first UN Population Advisor, and the Peruvian Alberto Arca Parró became the first President of the Population Commission. The commission's role was to advise the UN Council on matters such as changes in the size and structure of population, the interplay of demographic factors and economic and social ones, and policies designed to influence the size and structure of population.[49]

In addition to the Population Commission, the UN established the Economic Commission for Latin America (ECLA) in 1948. The importance of demographic data was a foundational assumption for ECLA. In 1950, Director Raúl Prebisch formulated what became ECLA's mantra during the 1950s, known also as the strategy of import-substitution industrialization (ISI): in order for Latin America to become more self-reliant and to develop most fully its economic and human resources, it needed strong programs of industrialization from within.[50] Underlying ECLA's thirst for demographic knowledge

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[49] "Interview with Former Population Association of America (PAA) President Philip Hauser, Chicago, 12 November 1988," in Jean van der Tak, Demographic Destinies: Interviews with Presidents and Secretary-Treasurers of the Population Association of America PAA Oral History Project 1, 1 (2005). Accessed online 17 November 2007. See also Frank Notestein, "Reminiscences: The Role of Foundations, the Population Association of America, Princeton University and the United Nations in Fostering American Interest in Population Problems," Milbank Memorial Fund Quarterly 49, 4 (1971, part 2): 67-85.

[50] Raul Prebisch, The Economic Development of Latin America and Its Principal Problems (NY: United Nations 1950). See also Joseph Love, "Economic Ideas and Ideologies in Latin America since 1930," in Leslie Bethell (ed.), Ideas and Ideologies in Twentieth Century Latin America (Cambridge: Cambridge University Press, 1996); Eliana Cardoso and Albert Fishlow, "Latin American Economic Development: 1950-

was the understanding that population increases, decreases, and movements were intimately linked to phenomena in the politico-economic sphere, including individual incomes, natural resource consumption, industrial productivity and governmental stability.[51]

Consistent with the belief in the link between population changes and economic and social development, in 1949 the UN determined to help the governments of member countries elaborate population policies. Most requests for help were for conducting censuses, for the training of statisticians, and for the funding of regional seminars on demography. A few years later, the UN began cooperating with local institutions for the further production of demographic knowledge. Accordingly, the Population Commission helped create regional demographic training and research centers in Chembur, India (1956), Santiago, Chile (1957), and Cairo, Egypt (1963).[52]

The UN regional center in Santiago, named the *Centro Latino Americano de Demografía* (CELADE), played a crucial role in the dissemination of new knowledge about population trends and in the training of Latin American demographers at a time when university and governmental research in Latin America in this field was negligible and uncoordinated.[53] CELADE educated professionals nominated by Latin American governments, with the understanding that they must return to their home countries and

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1980," Journal of Latin American Studies 24 (1992): 197-218; Rosemary Thorp, "A Reappraisal of the Origins of Import-Substituting Industrialisation 1930-1950," Journal of Latin American Studies 24 (1992): 181-195.

[51] CEPAL, Análisis y Proyecciones del Desarrollo Económico (México: Naciones Unidas, 1955); and especially CEPAL, Desarrollo Humano, Cambio Social y Crecimiento en América Latina (Santiago de Chile: CEPAL, 1975).

[52] Richard Symonds and Michael Carder, The United Nations and the Population Question, 1945-1970 (London: Sussex University Press, 1973).

[53] Rodolfo Stavenhagen, "Social and Demographic Research in Latin American Universities," Milbank Memorial Fund Quarterly 42, 2 (1964, part 2): 148-174.

assist in the formulation of population policies. In 1960, CELADE and ECLA began a joint program through which CELADE fellows would, as part of their training, work on projects determined by ECLA's needs for demographic estimates and projections. ECLA benefited from CELADE's talent, as the former did not have the in-house resources to do this work; in turn, CELADE's fellows gained insight into the practical and political dimensions of demographic research topics.[54]

Despite the availability of funds and the clear need for this work on the part of ECLA, CELADE had trouble identifying suitable candidates for its fellowships. As Director Carmen Miró acknowledged, "we are not swamped with requests." In fact, many CELADE fellows, though university graduates, "have very little background and ability in economics," and, despite being nominated by their own countries to receive this training, the fellows "do not know exactly what is going to happen [with their careers] if they study demography."[55] Frank Lorimer, a demographer at the Princeton OPR, blamed Spain's and Portugal's cultural influence for the low prestige of demography in Latin America: "The Latin aristocratic elite […] has favored 'culture' with a capital 'C'-poetry, philosophy, the arts. A gentleman entertains his friends with intellectual conversation and music, as well as with wine and food."[56]

Lorimer's quaint and biased observations about Iberian culture were likely less relevant than the fact that demographic research in Latin America was a very new

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[54] Jorge Somoza, "Demographic Research of the Centro Latinoamericano de Demografía (CELADE) and the Economic Commission for Latin America (ECLA)," Milbank Memorial Fund Quarterly 42, 2 (1964, part 2): 121-147.
[55] Carmen Miró, "Discussion," Milbank Memorial Fund Quarterly 42, 2 (1964, part 2): 147.
[56] Frank Lorimer, "Discussion," Milbank Memorial Fund Quarterly 42, 2 (1964, part 2): 143.

discipline. It was therefore not surprising that established academics and governments were still somewhat reluctant to see its value and seek out its advice. Still, between 1957 and 1963, CELADE staff and fellows produced some 150 papers. The raw data sets for these analyses were national censuses. Having cancelled its 1950 census, Peru suffered from a significant information void. As a result, only three CELADE publications dealt with the country, on the topics of infant mortality, the determination of demographic indicators, and the geographic distribution of population.[57] Over the years, however, CELADE's prestige increased, as did the number of its fellows, while the institution's mission remained consistent: to aid governments manage national resources to "catch up with the highly developed" through the statistical description, diagnosis, and prediction of social problems.[58] In the late 1950s, the United Nations launched its Population Census Program. Thanks to this initiative, 157 countries carried out comprehensive national censuses between 1958 and 1963. Peru benefited from CELADE's technical assistance in the performance of its 1961 census.[59]

In addition to teaching and technical assistance, CELADE disseminated research produced mainly in the United States. Importantly, some US-based scholars and activists in the 1940s and 1950s began to treat population growth as a threat to the collective well-

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[57] César San Román, "La Mortalidad Infantil en el Perú," CELADE B.59.1/14 (November 1959); Eduardo Mostajo Turner, "Determinación de Indices Demográficos y Proyección de la Población del Perú," CELADE B.59.1/11 (December 1959); and John Grauman, "Population Redistribution in Peru," CELADE mimeograph (October 1962).
[58] José Janer, Guillermo Arbona, J. S. McKenzie-Pollock, "The Place of Demography in Health and Welfare Planning in Latin America," Milbank Memorial Fund Quarterly 42, 2 (1964, part 2): 328-345, p. 328.
[59] Delicia Ferrando and Carlos Aramburú, "The Fertility Transition in Peru," in José Miguel Guzmán, Susheela Singh, Germán Rodríguez and Edith Pantelides (eds.), The Fertility Transition in Latin America (Oxford: Clarendon Press, 1996).

being of humanity.[60] In 1945, Frank Notestein predicted that food scarcity would become more likely once the world's population grew greater than three billion.[61] Environmentalist William Vogt, future Director of the Planned Parenthood Federation of America, warned of the need for humans to take better care of the planet's supply of natural resources.[62] Economist Richard Nelson formulated his theory of the "low-level equilibrium trap," in which economic development was hampered despite modest increases in the gross domestic product because per-capita income was outstripped by population growth.[63] Demographers Ansley Coale and Edgar Hoover argued that an increase in the number of young people in a developing country negatively affected the country's chances of developing its own industrial base, because the young required expenditures in health and education, money that would not be available, at least in the short term, for technology acquisition and capital investments.[64] Institutions such as the Population Council and the Population Crisis Committee advocated against population

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[60] John Wilmoth and Patrick Ball, "The Population Debate in American Popular Magazines, 1946-90," Population and Development Review 18, 4. (1992): 631-668. Reverend Thomas Malthus in the late eighteenth century was arguably the first to suggest population growth was a threat to the collective wellbeing of society. Hence, proponents of population reduction through birth control were often referred to as "neo-Malthusianists" by their opponents. See Thomas Malthus, An Essay on the Principle of Population (London: J. Johnson, 1798). Exemplary of the contempt some felt towards "neo-Malthusianism" is Bonnie Mass, Population Target: The Political Economy of Population Control in Latin America (Toronto: The Latin American Working Group and the Women's Press, 1976).

[61] Notestein, "Population-The Long View".

[62] William Vogt, Road to Survival (New York: William Sloane, 1948).

[63] Richard Nelson, "A Theory of the Low-Level Equilibrium Trap in Underdeveloped Economies," American Economic Review 46, 5 (1956): 894-908.

[64] Ansley Coale and Edgar Hoover, Population Growth and Economic Development in Low Income Countries: A Case Study of India's Prospects (Princeton: Princeton University Press, 1958).

growth in developing countries.[65] The main concern of these scholars and organizations was a Cold War classic: having too many children exacerbated poverty, which in turn bred dissatisfaction with existing political regimes, a process that could threaten US economic and political interests by creating popular sympathy for Communism.

Preventing the spread of Communism in the Americas was also one of the goals of the Alliance for Progress, which John F. Kennedy launched in 1961, shortly after Fidel Castro aligned Cuba with the Soviet Union.[66] The Alliance for Progress provided financial aid to Latin America for a variety of development projects. As several scholars have shown, this kind of development aid reflected an ethnocentric belief in the universal applicability of lessons learned in the course of US industrialization.[67] Trust in the power of private enterprise, free trade, open information flows, and faith in individuals as the main agents in the transformation of their societies, without necessarily addressing the constraining role of already-existing institutions and the environment, constituted the core principles of this ideology.[68] As Walt Rostow optimistically held, the laws of

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[65] Fred Sai of the International Planned Parenthood Federation even spoke sympathetically of "the Fourth Horseman of the Apocalypse," Death, which "has suddenly lost his power to keep down the population." See Fred Sai, Population and National Development – The Dilemma of Developing Countries (London: IPPF, 1977: 7). See also John Sharpless, "Population Science, Private Foundations and Development Aid," in Frederick Cooper and Randall Packard (eds.), International Development and the Social Sciences (Berkeley: University of California Press, 1997).

[66] Gareth Stedman Jones, "The Specificity of US Imperialism," New Left Review 60 (1970): 59-86; Allen Kelley, "Economic Consequences of Population Change in the Third World" Journal of Economic Literature 26, 4 (1988): 1685-1728; Peter Smith, Talons of the Eagle: Dynamics of U.S.-Latin American Relations (New York: Oxford University Press, 2000).

[67] Serge Latouche, The Westernisation of the World: The Significance, Scope and Limits of the Drive towards Global Uniformity (Cambridge: Polity Press, 1996).

[68] Rosenberg, Spreading the American Dream; Adas, Machines as the Measure of Men; William Stein, Deconstructing Development Discourse in Peru: A Meta-Ethnography of the Modernity Project at Vicos (Lanham: University Press of America, 2003).

development were the same for all countries. Once all the "right" conditions were in place, a "take-off" from a "traditional society" towards capitalist modernity was inevitable and irreversible.[69]

Despite the importance of the United States government's drive towards development in Latin America, it did not fund family planning projects until 1965, under Lyndon Johnson.[70] Between the 1950s and the mid-1960s, only a handful of US organizations deemed the curbing of population growth in Latin America a priority, and acted accordingly.[71] The Milbank Memorial Fund (MMF), for example, funded the Milbank Faculty Fellowship Program, which emphasized the importance of demography as a part of medical education.[72] In addition, the MMF disseminated demographic and contraception research in Latin America through its journal, The Milbank Memorial Fund Quarterly,[73] and sponsored two conferences in New York City featuring Latin American physicians and government officers supportive of family planning in 1965 and 1967.[74]

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[69] Rostow, The Stages of Economic Growth.
[70] Phyllis Piotrow, World Population Crisis: The United States Response (New York: Praeger, 1973: 90). The exact role of the United States government in family planning assistance in Peru is the subject of chapter five.
[71] Dudley Kirk, "Population Changes and the Postwar World," American Sociological Review, 9 (1944): 28-35.
[72] Kiser, "The Work of the Milbank Memorial Fund."
[73] Davis and Casis, "Urbanization in Latin America"; Kingsley Davis, "Future Migration into Latin America," Milbank Memorial Fund Quarterly 25, 1 (1946): 44-62; Kingsley Davis, "Puerto Rico's Population Problem: Research and Policy," Milbank Memorial Fund Quarterly 26, 3 (1948): 300-308; J. Mayone Stycos, "Contraception and Catholicism in Puerto Rico," Milbank Memorial Fund Quarterly 34, 2 (1956): 150-159; J. Mayone Stycos, "Female Employment and Fertility in Lima, Peru," Milbank Memorial Fund Quarterly 43, 1 (1965): 42-54; Marie-Françoise Hall, "Birth Control in Lima, Peru: Attitudes and Practices," Milbank Memorial Fund Quarterly 43, 4 (1965, part 1): 409-438; Marie-Françoise Hall, "Family Planning in Lima, Peru," Milbank Memorial Fund Quarterly 43, 4 (1965, part 2): 100-116; Kiser, "Population Trends and Public Health in Latin America"; Eduardo Arriaga, "Components of City Growth in Selected Latin American Countries," Milbank Memorial Fund Quarterly 46, 2 (1968): 237-252; John

The Population Council (PC) also promoted population reduction in Latin America. Established in 1952, following a meeting organized by John D. Rockefeller III with demographers, scientists, academic administrators, and population activists, the PC embraced the idea that the mass utilization of birth control was necessary for development to occur in the Third World. Frank Notestein had argued this since the mid-1940s, as Advisor to the United Nations Population Commission. In Notestein's opinion, the social and economic improvements brought on by modernization in developing countries would lead people to limit their fertility spontaneously, but not quickly enough to prevent damages to the environment and political instability.[75] Notestein became the third President of the PC, and his tenure (1959-1968) was the longest of any PC President in the period covered by this dissertation.

The PC's strategy, from the outset, was to fund studies to persuade medical and policymaking elites of the clinical and, especially, economic and political value of population limitation. As Notestein put it, "Probably the best way to make progress in a dangerous field is to sponsor 'research' rather than 'action.' Who can be against

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Weeks, "Urban and Rural Natural Increase in Chile," Milbank Memorial Fund Quarterly 48, 1 (1970): 71-89; Marie-Françoise Hall, "Male Use of Contraception and Attitudes toward Abortion, Santiago Chile 1968," Milbank Memorial Fund Quarterly 48, 2 (1970): 145-166; Clyde Kiser, "Unresolved Issues in Research on Fertility in Latin America," Milbank Memorial Fund Quarterly 49, 3 (1971): 379-388. See also Milbank Memorial Fund Quarterly special issue 42, 2 (1964, part 1), on "Demography and Public Health in Latin America."

[74] The conference on "Components of Population Change in Latin America," was held from April 5th to 7th, 1965; and that on "Current Research on Fertility and Family Planning in Latin America," was held on October 17th to 19th, 1967. See Milbank Memorial Fund Quarterly 43 4 (1965, part 2); and Milbank Memorial Fund Quarterly 46, 3 (1968).

[75] Frank Notestein, "Zero Population Growth," Population Index 36 (1970): 446.

'truth'?"[76] The PC's first major program consisted of fellowships in demography and reproductive physiology for post-graduate researchers.[77] Between 1953 and 1977, most of these fellows came from India (123) and the United States (167). In Latin America, the PC funded CELADE's activities, and awarded individual fellowships to twenty-three Argentinian, twenty-two Colombian, twenty Chilean, and eleven Peruvian researchers.[78]

What distinguished the PC in Latin America was its strong promotion of a particular kind of population research tool: the Knowledge-Attitudes-Practice (KAP) or Attitude-Use-Knowledge (AUK) survey. Carried out in dozens of countries starting in the late 1940s, including Peru, Chile, Argentina, Brazil, Colombia, Costa Rica, Mexico, Panama, Haiti, Puerto Rico, and Venezuela, and often published in the PC journal Studies in Family Planning, KAP surveys assessed what individuals of reproductive age knew, felt, and were doing about birth control.[79] Sociologist Joseph Mayone Stycos, Director of

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[76] Frank Notestein, "Demography in the United States: A Partial Account of the Development of the Field," Population and Development Review 8, 4 (1982): 651-687, 684.

[77] The program was established in 1954. See Frederick Osborn, "The Population Council Fellowship Program," Milbank Memorial Fund Quarterly 32, 1 (1954): 118-119.

[78] Elaine Moss, The Population Council: A Chronicle of the First Twenty-Five Years, 1952-1977 (New York: Population Council, 1978: 178-193). See also Somoza, "Demographic Research of CELADE," 124.

[79] KAP survey-based studies in Latin America include Hall, "Birth Control in Lima, Peru, Part 1"; Hall, "Family Planning in Lima, Peru, Part 2"; Alfredo Aguirre, "The Family in Candelaria," Studies in Family Planning 1, 10 (1966): 1-5; J. Mayone Stycos and Parker Marden, "Honduras: Fertility and an Evaluation of Family Planning Programs," Studies in Family Planning 1, 57 (1970): 20-24; Hall, "Male Use of Contraception and Attitudes toward Abortion"; Allan Keller, "Mexico City: A Clinic Dropout Study," Studies in Family Planning 2, 9 (1971): 197-201; Jerald Bailey, Guillermo Lopez Escobar and Alcides Estrada, "A Colombian View of the Condom," Studies in Family Planning 4, 3 (1973): 60-64; Pieter van Keep and Edris Rice-Wray "Attitudes Toward Family Planning in Mexico City," Studies in Family Planning 4, 11 (1973): 305-309; Jack Reynolds "Costa Rica: Measuring the Demographic Impact of Family Planning Programs," Studies in Family Planning 4, 10 (1973): 310-316; Jerald Bailey, Carol Measham and Maria Umana, "Fertility and Contraceptive Practice: Bogota, 1964-74," Studies in Family

the International Population Program at Cornell University and a PC fellow in 1954, became one of the foremost experts in the application of the KAP methodology in Latin America.[80]

KAP fertility surveys were derived from corporate marketing research pioneered in the United States, which aimed to demonstrate the existence of a latent demand for goods or services, birth control in this case. Politically, this research helped persuade policy makers that, with public support behind smaller families, there was little risk in embracing and sponsoring birth control technologies. As research tools, KAP fertility surveys were dramatic demonstrations of the power and flexibility of the survey methodology. These surveys routinely asked about the frequency of intercourse, the birth control methods used, the reasons why people had stopped using a particular method, and even the number of abortions a woman had had. These topics were, as Stycos put it, "generally believed accessible only within the confessional."[81] The fact that Latin American surveyees responded to embarrassing and potentially incriminating questions surprised US researchers. Following Marie-Françoise Hall's presentation of the results of her survey in Lima, for example, Dr. C.F. Westoff admitted that "these questions on contraception could not be asked for Catholics [in the United States]. It is amazing in

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Planning 7, 9 (1976): 249-260. See also Donald Warwick, "The Politics of Research on Fertility Control," Population and Development Review 20 (1994 Supplement): 179-193; John Cleland, "A Critique of KAP Studies and Some Suggestions for Their Improvement," Studies in Family Planning 4, 2 (1973): 42-47.

[80] Stycos, "Contraception and Catholicism in Puerto Rico"; J. Mayone Stycos, "Survey Research and Population Control in Latin America," Public Opinion Quarterly 28, 3 (1964): 367-372; Stycos, "Female Employment and Fertility in Lima, Peru"; J. Mayone Stycos, Human Fertility in Latin America: Sociological Perspectives (Ithaca: Cornell University Press, 1968); J. Mayone Stycos, "Public and Private Opinion on Population and Family Planning," Studies in Family Planning 1, 51 (1970): 10-17.

[81] Stycos, "Survey Research and Population Control in Latin America," 367.

Latin America, where fertility surveys started much later, that investigators moved much more quickly and without any seeming hesitation to ask questions on abortion and appear to get results."[82]

In 1960, Stycos became the first to conduct KAP fertility surveys in Peru.[83] With the help of a local marketing consultant, Carlos Uriarte, Stycos selected a random sample of city blocks stratified by three levels of income. Stycos also sought the assistance of the Faculty of Social Work at San Marcos University to select female students who could work as interviewers.[84] Belgian-Canadian physician Marie-Françoise Hall, from Johns Hopkins University's department of International Health, followed and then went farther than Stycos had. Hall also targeted women of childbearing age in Lima; she engaged the services of Carlos Uriarte to stratify her sample of city blocks by three levels of income; and she recruited female students from San Marcos University's Faculty of Social Work to work as interviewers. But while Stycos had not asked about specific methods of contraception, Hall did, and, furthermore, she asked women whether they had had induced abortions.[85]

Stycos's and Hall's publications were significant for many reasons. They provided evidence that women were interested in controlling their fertility more effectively, and that income levels directly affected how likely women were to use contraception. Their publications also confirmed suspicions that induced abortions were

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[82] Hall, "Family Planning in Lima, Peru, Part 2," 112-113.
[83] Stycos, "Female Employment and Fertility in Lima"; Stycos, Human Fertility in Latin America, 147-161.
[84] Stycos, Human Fertility in Latin America, 46.
[85] Marie-Françoise Hall, "Control de la Natalidad en Lima, Perú," Anales de la Facultad de Medicina 49, 1 (1966): 1-27.

as common an occurrence in Peru as they were elsewhere in Latin America.[86] Stycos predicted, accurately to some extent, that the Peruvian government would welcome family planning as it realized the economic benefits of population limitation.[87] At the same time, Hall recognized the tensions that existed within Latin American governments, Peru in particular, between recognizing some of the macroeconomic benefits of lower fertility rates, and other national objectives, such as populating the interior, which required population growth.[88] Hall also dismissed proposals emanating from the United States, which included making population limitation control a prerequisite for foreign aid, individual financial incentives to not have children, and disseminating long-term chemical contraceptives through the air and waterways.[89] Several Peruvian medical students copied Stycos's and Hall's questionnaires and performed similar KAP fertility studies in the low-income urban areas that surrounded Lima.[90] Their results were similar

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[86] Rice-Wray, "The Provoked Abortion." See also Proceedings of the 4th IPPF/WHR Conference, San Juan, Puerto Rico, April 1964 (New York: IPPF, 1965), particularly the papers by F.N. Gómez and V.C. García, "Investigación sobre Aborto Ilegal y Planificación de Familia en el Centro Municipal de Sexología (Hospital Rawson, Buenos Aires)"; I. Rozada, "La Situación del Aborto Voluntario en el Uruguay: Posibles Soluciones"; and L.D. Merchan, "First Results of Birth Control in Concepción Palacios Maternity, Caracas, Venezuela."

[87] Stycos, Human Fertility in Latin America, 4.

[88] Marie-Françoise Hall, "Population Growth, US and Latin American Views: An Interpretation of the Response of the United States and Latin America to the Latin American Population Growth," Population Studies 27, 3 (1973): 415-429.

[89] These included, but were not limited to: Notestein, "Zero Population Growth"; Stephen Enke, "The Economics of Government Payments to Limit Population," Economic Development and Cultural Change 8 (1960): 339-348; Ronald Ridker, "Synopsis of a Proposal for a Family Planning Board," Studies in Family Planning 43 (1969): 11-16; Paul Ehrlich, The Population Bomb (New York: Sierra Club, 1969); Lenni Kangas, "Integrated Incentives for Fertility Control," Science 169 (1970): 1278-1283); Edward Pohlman, How to Kill Population (Philadelphia: Westminster, 1971).

[90] Felipe Iannacone Martínez, "Vida Reproductiva en las Mujeres de 20 a 39 Años," (Tesis de Grado, Facultad de Medicina de San Fernando, 1964); Carlos Alberto Silva Valladares, "Vida Reproductiva de las Mujeres de 20-39 Años," (Tesis de Grado,

to Stycos's and Hall's. Hall's work was even featured in Caretas, still one of the most popular weekly news magazines in Peru.[91]

We must, however, not accept KAP survey results uncritically, as the surveys were deeply flawed by design. Researchers' reports presented answers as if respondents had thought about fertility enough to have formed a definitive and unchanging opinion about family size that they would be willing to share with a stranger. Not only that: surveyors interpreted women's and men's very willingness to answer their questions as signs that they had positive attitudes towards birth control. Perhaps most problematically, KAP surveys inferred actual practice from mere reported statements. Not surprisingly, KAP survey results were of devastating uniformity throughout the whole of Latin America: all women surveyed wanted a "moderate" number of children, all were convinced of the economic disadvantages of a large family, and they were all eager for information to do something about curbing the number of offspring. The KAP survey was above all a marketing exercise to best position a product before local decision-makers reluctant to sacrifice their political capital for a novel cause. To paraphrase former PC President Paul Demeny, KAP surveys were part of a demographic research industry, designed to attain specific demographic targets and little else.[92] We may actually know

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Facultad de Medicina de San Fernando, 1966); and José P. Navas Mena, "Planificación Familiar en el Medio Policial," (Tesis de Grado, Facultad de Medicina de San Fernando, 1966).

[91] "La Encuesta Hall," Caretas 296, 14 (29 August 1964): 30-38.

[92] Demeny, "Social Science and Population Policy."

less about the complex aspirations of women and men regarding their sexuality and children in the 1950s and 1960s *because* of the prevalence of KAP surveys.[93]

Population researchers such as Stycos and Hall were staunch promoters of massively used, long-term birth control, provided and monitored by physicians for developing countries.[94] Organizations such as the IPPF and the PC also promoted the study and utilization of such technologies, and fastened on the intra-uterine device (IUD) as the most promising among them.[95] Berlin obstetrician Ernst Gräfenberg had invented and used the first IUDs, made of coiled silver or gold wire, in the late 1920s. Despite the popularity of these devices in Europe in the early 1930s, few articles on IUDs were published between 1934 and 1959. It was only in the late 1940s, with the "demographic explosion" idea coming of age, that interest in the IUD re-emerged, as a "solution" for the problem of rapid population growth in developing countries.[96] Second generation IUDs, made of flexible plastic instead of metal, were effective and cheaper than hormonal contraceptives. Like birth control pills, foams, and cervical caps, IUDs placed the responsibility for family planning on women, who had most to gain from having fewer

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[93] For an even more critical take on the KAP methodology, see chapter seven in Donald Warwick, Bitter Pills: Population Policies and Their Implementation in Eight Developing Countries (Cambridge: Cambridge University Press, 1982).
[94] Taylor and Hall, "Health Population and Economic Development".
[95] Alan Guttmacher, "The Pill around the World," IPPF Medical Bulletin 1, 1 (1966): 1-2.
[96] M. Halton, R.L. Dickinson and C. Tietze, "Contraception with an Intrauterine Silk Coil", Human Fertility 13 (1948): 10-13; W. Oppenheimer, "Prevention of Pregnancy by the Gräfenberg Ring Method", American Journal of Obstetrics and Gynecology 78 (1959): 446-454. On the history of the IUD, see M. Thiery, "Pioneers of the Intrauterine Device," European Journal of Contraception and Reproductive Health Care 2, 1 (1997): 15-23; and W.A.A. Van Os, "The Intrauterine Device and Its Dynamics," Advances in Contraception 15 (1999): 119-132.

children, at least according to KAP fertility surveys.[97] Unlike other contraceptives, however, IUDs did not require any action by the user once fitted, and could not be removed without a medical procedure.

To US medical experts, the latter characteristic made the IUD ideal for women in developing countries, believed too irresponsible to be trusted with the simple task of swallowing a daily pill. Here, these experts showed a strong prejudice against women in the developing world, one they also showed against the racial minorities and the poor in their own countries.[98] The threatening discourse about the population explosion discouraged health workers and funding agencies from implementing longer-term projects to educate people about the advantages and disadvantages of what were radically new technologies in many developing nations. It also discouraged the establishment of channels through which users and health workers could formally discuss the problems IUDs caused.

IUDs gave more control to medical workers over women's reproductive choices in developing countries because the insertion of these contraceptives required special skills and tools, and because medical workers directed the circulation of IUDs donated by foreign aid agencies. The participation of health workers meant that experts could keep accurate records of IUD users. Faith in the IUD was such that PC Vice President Bernard Berelson believed that "from several standpoints, it may be best to provide a cafeteria choice – 'here are all the recommended methods, select the one most suitable to you' – but at the same time to stress the desirability of the IUD. Actually, it would probably be

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[97] Bernard Berelson, "National Family Planning Programs: A Guide," Studies in Family Planning 1, 5 (1964, Supplement): 1-12.
[98] Hartmann, Reproductive Rights and Wrongs.

more economic and no less effective to base a program on IUD and condom alone, with aerosol foam and the pill perhaps offered to women who cannot tolerate or do not wish the IUD."[99]

Beginning in 1962, the PC began to invest "heavily" in IUD research, granting some US$ 2 million by 1964.[100] The Ortho Pharmaceutical Company, which manufactured the Margulies spiral IUD and held the patent for the Lippes Loop, the most popular IUD at the time, gave the PC a royalty-free license for the manufacture of Lippes Loops to be used in large-scale family planning programs in developing countries.[101] In late April 1962, the Population Council held the first international conference on intra-uterine devices in New York, chaired by Alan F. Guttmacher, Chief of the department of Obstetrics and Gynecology at Mount Sinai Hospital and President of the IPPF.[102]

Presenters and attendees at this conference were overwhelmingly in favor of the mass use of IUDs in developing countries. At the conference's inauguration, Guttmacher warned that their efforts to arrest population growth moved slowly because "our methods are largely birth control for the individual, not birth control for a nation."[103] When Dr. Lehfeldt, of New York University's Bellevue Medical Center, cautioned that thorough medical histories were necessary to reveal pelvic inflammatory diseases, which were contraindicated with IUD use, Guttmacher objected because an elaborate history "would make a more time-consuming job out of intra-uterine contraception. We dare not lose

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[99] Berelson, "National Family Planning Programs", 8.
[100] Moss, The Population Council, 62.
[101] Moss, The Population Council, 63.
[102] Christopher Tietze and Sarah Lewit (eds.), Proceedings of the First International Conference on Intra-Uterine Devices (Amsterdam: Excerpta Medica, 1962).
[103] Tietze and Lewit, First International Conference on IUDs, 7.

sight of our goal – to apply this method to large populations."[104] Edris Rice-Wray, Director of Research of the *Asociación Mexicana Pro-Bienestar de la Familia*, an IPPF grantee in Mexico City, believed that in Latin America, "there would be no problem of patient acceptance. Once the patients have confidence in the doctor, they will accept almost anything."[105] Jaime Zipper and Hernán Sanhueza, from the Obstetrics and Gynecology department of the Barros Luco Hospital in Santiago, Chile, presented their new and very cheap IUD design, which consisted of a 2-meter long thread of sterilized nylon, coiled into a ring of 25mm in diameter. The physicians believed the low cost of their device made it an appropriate technology for use in low-income areas.[106]

There were no Peruvians at this first international conference on IUDs. However, a number of Peruvian physicians attended the next one. The conference was held in New York City in October of 1964, sponsored again by the PC.[107] Chilean Jaime Zipper emerged one more time as the most aggressive Latin American promoter of IUDs, as a means to prevent both the human and hospitalization costs of induced abortions.[108] The IUD was, as he put it, "a technique of great value for the safe control of mass population

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[104] Tietze and Lewit, First International Conference on IUDs, 122.
[105] Tietze and Lewit, First International Conference on IUDs, 135.
[106] Tietze and Lewit, First International Conference on IUDs, 57-59.
[107] S.J. Segal, A.L. Southam and K.D. Shafer (eds.), Proceedings of the Second International Conference on Intra-Uterine Contraception (Amsterdam: Excerpta Medica, 1965).
[108] By then, Zipper had been awarded a PC fellowship (1962). He spent that year learning reproductive physiology at the Worcester Foundation in Shrewsbury, Massachusetts, under Gregory Pincus, the inventor of the contraceptive pill. There he discovered the role of metal ions, like copper, in preventing the implantation of fertilized eggs in the uterus, which led to his invention of the copper-T IUD in 1968, for which he received numerous patents, held by G.D. Searle. See Thiery, "Pioneers of the Intrauterine Device." See also Zipper's patents: United States Patent 3,563,235, "Intrauterine Contraceptive Method," (18 September 1968); United States Patent 28,399, "Intrauterine Contraceptive Method (reissued 29 April 1975); United States Patent 4,040,417, "Intrauterine Device," (9 August 1977).

growth." He even believed that giving women choices of contraceptives was not advisable: "the medical profession rather than the patient must ultimately decide on the efficiency of any procedure in the light of all the relevant factors, and accommodate one or several techniques to the specific conditions of a country." Zipper continued using his coiled nylon ring, and, although he acknowledged that the device could aggravate chronic pelvic inflammations, to him, "it seems worthwhile to employ the method, especially if it enables us to reduce the rate of increase of the population with a penalty of only 8 hospitalizations in 4,130 woman-years of use."[109]

According to the logic of physicians such as Rice-Wray and Zipper, being poor and female in Latin America meant that a person could not be trusted to use a birth control method, such as the pill, that required the discipline to ingest a drug at regular intervals. The very act of consuming the pill regularly can be seen as a self-disciplining process, a form of power over oneself acquired through education and practice. Yet some physicians thought of self-discipline as something that a person had or had not, not as something to be cultivated over time.[110] To the former, the poor lacked discipline to such an extent that permitting them to use the pill would be wasteful and futile. Not surprisingly, these physicians welcomed the IUD's bypassing of user involvement and its dependence on medical skill. The device itself, expertly fitted, could reduce fertility without necessarily educating women about its advantages or changing their daily behaviors to induce self-disciplining habits. In that sense, the IUD was at the same time a vehicle for medical authoritarianism and female *in*disciplining.

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[109] Segal, Southam and Shafer, Second International Conference on IUDs, 90-92.
[110] Several US social scientists took a similar view of the urban poor as lacking discipline. See for example, Oscar Lewis, "The Culture of Poverty," Scientific American 215, 4 (October 1966): 19-25.

Between the two PC conferences on IUDs, the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) sponsored its First and Second Family Planning Seminars for Latin American Leaders in New York City, in June of 1962 and in October of 1963.[111] These were small information and promotional conferences for physicians, nurses, and social workers. The IPPF/WHR had been established eight years before, in 1954, mainly as a result of the efforts of the Planned Parenthood Federation of America (PPFA).[112] The PPFA played an important role organizing the national family planning agencies that came together as the International Planned Parenthood Federation (IPPF) in 1952. In the 1950s, the PPFA began to expand its activities in the Americas, first funding a birth control clinic in Jamaica, then in Barbados, Bermuda, and Puerto Rico. At a meeting in San Juan, Puerto Rico, in 1954, these advocates launched the IPPF/WHR to fund and promote the use of birth control in Latin America. Shortly thereafter, the IPPF/WHR recruited Honduran sociologist Ofelia Mendoza as Field Director and liaison with the various constituencies of physicians and policymakers the IPPF/WHR sought to sway.[113]

The IPPF/WHR provided the funds to set up and operate birth control clinics in several Latin American countries: Mexico City in 1959, Montevideo in 1961, Santiago in 1962, Tegucigalpa and Caracas in 1963, and Bogota in 1964. Between 1964 and 1965, new IPPF/WHR-funded clinics opened in Buenos Aires, Rio de Janeiro, San Jose, Quito,

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[111] Sophia Smith Collection, Papers of the Planned Parenthood Federation of America (hereafter SSC): PPFA II, box 204, folder 17: "First Family Planning Seminar for Latin American Leaders, 2-15 June 1962"; and folder 16: "Second Family Planning Seminar for Latin American Leaders, 6-18 October 1963."
[112] On the history of the PPFA, see Gordon, Woman's Body, Woman's Right; Tone, Devices and Desires; and Meyer, Any Friend of the Movement.
[113] Anonymous, "The First Forty Years," IPPF/WHR Forum 10, 1 (1994): 36-41.

San Salvador, Port-au-Prince, Panama City, and Asuncion. An IPPF/WHR-funded clinic opened in Lima, Peru, in 1967. Because the IPPF/WHR's primary strategy was to normalize the use of birth control, it funded clinics in the most populous cities, and targeted high-parity women, particularly those who were about to or had recently given birth, hoping, as PC Vice-President Bernard Berelson hoped, that "[o]nce the practice of family planning gets well-established among those couples with 3-4 children, it will filter down to be acceptable at the lower ranges too." These "lower ranges" included smaller cities and rural areas.[114]

Ofelia Mendoza conducted the negotiations to set up local clinics personally in all cases. She was responsible for the strategy of marketing birth control as something that protected families from poverty and ill-health, which was emphasized in the very name of every IPPF/WHR-funded organization, such as the Puerto Rican Association for Family Welfare (*Asociación Puertorriqueña Pro-Bienestar de la Familia*), the Mexican Association for Family Welfare (*Asociación Mexicana Pro-Bienestar de la Familia*), Colombia's Profamilia, the Chilean Association for Family Protection (*Asociación Chilena para la Protección Familiar*), the Civil Association for Family Welfare of Brazil (*Sociedade Civil de Bem-Estar Familiar no Brasil, BEMFAM*), and the Peruvian Association for Family Protection (*Asociación Peruana para la Protección Familiar*).[115]

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[114] Berelson, "National Family Planning Programs: A Guide", 3.
[115] SSC: PPFA II, box 205, folder 3; box 202, folder 26; and box 204, folder 20 for examples of Mendoza's correspondence to set up local clinics. See also Anonymous, "The First Forty Years," 38; and Axel Mundigo, "The Role of Family Planning Programmes in the Fertility Transition of Latin America," in José Miguel Guzmán, Susheela Singh, Germán Rodríguez and Edith Pantelides (eds.), The Fertility Transition in Latin America (Oxford: Clarendon, 1996).

The IPPF/WHR Family Planning Seminars for Latin American Leaders of 1962 and 1963 revealed a high degree of coordination between the IPPF and the PC. Speakers at the conferences included IPPF officers such as Dr. Alan Guttmacher and Ofelia Mendoza; as well as PC and IPPF fellowship awardees such as Dr. John Rock and Dr. Gregory Pincus, developers of the contraceptive pill, IUD inventors Dr. Lazar Margulies and Dr. Jaime Zipper, and sociologist Joseph Stycos. The objective was to impart practical advice to set up family planning clinics. Consequently, the Latin American guests visited the headquarters of New York City's Department of Health, the IPPF, and the PC. They toured the Bellevue and Mount Sinai hospitals, IPPF clinics, and the IUD manufacturing plant of the Ortho Pharmaceutical Corporation in Raritan, New Jersey.[116]

The support of institutions such as the IPPF/WHR and the PC played a role in the formation of the small Peruvian constituency that actively supported birth control. None of the eighteen attendees of the first IPPF/WHR Family Planning Seminar for Latin American Leaders came from Peru, but five of them were invited to the second one. In fact, Peru's was the largest delegation of any Latin American nation at that second meeting, which included representatives from Puerto Rico, Argentina, Colombia, Ecuador, Chile, Uruguay, Panama, Paraguay, Venezuela, and Brazil.[117] Likewise, none of the attendees at the 1962 PC-sponsored First International Conference on IUDs was from Peru, yet at least one was on the occasion of the Second International Conference on IUDs in 1964.

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[116] SSC: PPFA II, box 204, folders 16 and 17: "First and Second Family Planning Seminars for Latin American Leaders, 2-15 June 1962, and 6-18 October 1963."
[117] Only Argentina, Bolivia, Chile, El Salvador, Guatemala, Honduras, Mexico and Puerto Rico sent delegates to the 1962 seminar.

Again, however, we must pay attention to more circumscribed events to better understand the origins of the Peruvian birth control establishment. This was the outcome of a process that lasted approximately twenty years. It required a broad expansion in the regional capacity to conduct demographic research, through CELADE and ECLA, as well as the popularization of the KAP fertility survey. This provided evidence to medical workers that poverty, ill health, induced abortions, and underdevelopment were related phenomena. Even then, local pro-natalist policies and General Odría's decision not to conduct a census in 1950 indicate that politically powerful groups would not tolerate governmental involvement with birth control. The physicians, researchers, and bureaucrats that were persuaded of the benefits of these technologies were few in number, but they were also well trained, well connected to prestigious colleagues abroad, and, thanks to the PC and IPPF/WHR, well-funded. This professional community is the subject of the next section.

Diffusion Strategies in Peruvian Family Planning, 1964-1974

Birth control services became more publicly available, through privately- and state-funded initiatives between 1964 and 1968. The 1961 census, the creation of Cayetano Heredia University in 1961, and the establishment of the government's Center for the Study of Population and Development (*Centro de Estudios de Población y Desarrollo*, CEPD) in 1964 were responsible for this expansion. The contraction period began with General Juan Velasco Alvarado's coup d'état in 1968, and was singularly marked by Grl. Velasco's banishing of the most prominent IPPF grantee in the country, the Peruvian Association for Family Protection, in 1974. In this section I will present the

different ways in which the Peruvian birth control establishment inserted itself within the nation's broader scientific, medical, and political circles.

Consistent with the trends in clinical and public health thinking that dominated the 1940s and 1950s, discussed in the first section, these actors emphasized the individual health benefits, the familial stability, and the national improvements that would follow a moderate reduction in birth rates. Influenced by KAP research, birth control advocates in Peru embraced the notion that there indeed was a large unstated demand for contraceptives. However, Peruvian birth control advocates did not support the more aggressive claims of their US allies about the pressing need to reduce population size, which were more popular in countries like Chile and Colombia.[118] Rather, from the beginning, the CEPD cast birth control services as a means to soften the impact of an imminent population explosion.

Several important institutional changes occurred in the early 1960s. First, a new school of medicine opened as a result of a schism within San Marcos University. In the 1920s, President Augusto B. Leguía legalized the participation of university students within the governing council of San Marcos University, which, among other things, decided professorial hirings and promotions. The power of students at the highest levels of university decision-making marked the beginning of an embattled relation between professors and the more politically active students. Between 1935 and 1949, subsequent

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[118] See Hugh Davis, (ed.), Proceedings of the Third Panamerican Sanitary Bureau Conference on Population Dynamics, 13 February 1967 (Washington: PASB, 1967), particularly the interventions of Dr. Hernan Mendoza Hoyos, of the Colombian Association of Faculties of Medicine (ASCOFAME) and Dr. Dr. Juan A. Zañartu, of the Faculty of Medicine of the Universidad de Chile. See also María Fajardo Hernández, La Construcción del "Problema de Población" en Colombia, 1965-1970: Autoridad Científica, Orden Social y Desarrollo (Bogota: Departamento de Historia, Universidad de los Andes, 2007).

governments repealed and reinstated the law. The first half of 1961 was particularly acrimonious, and ended with the resignation of 423 of 711 San Marcos professors. Those among them who specialized in science and medicine banded together and established the *Universidad Peruana Cayetano Heredia* (Cayetano Heredia University, UPCH). A private university, the UPCH was not only better funded, but also successfully discouraged student participation in administrative affairs. Soon, the UPCH established its own medical school, the second one in the country, and made an agreement with the Arzobispo Loayza Hospital to make the latter the UPCH Medical Faculty's teaching hospital.[119] Within a few years, UPCH researchers became important participants in the promotion of birth control programs, as I will show below.

With CELADE's help, Peru conducted its Sixth National Population census also in 1961. According to this census, the country's population had grown to over ten million people, from seven million in 1940.[120] That is, the population had grown by almost half in the span of twenty years. The results were consistent with those projected by a study President Manuel Prado commissioned from Boston consulting firm Arthur D. Little in 1960. This report indicated that Peru faced "one of the most serious demographic growth situations in the world."[121] However, two years of political turmoil prevented the Peruvian political apparatus from addressing the marked population growth. The Peruvian military formed a Governing Junta in 1962, displeased with election results that

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[119] Bustios Romaní, "Historia de la Educación Médica en el Perú, Primera Parte"; and Bustios Romaní, "Historia de la Educación Médica, Segunda Parte."
[120] INEI, "Historia de los Censos en el Perú."
[121] "A Program for the Industrial and Regional Development of Peru: Report to the Government of Peru," cited in Alberto Varillas and Patricia Mostajo, La Situación Poblacional Peruana: Balance y Perspectivas (Lima: Instituto Andino de Estudios en Poblacion y Desarrollo, 1990: 315).

made it likely for APRA's Victor Raúl Haya de la Torre to win the presidency. The Junta called for elections in 1963, and Fernando Belaúnde of the *Acción Popular* party was elected President.[122]

President Belaúnde acted swiftly on the population question. Within a year, the National Office of Statistics and the Census had created its Demographic Analysis Unit, complete with IBM computers to process data. Likewise, the Biostatistics Division of the Ministry of Health upgraded its procedures for the registration of births, deaths, and diseases. Most importantly, in 1964 Belaúnde created the Center for Population and Development Studies (*Centro de Estudios de Población y Desarrollo*, CEPD), within the Ministry of Labor, and appointed then-Senator Alberto Arca Parró as its first Director.[123]

The CEPD's purpose was to conduct research on the relationship between demographic phenomena and economic and social ones, as well as to disseminate this research and train demography specialists. The CEPD was also to represent the state internationally in the population field and serve as liaison between the Peruvian government and foreign agencies interested in population issues. Support from international organizations had been crucial to the CEPD's establishment. The US Agency for International Development, the Population Council, the Ford Foundation, the Milbank Memorial Fund, and the IPPF/WHR provided funding for the CEPD's planned activities. In fact, Senator Alberto Arca Parró, Minister of Health Javier Arias Stella, and UPCH Professor Carlos Muñoz Torcello had begun conversations with the PC's Latin

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[122] On Belaúnde's reforms, see Caballero, Economía Agraria de la Sierra Peruana.
[123] Rockefeller Archive Center's Population Council collection (hereafter "RAC-PC"): Grant files, accession 1, box 66, folder 1156: "First National Seminar on Population and Development (Paracas, December 5-11, 1965), Summary of the General Report presented at the Closing Ceremony."

American Consultant, Joseph Stycos, shortly after the withdrawal of the military junta from power in 1963. These conversations made it clear that these experts believed the incoming administration of Fernando Belaúnde would tolerate family planning initiatives.[124] When the CEPD was created, Muñoz Torcello became its Sub-Director, and he wrote to the IPPF/WHR's Ofelia Mendoza to share the news that Peruvians "have started to study the problem at a very high level, which we were able to do after only a short time of having known the work that you people were carrying out."[125]

The Presidential Decree establishing the CEPD acknowledged growing population could be problematic, yet, importantly, it did not make the promotion of birth control a part of the CEPD's original mandate. In fact, it only stated that "the close relationship between demographic growth and economic development should be systematically studied in order to formulate programs of action with which to face the problems of population and socio-economic development, as has been consistently recommended by the General Assembly of the United Nations under the auspices of its Economic and Social Council."[126]

Within its first year of operations, the CEPD began publishing a newsletter, the Boletín Informativo del Centro de Estudios de Población y Desarrollo, and, later, the journal Estudios de Población y Desarrollo. In addition, it organized a seminar in December of 1965. The meeting gathered seventy-four guests from the Organization of American States, CELADE, the Food and Agriculture Organization, the Pan-American

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[124] RAC-PC: Letter from Carlos Muñoz Torcello, CEPD, to J. Mayone Stycos, PC (24 May 1965).
[125] SSC: PPFA II, box 204, folder 20: Carlos Muñoz Torcello to Ofelia Mendoza (21 December 1964).
[126] "Decreto Supremo 244/64-DGS: Centro de Estudios de Población y Desarrollo," El Peruano (5 December 1964: 1).

Health Organization, the US Agency for International Development, the Ford Foundation, the Population Council, and several ministries. CEPD Director Alberto Arca Parró opened the meeting with an explosive admission: Latin America could not match its population growth with corresponding levels of economic and social development. It was time, Arca Parró argued, to consider family planning as part of a population policy. President Belaúnde concurred, admitting that "the demographic explosion is a reality", and calling on all government sectors to brace for further population growth.[127]

Some CEPD collaborators welcomed this attitude by the two most important officers in attendance, including UPCH endocrinologists José Donayre Valle and Luis Sobrevilla Alcázar (a former PC fellow).[128] In 1961, these scientists had established the UPCH's High Altitude Research Center (HARC) in the city of Cerro de Pasco, located at over 4,000 meters above sea level, to study the effects of high altitude on human physiology. In 1966, with PC funds, Donayre and Sobrevilla began studying different aspects of fertility at high altitudes, and even set up a clinic that fitted the Zipper nylon ring IUD on over 1,000 women.[129]

However, not all CEPD collaborators were as warm towards birth control. What some considered excessive population growth, Carlos Monge, Indigenous Policy Advisor at the Ministry of Labor, deemed Peru's "reserve demographic capital."[130] Armando

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[127] CEPD, Primer Seminario de Población y Desarrollo (Lima: CEPD, 1966: xxxi-xxxii).
[128] Richard Clinton, Población y Desarrollo en el Perú (Lima: Universidad de Lima, 1985); Moss, The Population Council, 189.
[129] José Donayre, Rafael Paucar, Francisco Kruger y Mariano Escalante, "Uso del Anillo de Nylon de Zipper en una Comunidad de la Sierra Peruana," Ginecología y Obstetricia 16, 2 (1970): 137-144. For a complete list of HARC publications on human fertility, see UPCH, Instituto de Investigaciones de la Altura, 1961-1986 (Lima: UPCH, 1986).
[130] Carlos Monge, "Distribucion Vertical de la Poblacion," in CEPD, Primer Seminario de Población y Desarrollo, 113-116.

Petrozzi, of the Ministry of Health, presented the 1966-1970 National Health Plan, which emphasized preventive medicine projects to lower infant mortality rates further, and announced that "[s]omewhat optimistically, we might predict that our population ought to still grow further."[131] Luis Barúa Castañeda, of the National Planning Institute, showed how the Peruvian economy had outperformed the Latin American average of two percent per capita growth between 1950 and 1962, growing at 2.5 percent per year per capita during the same period, with less help from the Alliance for Progress than other countries in the region received. However, Barúa's analyses of per capita incomes demonstrated the existence of a very uneven distribution of wealth. To close this gap and reduce migration into coastal cities, he proposed an agrarian reform that privileged the colonization of the Amazon region and the intensive utilization of its presumably underexploited riches.[132]

By 1966, the CEPD had a new Director, UPCH Professor José Donayre. Under his tenure, the CEPD began to conduct its own KAP fertility surveys in low-income urban areas. The CEPD also projected a KAP survey on the incidence of induced abortion in Lima.[133] In addition, the CEPD began to operate family planning clinics in two of Lima's low-income neighborhoods: Pamplona Alta and El Agustino. The Population

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[131] Armando Petrozzi, "El Plan Nacional de Salud," in CEPD, Primer Seminario de Población y Desarrollo, 230.

[132] Luis Barua Castañeda, "El Desarrollo Económico y Social y las Características Demográficas en el Perú," in CEPD, Primer Seminario de Población y Desarrollo, 119-137.

[133] Guillermo Guardia Salas, "Evaluación Quirúrgica de Dispositivos Intrauterinos Aplicados en un Plan Piloto de Planificación Familiar en Pamplona Alta," (Tesis Doctoral, Facultad de Medicina de San Fernando, 1971); José Donayre, "Research Planned by the Center of Studies of Population and Development in Peru," Milbank Memorial Fund Quarterly 46, 3 (1968, part 2): 155-166; and Krishna Roy, "Aspectos Saltantes del Estudio de Fecundidad en El Agustino," Estudios de Población y Desarrollo 3, 4 (1969): 1-8.

Council supplied the CEPD with the contraceptives it needed, mainly IUDs and birth control pills, free of charge. Approximately fifty women visited each clinic every day. As Sanders reported, the clinics' physicians were "convinced IUDs are best for this population, due to their low cost, the low level of education in the community, and the risk that children might eat the contraceptive pills."[134]

The location of the CEPD clinics was not random. It was consistent with the view, prevalent among physicians since the 1930s, that low-income recent immigrants from rural areas were in greater need of medical management than other Peruvians. Likewise, the preference for the IUD suggests the extent to which Peruvian physicians had internalized the advice of donors about its advantages. Even before Peruvian researchers conducted any studies regarding the use and acceptability of different birth control methods, they already favored the IUD. That, of course, should not suggest that health workers were in any capacity to impose the use of birth control on a majority of women. As I will show below, the promotion of birth control use faced tremendous obstacles throughout the 1960s and 1970s.

The friendly attitude of the CEPD toward birth control marked the beginning of an era of greater openness to discuss and act in this field. Dr. Javier Moreno, for example, discussed his practice of voluntary surgical sterilization in the gynecology department of the San Juan Hospital, property of the Marcona Mining Co., a foreign iron mining firm located in Peru's south-central highlands. Moreno had sterilized twenty-two women since 1965 using a tubal electrocauthery technique and noted how, despite the lack of complications or failures, it had been hard for him "to satisfy the medical registration

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[134] Thomas Sanders, La Planificación Familiar en el Peru: Antecedentes de la Política Peruana de Población (Lima: Consejo Nacional de Población, 1984: 39).

committees."[135] Indeed, although Peruvian law did not sanction surgical contraception, the 1933 Constitution criminalized causing injuries to a person. The Peruvian Medical College's Ethics Committee interpreted sterilizations as causing bodily injuries that disabled the reproductive function, and ruled against the performance of these surgeries by members of the medical profession.[136]

This self-censorship by the most important collegiate organization of physicians made it difficult to justify sterilizations in public hospitals. Nevertheless, physicians got around this prohibition by adopting a liberal definition of "risky pregnancies" in practice. When a physician deemed that a future pregnancy could endanger a woman's life, that woman became eligible for the operation at the Lima Maternity Hospital. Physicians scheduled caesarean section surgeries and took the opportunity to perform the sterilization surgeries at the same time. Following their historical analysis of the ratio of caesarean surgeries to vaginal births in the early 1970s, Dr. Elmer Chávez and Dr. Carlos Bachmann became convinced that their colleagues at the Lima Maternity Hospital exaggerated the need for caesarean surgeries, only to have an opportunity to perform

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[135] Javier Moreno, "Esterilización Tubárica Bilateral por Pinzamientos Sucesivos y Electrocauterización," Tribuna Médica 4, 157 (18 September 1967): 1, 6-7, 7. The earliest reported voluntary surgical sterilizations date from 1953. Dr. Landauro Valentini, performed at least four tubal ligations on women. He insisted on the need for these interventions to occur following consultation with at least three medical colleagues, while requiring only the affirmation of a desire to not have any more children on the acceptor's behalf. See Landauro Valentini Alonso, "La Esterilización Quirúrgica en Obstetricia," Boletín de la Asociación de Médicos del Hospital de Mujeres y Maternidad del Callao IX, VII, 37 (July-August 1953): 857-863. On surgical contraceptive techniques available in the 1950s and 1960s, see T.N. Evans, "Female Sterilization," in E.S.E. Hafez, Human Reproduction: Conception and Contraception (Hagerstown: Harper & Row, 1980).

[136] CENDOC-Mujer: Centro de la Mujer Peruana Flora Tristán, Movimiento Manuela Ramos, Red Nacional de Promoción de la Mujer, APROPO, INPPARES and REDESS Jóvenes, "Informe de Sociedad Civil sobre Avances y Retrocesos en Salud Reproductiva y Equidad de Género," (15 June 2003).

sterilizations with the consent of women. The researchers also indicated that their colleagues seldom reported having performed these surgeries.[137]

In addition to the more public debate about sterilization, research on IUDs also increased in the mid-1960s. Investigators, physicians, nurses, and social workers worried about the women who failed to keep their appointments for IUD fittings and post-fitting follow-up interviews. Researchers were aware of common problems caused by IUD use, including bleeding and headaches, but they minimized these problems as "discomforts" that went away over time. Yet they soon learned that these "discomforts" were severe for some women, and that these women had their IUDs removed at hospitals, and even attempted to remove the IUDs themselves. Perhaps most damaging to the promotion of the IUD, dissatisfied users shared their negative experiences with other women, discouraging them.[138]

An important outcome of this early research on IUDs was the conclusion that offering birth control as a stand-alone service was not as effective as integrating birth control with other health services. As Mundigo has shown, these discoveries paved the way for making family planning a part of maternal and child health services in several

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[137] Elmer Chávez Silva and Carlos Bachmann Sanchez, "Esterilización Quirúrgica en Pacientes Cesareadas," Revista del Hospital de Maternidad de Lima 1, 1 (1975): 23-26.
[138] See for example Juan Manuel Vicuña Ríos, Esteban Kesseru Koos and Alfredo Larrañaga Leguía, "Evaluación del Uso del Dispositivo Intrauterino de Lippes como Método de Planificación Familiar," Ginecología y Obstetricia 16, 2 (1970): 101-118; Guardia Salas, "Evaluación de Dispositivos Intrauterinos en Pamplona Alta"; María de los Angeles Montero Mogollón, "Motivaciones de las Pacientes con Dispositivo Intrauterino Perdidas al Seguimiento," (Tesis de Grado, Facultad de Trabajo Social de la Universidad de San Marcos, 1972); J. Emilio Martínez Valdez, "Anticoncepción Intrauterina: Evaluación de los Dispositivos Intrauterinos en el Centro de Protección Familiar de Breña," (Tesis de Grado, Facultad de Medicina de San Fernando, 1974).

Latin American countries by the 1970s.[139] In addition, researchers and even the popular press highlighted the role IUDs could play in the prevention of induced abortions, which not only endangered women's lives, but also taxed the human and technical resources of hospitals.[140] Carlos Bachmann, of the Lima Maternity Hospital, even took it upon himself to provide instruction on contraceptive methods for women who had just given birth or were recovering from an attempted abortion. He reported that "most" of his patients in either of those two conditions had no knowledge of birth control methods, and that, after his "informational lecture", about sixty percent of them "chose" to have an IUD fitted.[141]

Public health researchers also noted the important role that people in the community played in the acceptance of birth control methods. Since the availability of these services spread by word of mouth, the support of local opinion leaders and neighbors with wide social networks became crucial for the birth control providers. Peru, on this issue, was similar to other Latin American countries.[142] Researchers approached people in the community in a variety of ways. Social worker María Montero, for example, asked long-term residents of the El Agustino neighborhood for help finding the

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[139] Mundigo, "The Role of Family Planning Programmes in the Fertility Transition of Latin America."

[140] Victor Manuel Gavidia Lino, "El Aborto como Problema de Seguridad Social," (Tesis de Grado, Facultad de Medicina de San Fernando, 1968); Carlos Bachmann, "El Aborto Inducido como Problema Social: Su Prevención," Tribuna Médica 5, 222, (20 Enero 1969): 1, 3, 6-7; Mario Medel, "Avances en Anticoncepción Intrauterina," Ginecología y Obstetricia 21, 1-3 (1975): 244-259; Salvador Robles Ramírez, Páginas de la Vida Real: Guía Matrimonial, Control de la Natalidad, Para Que? (Lima: Ediciones Luz, 1967); "Inquietante Pregunta: ¿Píldora o Dispositivo Intrauterino?" Fémina 1, 4 (4 Enero 1975): 12-13.

[141] Bachmann, "El Aborto Inducido como Problema Social: Su Prevención," 6.

[142] Berelson, "National Family Planning Programs: A Guide," 6; Anonymous, "The First Forty Years"; Deirdre Wulf, "Overcoming Circumstances," International Family Planning Perspectives 9, 1 (1983): 2-8.

women who missed their appointments for IUD fittings.[143] Others asked community governance organizations for suggestions as to the best ways to approach local women.[144]

The better funded family planning advocates attempted to hire influential members of communities, to work as community-based distributors (CBDs) of information and birth control methods. This was the strategy the *Asociación Peruana de Protección Familiar* (APPF, an IPPF/WHR grantee) used. For the most part, CBDs were outgoing women with little formal education, and few economic means, who knew their neighborhoods and neighbors well. CBDs received some classroom training in human reproduction, first aid, and various contraceptives. The APPF allowed its CBDs to keep a small supply of barrier contraceptives, such as condoms and jellies, in their homes, to entice potential "acceptors" with samples. CBDs received commissions depending on the number of women and men they could persuade to approach APPF clinics. Although these wages were small, some CBDs used their earning to buy themselves uniforms.[145]

Efforts to recruit CBDs did not succeed without effort. In the early 1970s, for example, a group of nursing students from San Marcos University worked in the El Planeta shantytown of Lima, delivering talks on first aid, children's health and nutrition, as well as on flower arranging, rug making, weaving and bottle decoration. When the university students attempted to persuade the leaders of the communal assembly of the

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[143] Montero, "Motivaciones de las Pacientes con DIU Perdidas al Seguimiento," 43.
[144] Juana Echandía, Giovanna Elescano, Dominga Dueñas, Elena Castillo, María Medina, Luis Sánchez, Clara Tasaico, Pablo Castro, Regina Arakaki, Rosa Agüero and Esther Reyes, "Estudio de la Comunidad y Programación de Actividades de Salud del Pueblo Joven El Planeta," (Tesis de Grado, Facultad de Enfermería de San Fernando, 1972).
[145] Interview with Miguel Ramos Zambrano, former Director of the APPF (18 April 2006). On the recruitment of influential people as CBDs in Lima, see John Saunders, J. Michael Davis, and David Monsees, "Opinion Leadership in Family Planning," Journal of Health and Social Behavior 15, 3 (1974): 217-227.

importance of disseminating information about family planning, the latter began to bargain with the students. Many of the most influential assembly members worked during the nighttime, and they did not wish to spend their days persuading their neighbors to use birth control, at least not without proper compensation. The students, assembly members claimed, "wanted something without giving anything back." After a heated discussion, the assembly voted to help the students, by a slim margin of two votes in the 26-person governing body.[146]

The use of CBDs, however, attracted a level of attention that made some family planning advocates uncomfortable. Among them was one of the most entrepreneurial researchers in the field of hormone-based birth control, Dr. Alfredo Larrañaga. Larrañaga worked for four years as a gynecologist at St. Luke's Presbyterian Hospital in Chicago after graduating from San Marcos University in 1955. Representatives of the Schering Pharmaceutical Corporation contacted him in 1961 as a language translator. Hormonal contraceptive pills, such as G.D. Searle's Enovid and Schering's Anovlar 21, began to be sold in the 1960s in Peru.[147] Manufacturers advertised them as "pregnancy protectors" that required medical prescriptions, although pharmacies rarely asked for them.[148] The marketability of hormonal contraceptives stimulated pharmaceutical research. By 1962, Esteban Kesserü, an Argentinian gynecologist, asked for Larrañaga's help conducting human trials for an injectable hormonal contraceptive developed by Schering.

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[146] Echandía et al., "Pueblo Joven El Planeta," 6.
[147] SSC: PPFA II, box 204, folder 17: "Distributor list of Enovid, Establecimientos Leonard, S.A., Casilla 2554, Lima," which indicates Enovid was sold in Peru since 1962. See also advertisements for Anovlar 21 in an issue of the Revista Médica del Hospital Central del Empleado 5, 4 (Octubre 1965). On the invention of the contraceptive pill, see Watkins, On the Pill; and Marks, Sexual Chemistry.
[148] "Un Problema de Conciencia," Intima 3, 22 (February 1966): 7-10.

Larrañaga's friends, the brothers Fernando and Antonio Graña, allowed him to carry out the trials on the peasants working in their Huando hacienda, in the highlands of Lima, between 1966 and 1969.[149]

Schering was satisfied with the trial, and subsequently funded Larrañaga's own birth control clinic and research center, the *Instituto Marcelino* (IM), in Lima. The IM thrived in the late 1960s and early 1970s. Pharmaceutical firms like Schering, Wyeth and Warner-Lambert provided its main source of funding. The IM tested compounds these companies were developing, such as once-a-month pills, post-coital pills, and injectable long-term hormonal contraceptives, mainly on low-income women from urban areas in Lima who volunteered to receive the contraceptives.[150] In addition to contract research on hormonal contraceptives, the IM also provided family planning services on demand, including IUD fittings and infertility consultations, which provided a secondary source of income. During its heyday in the early 1970s, between 60 and 100 women visited the IM every day, without using any form of advertising.[151] Over time, the IM staff grew to seven physicians, who also worked in various state hospitals, such as the San Bartolomé, Dos

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[149] Alfredo Larrañaga and Esteban Kesserü, "Dos Años de Experiencia Clínica con el Enantato de Noretisterona como Anticonceptivo Inyectable de Deposito," Ginecología y Obstetricia 14, 2 (1968): 209-221. See also Jorge Pailles, La Cigueña No Existe: Mitos y Realidades de la Planificacion Familiar en el Peru (Lima: Proyecto SPF, 1987: 42).

[150] Max Winterhalter Uriarte, "Un Nuevo Contraceptivo Oral," (Tesis de Grado, Facultad de Medicina de San Fernando, 1969); Hilario Hurtado, Esteban Kesserü and Alfredo Larrañaga, "D-Norgestrel, un Progestágeno a Microdosis como Anticonceptivo Oral de Administración Continua," Ginecología y Obstetricia 16, 2 (1970): 119-126; E. Kesserü, A. Larrañaga, H. Hurtado and G. Benavides, "Fertility Control by Continuous Administration of d-Norgestrel, 0.03mg," International Journal of Fertility 17 (1972): 17-27; Esteban Kesserü, Alfredo Larrañaga and Julio Parada, "Postcoital Contraception with D-Norgestrel," Contraception 7, 5 (1973): 367-379; Alfredo Larrañaga, Max Winterhaltel and José Natal, "Evaluation of d-Norgestrel 1.0mg as a Post-coital Contraceptive," International Journal of Fertility 20 (1975): 156-160.

[151] Yet, the IM was featured in a popular upper-class women's magazine at the time. See "La Planificación Familiar," Patricia: Para la Mujer Moderna 1, 7 (March 1971): 21-25.

de Mayo, and the Arzobispo Loayza. In addition, Larrañaga and Kesserü were members of the medical faculties at San Marcos University and the UPCH, respectively. These academic and hospital connections allowed medical students in obstetrics and gynecology to acquire some practical experience providing contraceptives at the IM.[152]

It was the IPPF/WHR, however, that permitted the largest expansion of birth control services in this period. The earliest contacts between Peruvians and this organization were sporadic, and date back to the late 1930s, when William Vogt worked as consulting ornithologist for Peru's Guano Management Agency.[153] As National Director of the PPFA between 1951 and 1961, Vogt began to correspond with Senator Carlos Barreda in 1952 regarding the importance of making oil producers comply with Peruvian wildlife preservation laws.[154] When Dr. Carlos Ruiz, Medical Director of the International Petroleum Company in Peru (a subsidiary of the Standard Oil Co., property of the Rockefellers) wrote to the PPFA in 1958, he received a direct response from Vogt. The International Petroleum Co. requested help to roll out an educational program on the rhythm method for the company's workers' wives in the town of Talara, on Peru's northern coast, and Vogt obliged, sending him several pamphlets and charts.[155]

In the 1960s, Ofelia Mendoza began to recruit US travelers to report their impressions regarding the potential for family planning clinics. In early 1963, for example, Catherine Campbell took a three-week trip to Lima and Rio de Janeiro with her

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[152] Interview with Alfredo Larrañaga Leguía (Lima, 11 July 2006).
[153] "William Vogt, Former Director of Planned Parenthood, Is Dead," New York Times (12 July 1968): 31.
[154] SSC: PPFA I, series III, box 41, folder 16: Correspondence between William Vogt and Carlos Barreda (July 1952); and between William Vogt and Enrique Avila, Compañía Administradora del Guano (3 July 1952, 21 July 1953, and 14 October 1952).
[155] SSC: PPFA II, box 205, folder 7: Dr. Carlos Ruiz to Planned Parenthood of Manhattan and the Bronx (4 February 1958).

husband, Crawford Campbell.[156] Her suggestions for future work in Brazil included targeting the leading students in samba schools in shantytowns as potential advocates of birth control, as they were generally regarded as opinion leaders within their communities. In Lima, Mrs. Campbell met Peace Corps volunteer Margaret Loomis. Campbell offered Loomis some family planning information, and the latter accepted, offering to give contraceptives "full coverage as soon as an opening presents itself for the subject" among the women with whom Loomis worked. Campbell also noted the potential of wealthy women in the promotion of birth control: "The enormously wealthy women of Lima have begun to take an interest (through boredom?) in charitable hospital work, such as San Juan de Dios Hospital, and in the formation of a museum. They would be a potential power house of money and influence, given Church sanction."[157]

Another Peace Corps volunteer contacted the IPPF/WHR in 1964 because her work as a family counselor put her in regular contact with women of childbearing age. Florence Widutis requested printed materials on family planning, and was careful to note that her request was "entirely upon my responsibility and not on behalf of the Peace Corps." Widutis received brochures in Spanish with titles such as "Questions and Answers about the Contraceptive Pill", "You Can Plan Your Family" and "The Rhythm Method." Field consultant Elsie Jackson, in her answer to Widutis, suggested that, because part of her volunteer training would take place in Puerto Rico, Widutis get in touch with Celestina Zalduondo, Director of the *Asociación Puertorriqueña Pro-*

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[156] In 1959, orthopedic surgeon Crawford Campbell lost his job at St. Peter's Hospital in Albany, New York, because of the Campbells association with the PPFA. See Mary Kahl, Controversy and Courage: Upper Hudson Planned Parenthood from 1934 to 2004 (Albany: UHPP, 2004).

[157] SSC: PPFA II, box 204, folder 18: "Report on trip to Rio de Janeiro and Lima by Mrs. Catherine Campbell," (March 1963).

Bienestar de la Familia (APBF), for further information.[158] The recommendation to contact Zalduondo was not gratuitous. Since 1959, the APBF had used volunteers, instead of trained health professionals, to deliver birth control information and contraceptives to women in low-income areas.[159]

The IPPF/WHR funded its first Peruvian national organization, the Peruvian Association for Family Protection (*Asociación Peruana de Protección Familiar*, APPF) in 1967. The first issue of the Boletín de la APPF defined the APPF's mission as providing family planning services, and defined family planning as "a way of thinking and living that is voluntarily adopted. It is based on rational knowledge, attitudes and decisions, and aims to achieve the welfare of the family and contribute to social development."[160] In line with the goals the CEPD established for birth control use in Peru, a later issue of the Boletín described the APPF as engaged in the defense of the family and in a struggle against the forces that lay siege to it: "poverty, ignorance, disease, injustice and chaos."[161] While the APPF's business office was located in the posh Lima district of San Isidro, its first clinics were located in the low-income neighborhoods of Callao, San Miguel, Rimac, Breña, Surquillo, El Agustino and Barrios Altos. In addition, by 1970 the APPF had three clinics outside of Lima, in Ica, Huancayo and Chimbote.[162]

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[158] SSC: PPFA II, box 205, folder 7: Florence Widutis to Mr. Winfred Best, PPFA (6 May 1964).
[159] "Puerto Rico: The Emko Program," Studies in Family Planning 1, 1 (1963): 7-9. On the Peace Corps program, see Fritz Fischer, Making Them LikeUs: Peace Corps Volunteers in the 1960s (Washington: Smithsonian Institution Press, 1998).
[160] Boletín de la Asociación Peruana de Protección Familiar 1 (1970): 1.
[161] Boletín de la Asociación Peruana de Protección Familiar 4, 1 (Marzo 1973): 1.
[162] Personal archive of Dr. Miguel Ramos Zambrano, former APPF Director (hereafter "MRZ"): Ministerio de Trabajo to APPF (18 July 1970); and MRZ: "Convenio entre el Concejo Distrital de San Miguel y la APPF," (2 June 1972).

Between its establishment in 1967 and 1970, the APPF reported that 4,032 women had been fitted with IUDs; 3,673 were on the pill; 1,898 had received injectable contraceptives; and 120 had received some other form of birth control.[163] By 1971, forty-one people worked for the APPF, between janitorial and office staff, administrators, physicians, health technicians, and training specialists.[164] More importantly, the APPF had a group of supporting members that consisted of 197 people, between physicians (106), teachers (38) and midwives (28). The membership also included lawyers, social workers, nurses, urban planners, architects, engineers, accountants, writers, a chemist, a customs agent, and two executives of Schering Pharmaceuticals. Most of these came from Lima, but a few came from cities such as Iquitos, Huancayo, Juliaca, Chiclayo, Chimbote, and Trujillo.[165]

Schering Pharmaceuticals was not the only institutional member of APPF's network. The US Agency for International Development provided it with training funds and, just as importantly, listened to APPF officers' suggestions regarding the aptness of US Population Office appointees. In 1970, APPF Executive Director Carlos Alfaro, for example, endorsed the nomination of John Morse as US Population Officer in Peru, because the latter had supported the CEPD's establishment. Based on this assessment, IPPF President Alan Guttmacher also backed Morse before the USAID's Office of Population in Washington.[166] The APPF was also a member of a Peruvian network of private social welfare organizations that assisted orphans and destitute pregnant women, a

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[163] Carlos Alfaro, "La Asociación Peruana de Protección Familiar y la Planificación Familiar," Ginecologia y Obstetricia 16, 2 (1970): 145-152.
[164] MRZ: "APPF Relación de Planilla," (30 June 1971).
[165] MRZ: "Lista de Socios," (3 July 1973).
[166] SSC: PPFA II, box 205, folder 7: Alan Guttmacher to Dr. Reimert T. Ravenholt, Director, Bureau of Technical Assistance, USAID Office of Population (13 July 1970).

network that included Catholic activists.[167] In fact, the APPF was not at odds with the Catholic Church, at least not overtly, during this period. In 1970, for example, the Foundation for Human Life (*Fundación para la Vida Humana*, FVH), led by Catholic Bishops, pledged 42,750 Peruvian soles for the APPF to study birth spacing methods. In turn, APPF supported the FVH financially when it sponsored a seminar on sex education and family life in a country club outside of Lima.[168]

The APPF continued to grow its network in the early 1970s. In 1971 it took on the management of the UPCH's birth control clinic in Cerro de Pasco. The clinic's grant from the Population Council expired and was not renewed. The APPF requested financial aid from the IPPF, stating that current birth control users would be harmed by the lack of service continuity, and that there was still much to learn about the factors that influenced the acceptance of contraceptives by the indigenous population. In addition, the APPF planned to give a pap smear test to every woman who attended the clinic, so as to increase the ability to diagnose cervical cancer in its early stages, and to refer every pregnant woman to the local hospital. The APPF's goal was to use this clinic as an example of how family planning services could become integrated into national maternal and child health programs.[169] To pay for the medicines, materials, and the salaries of the Cerro de Pasco clinic's physician, social worker, nurse, receptionist and janitor, the APPF requested US$ 7,019 for 1972, or approximately 304,484 Peruvian soles. That amount of money was a fraction of the total APPF budget for 1972. The organization's fund to

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[167] Boletín de la Asociación Peruana de Protección Familiar 2, 4 (1971): 1.
[168] Boletín de la Asociación Peruana de Protección Familiar 1 (1970): 1.
[169] MRZ: Grant proposal, "Cerro de Pasco Project," (July 1971); "Convenio entre Universidad Peruana Cayetano Heredia y Asociación Peruana de Protección Familiar," (12 January 1972).

December 1972 consisted of nine million soles, of which eight million came from the IPPF. Individual donations from members made up most of the remainder, although the APPF also raised some of its own funds, from the fees paid to attend the family planning and sex education seminars they sponsored.[170]

These educational seminars helped the APPF establish goodwill within government offices, particularly the Ministry of Education. In 1972, for example, an officer from the Ministry of Education in Huancayo, in Peru's central highlands, asked the APPF for some family planning training assistance for three handpicked social work students.[171] It would not be the last request from the Ministry of Education. A few months later, a representative from Callao invited the APPF to partake in "Family Education Day", and asked for a copy of the film "*Reproducción Humana (Métodos Anticonceptivos*)", as well as a projector and a projector operator, to play the movie at a local church. Again, in July of 1973, the Ministry of Education requested APPF's sex education teaching materials. "Such information," the Ministry assured, "will be used for the formulation of sexual education policy in the country."[172]

In 1973, the IPPF began to fund its largest educational venture yet in Peru, a training and clinical practice program at the Arzobispo Loayza Hospital in Lima. Dr. Carlos Muñoz, Professor at the UPCH and chief of the hospital's Obstetrics and Gynecology department, directed the program, euphemistically called "Studies in Human

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[170] MRZ: "Relación de Donaciones," (December 1972).
[171] MRZ: Isabel Mendoza de Dionisio, Jefa de Mejoramiento de Hogares Rurales, Escuela de Peritos Agrícolas de Huancayo, Ministerio de Educación Pública, to Ernesto Gutierrez, Director del Centro de Protección Familiar (18 May 1972).
[172] MRZ: Adrián Albarracín Goycochea, Director de la Segunda Región Educativa, Ministerio de Educación, to APPF Director (23 March 1973); Miguel Picasso Muñoz, Ministerio de Educacion, to the APPF President (30 July 1973).

Fertility." Some training in birth control methods for medical students had taken place in the hospital since 1968, but the training became formalized and expanded with IPPF support, following a visit from IPPF President Alan Guttmacher in 1973. The program provided instruction and practical experience opportunities for health care workers and medical students in counseling techniques, physical exams, pelvic exams, pap smear tests, and the use of all contraceptive methods available, except abortion and sterilization. A secondary goal of the program was to organize family planning seminars in hospitals, health centers and private businesses.

Between November of 1973 and January of 1976 the Arzobispo Loayza Hospital program received approximately US$ 44,000. Almost ninety percent of these funds were earmarked for instructors' salaries and the UPCH's administrative fee. By 1976, the program had trained at least 10 physicians and 62 medical students, and provided family planning services to 481 "new acceptors" and 1,842 "continuing acceptors" for free. IUDs were the most used method: between February and October of 1974, ninety percent of all 509 birth control acceptors had been fitted with IUDs. In addition, by 1976 at least 182 groups of hospital patients (over 1,347 people in total) had received a one-hour family planning education course. The program had also sponsored a postgraduate course for sixteen doctors and six nurses at the Cajamarca Regional Hospital, in Peru's northern highlands. In 1977, the program trained 186 health workers, enrolled 1,725 "new acceptors", and continued supporting 7,305 "existing acceptors", for free. In addition,

210 patient groups received family planning courses, and the program's organizers held nine family planning seminars for community groups throughout the country.[173]

Ironically, the year 1973, which marked the beginning of the IPPF's program at the Arzobispo Loayza's Hospital, was also the year of the demise of the APPF. Almost from the beginning of his administration, President Belaúnde had had to deal with an effective opposition in Congress. This opposition and Belaúnde's own unwillingness to take on the powerful landed elite prevented Belaúnde's promised agrarian reform. Alienated, a wing of the military, led by General Juan Velasco Alvarado, ousted Belaúnde and instituted the left-leaning "Revolutionary Government of the Armed Forces" in October of 1968.

With great celerity, Velasco nationalized the oil reserves of La Brea and Pariñas, which were owned by the Standard Oil-controlled International Petroleum Company. Then, he set out to organize a sweeping agrarian reform, which began with the expropriation of the large sugar cane-producing estates in the northern coast. Velasco's regime grew more authoritarian in the early 1970s, sending political opponents into exile and even expropriating newspapers that criticized his initiatives.[174] In December of 1973, Velasco accused the APPF of receiving financial support from an organization, the IPPF,

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[173] SSC: PPFA II, box 83, folder 27: UPCH request for renewal of funds to Family Planning International Assistance (February 1976); folder 28: UPCH request for renewal of funds to Family Planning International Assistance (February 1978). In the same folder, see letter from Dr. Daniel Weintraub, FPIA Chief Operating Officer, to Gerard Bowers, Chief of the Grants Management Branch of the Family Planning Services Division, Office of Population, USAID (2 March 1978).

[174] On Velasco's economic reforms, see McClintock and Lowenthal, The Peruvian Experiment Reconsidered; and Pease, El Ocaso del Poder Oligárquico.

whose goals "do not match the humanist ideals of the Revolutionary Government of the Armed Forces", and of being "an affront to morality and decency."[175]

The APPF contested this judgment in the media, insisting that it "had never been linked to the interests of imperialist powers," and that it had "never fitted an IUD or provided a pill without the consent of a couple." Although these actions harmed "fifteen thousand women" who used its services, the APPF would, "following the teachings of Christ, forgive the injuries received."[176] APPF President Miguel Ramos Zambrano also asked the US Agency for International Development to divulge the APPF's predicament to foreign press agencies, "so the world may know of this unjust situation."[177] The closing of the APPF was a blow to the IPPF, but there was little the organization could do to help its ailing grantee. Instead, the IPPF began to channel more financial, material and technical aid to the newer "Studies in Human Fertility" program at the Arzobispo Loayza Hospital. IPPF grants officer John Robbins not only recommended the approval of the program's application for funding renewal for 1975 and 1976, but also, "because of the situation of the IPPF affiliate in Peru," recommended upgrading its level of significance. "Let's keep the flag flying," urged an energized Robbins.[178]

It is not entirely clear why Velasco singled out the APPF for obliteration. Its fifteen clinics made it the most prominent family planning organization in the country, but the APPF was not the only organization that received foreign funding: the *Instituto*

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[175] "Resolution Ministerial 000293-73-SA/DS," El Peruano (21 December 1973: 1).
[176] MRZ: "Carta al Editor de Miguel Ramos Zambrano y Carlos Alfaro Alvarez," Correo (3 February 1974): 10.
[177] MRZ: Miguel Ramos Zambrano to Charles Briggs, Human Resources Advisor, US Agency for International Development (10 December 1975).
[178] See the handwritten note from Robbins in "Memorandum from Daniel Weintraub to John Robbins," (14 January 1975), in SSC: PPFA II, box 83, folder 27: "Family Planning International Assistance memorandum, Subject: Peru-06 Modification #3 (Refunding)."

Marcelino, the Catholic Church's Responsible Parenthood Program,[179] and the Arzobispo Loayza Hospital training program also received money from the IPPF and pharmaceutical companies. Even so, Velasco's resolution to shut down the APPF did not take effect immediately. APPF clinics continued operating until January of 1975, when the Ministry of Police shut down all clinics and confiscated all of the APPF's equipment and materials.[180] For practical purposes, this is when the APPF ceased to exist.[181]

Conclusion

Established in 1976, the Peruvian Institute for Responsible Parenthood (*Instituto Peruano de Paternidad Responsable*, INPPARES), is the oldest non-governmental family planning organization in Peru. Its training manual for Human Sexuality Educators recounts the story of INPPARES's predecessor, the APPF. One of the key anecdotes in the manual is the jailing of Dr. Miguel Ramos Zambrano, founder and, in 1974, APPF Director, when he protested the confiscation of the APPF's property.[182] I have heard the story often from other physicians, who present the alleged jailing as a courageous and defiant act of professional integrity. The story is also a pedagogical tool that reminds

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[179] To be analyzed in detail in chapter six.
[180] A 1974 inventory of the APPF's two warehouses revealed the organization still had a large amount of unused contraceptives: 13,480 boxes of different kinds of IUDs, 3,470 boxes of contraceptive pills, 197 doses of injectable contraceptives, 6,162 tubs of contraceptive foams and jellies, 5,067 boxes of condoms, and 253 boxes of diaphragms. The organization's educational materials included booklets on the pill and IUDs, slide presentations, and at fifteen films in Spanish, including "Walt Disney's Family Planning", "IUD Insertion and Removal", "Plan your Family", "From Boy to Man", "From Girl to Woman", "Fertility Control and the Physician", and "The Gift of Choosing." See MRZ: "Inventario físico de APPF, almacenes 1 y 2." (30 May 1974).
[181] MRZ: Demanda a la Corte Suprema de Justicia del Perú por parte del Teniente Coronel FAP Fernando Miró Quesada Bahamonde, (24 April 1975).
[182] INPPARES archive: "Breve Historia de INPPARES," in Curso de Orientadores en Sexualidad Humana (1992-1993): 2.

trainees of the values on which INPPARES was built, and creates a historical continuity between the 1960s and the present.[183]

The earliest historiography of birth control in Latin America tends to focus on how foreign agents, mainly from the US, established organizations such as the APPF and INPPARES, carving a niche for family planning in the hostile territory dominated by the Catholic Church, conservative military forces, and left-leaning nationalists, all of whom allegedly deplored birth control as an imperialist tool.[184] This downplays the crucial participation of local agents and flattens the distinctions between Latin American countries. More recent scholarship, however, addresses the role Latin Americans themselves have played in institutionalizing birth control in their own countries.[185] This latter strand of research can be enriched in numerous ways with the Peruvian case. First, this case highlights the awareness of the link between state-directed planning for population growth and national development, which began in the 1930s with institutions like the Princeton OPR and the Milbank Memorial Foundation; as well as the efforts to develop the capacity to conduct demographic research fostered by the United Nations

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[183] There is a parallel here with Hobsbawm's notion of "invented tradition", though in this case traditions are made and re-made at the organizational and not the national level. See Eric Hobsbawm, "Inventing Traditions," in Eric Hobsbawm and Terence Ranger (eds.), The Invention of Tradition (Cambridge: Cambridge University Press, 1983).

[184] Julio Silva Colmenares, No… Mas… Hijos! Genocidio Preventivo en los Países Subdesarollados (Bogotá: Paulinas, 1973); Carlos Malpica Silva Santisteban, El Desarrollismo en el Perú: Década de Esperanzas y Fracasos, 1961-1971 (Lima: Horizonte, 1975); Mass, Population Target; Hartmann, Reproductive Rights and Wrongs.

[185] Sobrinho, Estado e Populaçao; Guzmán et al., Fertility Transition in Latin America; Randall Packard, "Visions of Postwar Health and Development and their Impact on Public Health Interventions in the Developing World," in Frederick Cooper and Randall Packard (eds.) International Development and the Social Sciences (Berkeley: University of California Press, 1997); Briggs, Reproducing Empire; Norman Miller, "Empirical Essays on Major Forces in Health, Population and Development," (PhD dissertation, Harvard University, 2005).

and, more specifically for Latin America, by ECLA in the 1940s. In our case, these efforts led to the development of CELADE in the 1950s and, through it, the education of the first generation of Latin American demographers and the diffusion of the idea that underplanned population growth could constrain a nation's economic development. This was the key assumption behind the creation of Peru's CEPD. No other Latin American government made population growth a direct concern of the executive branch during this period.[186]

Secondly, many kinds of Peruvian health workers were involved in the birth control field between the 1950s and the 1970s. However, the existing historiography tends to focus on the role of single national organizations, such as the *Asociación Mexicana Pro-Bienestar de la Familia*, Colombia's Profamilia, the *Asociación Puertorriqueña Pro-Bienestar de la Familia*, the *Asociación Chilena de Protección Familiar*, and Brazil's Bemfam. In a way, this is understandable in a field that is only beginning to attract historical attention. Therefore, the Peruvian case provides a good opportunity to stress how protean the work of birth control advocates and researchers was. Physicians, medical students, biomedical researchers, social scientists, pharmaceutical company representatives, nurses, social workers, lawyers, hacienda owners, community-based distributors, and even the Catholic Church: all were part of a wide-ranging and loosely coordinated group. The field was rife with opportunity for individuals and organizations to receive training, equipment, educational and promotional materials, travel opportunities, networking prospects, and, of course, cash. Foreign funding for family planning promotion was a boon to the workers who became connected

[186] Davis, Third Panamerican Sanitary Bureau Conference on Population Dynamics, 52.

to the population control juggernaut. Many furthered their careers by becoming managers, distributors, researchers, and advocates for various contraceptives.

Of course, Peruvian physicians working in this field rarely mention profit and career advancement as reasons that motivated them.[187] Instead, they stress the sacrifices they made to persuade politicians and lay people of the value of family planning to protect women's lives from risky pregnancies and to prevent families and communities from sinking further into poverty. In marked contrast to US organizations like the PC, the IPPF and the Population Crisis Committee, and Latin American researchers in Chile (like Jaime Zipper) and Colombia (like those affiliated with the Colombian Association of Medical Faculties), Peruvian birth control advocates seldom argued in favor of population reduction as a main goal of theirs. Thus, this chapter shows that, when it comes to the promotion of birth control by medical workers, it is not possible to speak of a "Latin American experience," regardless of the uniformity of the KAP survey results in the region.

On the other hand, it is also true that Peruvian advocates failed to promote education about contraception as vigorously as they promoted the use of IUDs: there simply were fewer financial rewards for doing so. As Dr. Walter Llaque, a gynecologist who ran a community program for the teaching of periodic abstinence methods of birth control in a shantytown in northern Peru in the 1960s, lamented, "if you did not insert

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[187] Interviews with Guillermo Tagliabue (17 Julio 2004); Helí Cancino (19 July 2004); Hugo Oblitas (19 July 2004); Ricardo Subiria (6 March 2006); Miguel Ramos Zambrano (18 April 2006); Miguel Ascenzo Palacio (4 May 2006); René Cervantes (16 December 2008); and Luz Jefferson (17 December 2008). See also José Donayre Valle, "Editorial," Ginecología y Obstetricia 16, 2 (1970): 99-100.

IUDs, there was no money for you."[188] Yet focusing mainly on providing birth control services, instead of education, does not mean such work was easy or that birth control could be simply imposed on women. Recruiting capable demographers, creating interest among gynecologists, and training health workers, community-based distributors, and foreign volunteers took time and money. Interfacing with local and foreign stakeholders, and canvassing communities to let people know of the availability of what were radically new and unfamiliar services, required a tremendous effort by many. Making women keep their appointments for IUD insertions was a task in itself. Countering the stories disseminated by dissatisfied IUD users was difficult. Persuading leaders in organized communities required careful negotiation skills that birth control advocates sometimes lacked, as the example of the nursing students in the El Planeta shantytown demonstrates. Compensating for setbacks such as the closing of the APPF reveals how flexible local advocates and their foreign allies had to be.

Considering this picture, it is difficult to think of birth control as something that Peruvian family planning advocates could simply impose on the general population. In Peru between the 1940s and 1970s, what we witness instead is the development of a vast, complex, and fragile local family planning establishment that managed to convince many women and men of the value of having fewer children. Birth control institutions in Peru did not just erupt on the scene in the 1960s; they were made possible by a long process of thinking about population and its link to industrialization, poverty, disease, and human suffering, albeit a process that was characterized by political instability and a scarcity of trained personnel. To complicate matters, groups like the Catholic Church and the

[188] Interview with Walter Llaque Dávila (Trujillo, 12 July 2006). Llaque's program was funded by a group of Irish nuns of the Bonsecours missionary order.

military would not even consider family planning except on their own terms. I will turn to these two institutions in the next two chapters.

Chapter Five

The Institutionalization of Birth Control in Peru II:

The Making of a Population Policy, 1968-1976

Birth control initiatives began in Peru before the country had a policy regulating them. Transnational organizations such as the International Planned Parenthood Federation and the Population Council, as well as local ones such as the *Instituto Marcelino* and the *Asociación Peruana de Protección Familiar* (APPF) trained physicians, ran clinics, organized conferences, and conducted surveys as early as 1961. As shown in the previous chapter, population limitation, maternal health, and national development were all motives behind these activities. The military government of General Juan Velasco Alvarado (1968-1975), however, repudiated the work of the birth control establishment, most notably through the banishment of the APPF in 1973. Despite this, neither Velasco nor his successor, General Francisco Morales Bermúdez (1975-1980), were oblivious to the challenges population growth posed to health, national security, and development. In this chapter, I discuss how the curbing of population growth became a governance issue during the twelve years of military rule, and finally became institutionalized through a set of guidelines that has since been the basis of the country's family planning program.

The study of population limitation policies has been important since the earliest efforts to curb demographic growth in low-income countries began in the second half of the twentieth century. As discusses in the previous chapter, several scholars and policymakers began to posit a direct link between population growth and poverty as early

as the 1930s.[1] As Amy Ong shows, from their inception, most population limitation policies privileged family planning service delivery, public recognition of modern contraceptive methods, and knowledge of service sites.[2] Asian countries, including Japan, China and India, were the first to implement such policies in the early 1950s, with substantial prodding and assistance from United States birth control organizations.[3] By the mid-1970s, the reduction of birth rates had become such a prevalent goal of population policy making that the Population Council's Maxwell Stamper was able to conduct a comparative survey of sixty such policies, including Peru's.[4] Critics such as Donald Warwick have pointed out, however, that this approach makes it seem as though the adoption of policies to curb demographic growth responds to a sort of pre-programmed rationality with clearly demarcated features to be accomplished within specific time limits, instead of being historically dynamic processes in which policies "gain and lose energy through interchanges with the surrounding society."[5]

Teasing out the historical distinctiveness of population policy formulation has been a fruitful way to address the aspirations and interests of different societies, and

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[1] The relation between poverty and population growth has continued to receive a significant amount of scholarly attention ever since. See for example Kelley, "Economic Consequences of Population Change in the Third World"; Nancy Birdsall, "Government, Population and Policy: A Win-Win Tale," in Robert Cassen (ed.), Population and Development: Old Debates, New Conclusions (New Brunswick: Transaction, 1994); Steven Sinding, "The Great Population Debates: How Relevant Are They for the 21st Century?" American Journal of Public Health 90, 12 (2000): 1841-1845; Thomas Merrick, "Population and Poverty: New Views on an Old Controversy," International Family Planning Perspectives 28, 1 (2002): 41-46; Mohammed Sharif, Poverty Reduction – An Effective Means of Population Control (Hampshire: Ashgate, 2007).
[2] Amy Ong Tsui, "Population Policies, Family Planning Programs, and Fertility: The Record," Population and Development Review 27 (2001): 184-204.
[3] Connelly, Fatal Misconception, 142, 168).
[4] B. Maxwell Stamper, Population and Planning in Developing Nations: A Review of Sixty Development Plans for the 1970s (New York: Population Council, 1977).
[5] Warwick, Bitter Pills, ix.

different groups within those societies. Policymakers from the 1950s on asked themselves how, for example, could a population limitation policy help a nation become wealthier? How could it protect the lives of women and infants? How did it affect phenomena like migration and the provision of social services? Who should be technically and politically responsible for the implementation of these policies? What national resources should they receive? Scholars working in countries as diverse as China, Mexico, Egypt, Colombia, and Nigeria have shown that governments established and regulated birth control programs following different paths, contingent on diverse power configurations within the state and society.[6] By 1976 Peru too had a population policy that permitted the use of birth control methods, but we know little of the value that the military governments of the day assigned to these technologies within such policy. The history of the development of the Peruvian policy can help us better understand the multiple aspirations of the governments that implemented population limitation policies in the developing world, thus building a more nuanced picture about the role of governments in this field.

The chapter first introduces the state of the policy debate concerning the links between population, development, and family planning in the 1960s. It then discusses the changes imposed on this debate by the military government of General Velasco, as well as the way in which family planning factored in his national development plans. Finally, I

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[6] Emiline Royco Ott, "Population Policy Formation in Colombia: The Role of ASCOFAME," Studies in Family Planning 8, 1 (1977): 2-10; Gustavo Cabrera, "Demographic Dynamics and Development: The Role of Population Policy in Mexico," Population and Development Review 20 (1994 Supplement): 105-120; Soheir Morsy, "Deadly Reproduction among Egyptian Women: Maternal Mortality and the Medicalization of Population Control," in Ginsburg and Rapp (eds.), Conceiving the New World Order; Susan Greenhalgh, "Science, Modernity and the Making of China's One-Child Policy," Population and Development Review 29, 2 (2003): 163-196; Olukunle Adegbola, "Population Policy Implementation in Nigeria, 1988-2003," Population Review 47, 1 (2008): 56-110.

discuss the formulation of Peru's first population policy legalizing and regulating the use of birth control technologies. My argument is that the 1976 Population Policy Guideline conceived of family planning as only one, and not the most important, activity among the many in which the state should be engaged in order to lower fertility. The Guideline addressed in detail a series of complex and interdependent national development policies, in family planning, health, education, and employment, foreseeing actions by the government that ought to lower fertility rates. Ironically, as I discuss in the concluding section, the government did not become an effective locus for the public debate of the links between birth control, health, and national development after 1976. Rather, an invigorated group of Peruvian intellectuals, including those in the Catholic Church, took on this role.

So Close, Yet So Far: Peru's Frustrated Population Policy of 1967

As shown in the previous chapter, the government of Peru supported research on the relationship between demographic phenomena and economic and social development in 1964. The Center for the Study of Population and Development (CEPD), a branch of the Ministry of Labor, conducted this research. In addition, the CEPD served as a liaison between the Peruvian government and foreign agencies interested in population limitation, including those agencies that helped fund the CEPD, such as the Population Council, the Ford Foundation, the Milbank Memorial Fund, and the International Planned Parenthood Federation. The CEPD began operating a series of birth control clinics in low-income neighborhoods in Lima in 1966. Soon after, other local birth control

organizations set up clinics of their own, under the umbrella of legitimacy the CEPD provided for these activities.

A year later, in 1967, the CEPD began brokering an agreement between the government of Peru and the United Nations Trust Fund for Population Activities (the precursor to the UN's Fund for Population Activities, UNFPA) to create a population policy, with technical and financial support from the United States Agency for International Development (USAID). Reports from the USAID indicated that "[w]ork plans were prepared, budgets established, equipment purchased and distributed, and personnel trained," when President Fernando Belaúnde, who established the CEPD, was ousted by General Juan Velasco Alvarado in 1968.[7] Velasco cancelled the plan-in-progress, although direct collaboration between the USAID and the Peruvian government in the field of population continued until 1973, after which it stopped for several years. Both countried resumed relations in this area only in 1979.[8] In this section I will discuss how family planning almost became a part of the government's population policy in the 1960s, by analyzing the local and transnational forces that supported such a project and emphasized the links between population growth, health, and development.

The year 1967 had been an especially auspicious one for governmental proponents of population limitation. Just four years earlier, Congressman Napoleón Vílchez, representing the *departamento* of Cajamarca, in Peru's northern highlands, had proposed a bill to legalize the prescription of contraceptives and the performance of

[7] USAID Office of Health and Population, Peru, "History of Family Planning in Peru," (1997: 1).
[8] USAID Office of Health and Population, Peru, "Aide Memoire Regarding USAID Peru's Contraceptive Logistics Program," (1997).

abortions by physicians, only to be shunned by his peers and lambasted by the press.[9] Soon after, however, Peru created its CEPD and transnational agencies such as the World Health Organization and the Pan-American Health Organization began to show more flexibility regarding the governmental implementation of family planning policies. Their support lent legitimacy to what almost became Peru's first population policy.

Since its inception in 1945, the World Health Organization (WHO) had been hesitant regarding family planning programs. At the First World Health Assembly of July 1948, Resolution 1.43 recommended that the WHO "give appropriate assistance to States with the agreement and on the request of the governments concerned, on matters concerning investigation and lowering of maternal and infant mortality and maternal and child health services." The WHO did not refer to contraceptives among these services, even though it acknowledged "the problems" faced by pregnant adolescent girls and working nursing mothers.[10] By the 1950s, the WHO defined pregnant women and infants as groups with special needs, because their health was "exposed to the processes of reproduction, growth, and development."[11] Even though the WHO already recognized the risks frequent pregnancies involved for women and children, most member states felt the organization should not promote the use of contraception. Governments that asked the WHO for help setting up family planning programs were informed that this was not part of its mandate. As late as 1957, the World Health Assembly passed a resolution introduced by Peru, Mexico, Brazil, Italy and Pakistan that affirmed the importance of

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[9] Emilio Santillán Soto, "Carta al Editor," Caretas 261, 13 (15 February 1963): 14.
[10] World Health Organization, Handbook of Resolutions and Decisions of the World Health Assembly and the Executive Board, Volume 1: 1948-1972 (Geneva: WHO, 1973).
[11] WHO, "Administration of Maternal and Child Health Services," Technical Report 115 (1957): 5.

demographic factors in economic development, but without committing the WHO to providing information on contraceptive technologies to member states.[12]

The WHO changed its position by the mid-1960s. The 18th World Health Assembly of 1965 declared that the WHO could advise governments upon request in developing family planning programs, if such governments already had established health services, and if this type of assistance did not impair the curative and preventive functions of these services.[13] Thence, the WHO became the world's largest and most prestigious technical information clearinghouse on family planning, producing reports between 1966 and 1975 on topics that included the training of health personnel to use family planning methods, the properties of diverse contraceptives, periodic abstinence from sex as a means to regulate fertility, the link between health education and birth control, and the administration and evaluation of family planning programs within health systems.[14]

As the WHO's representative in Latin America, the Pan-American Health Organization (PAHO) prioritized the goals of protecting the health and welfare of women

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[12] Symonds and Carder, The United Nations and the Population Question.
[13] See World Health Assembly (WHA) resolution 18.49 of May 1965, reaffirmed as WHA 19.43 in May 1966, and WHA 20.41 in May 1967, in WHO, Handbook of Resolutions and Decisions, 1948-1972.
[14] WHO, "The Midwife in Maternity Care," Technical Report 331 (1966); WHO, "Basic and Clinical Aspects of Intra-Uterine Devices," Technical Report 332 (1966); WHO, "Clinical Aspects of Oral Gestogens," Technical Report 326 (1966); WHO, "Biology of Fertility Control by Periodic Abstinence," Technical Report 360 (1967); WHO, "Hormonal Steroids in Contraception," Technical Report 386 (1968); WHO, "Intra-Uterine Devices: Physiological and Clinical Aspects," Technical Report 397 (1968); WHO, "Developments in Fertility Control," Technical Report 424 (1969); WHO, "The Organization and Administration of Maternal and Child Health Services," Technical Report 428 (1969); WHO, "Aspectos Sanitarios de la Planificación Familiar," Informe Técnico 442 (1970); WHO, "Family Planning in Health Services," Technical Report 476 (1971); WHO, "Health Education in Health Aspects of Family Planning," Technical Report 483 (1971); WHO, "Education and Training for Family Planning in Health Services," Technical Report 508 (1972); WHO, "Evaluation of Family Planning in Health Services," Technical Report 569 (1975).

and infants, as well as, less overtly, that of promoting national development, as it considered family planning policies in the mid-1960s.[15] In 1967, Chilean Abraham Horwitz, the first Latin American Director of the PAHO, convened a meeting of experts from the Americas to address the broad topic of "Population Dynamics."[16] Latin American participants, most of whom were medical doctors, were amply in favor of the implementation of population policies with a view to curb birth rates. The majority believed, as did Guillermo Adriasola, Dean of the School of Public Health at the *Universidad de Chile*, that such policies were the "common responsibility of professional people and governments."[17] At the same time, they emphasized that, regardless of how convinced physicians were of the importance of family planning policies, it was very difficult for them to effect political changes. As José Patiño of the Colombian Association of Medical Faculties remarked, "physicians are not the owners of the field."[18] Dr. Marie-Françoise Hall, of the International Health division at Johns Hopkins, concurred. Despite the existence of great differences between Latin American countries in terms of their family planning and demographic research activities, a professional community was rapidly forming to address these subjects. However, the political impact

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[15] On the Pan-American Health Organization, see Cueto, El Valor de la Salud.
[16] Davis, Third PASB Conference. US attendees were more abundant than Latin American ones. The former included representatives of the USAID, the Department of Health, Education and Welfare, the Department of Commerce, the American Medical Association, the Margaret Sanger Research Bureau, the Ford Foundation, the Population Council, the Milbank Memorial Fund, the Pathfinder Fund, as well as participants from universities like Cornell, Georgetown, Harvard, Johns Hopkins, Princeton, Tulane, the University of Chicago, and the University of Michigan. Latin Americans were represented by academics from the Universidad de Chile, the Colombian Association of Medical Faculties, and the Universidade de São Paulo. Transnational organizations like the Latin American Center for Demography (CELADE), the UN, the Organization of American States, and the IPPF also sent representatives.
[17] Davis, Third PASB Conference, 7.
[18] Davis, Third PASB Conference, 18.

of these professionals was still very limited or, as Hall put it, "[t]he amount of attention and energy devoted to population work is still not at all commensurate with the magnitude of the problem population growth poses for the area."[19]

This glum evaluation of the future of population policies for Latin America by Latin American and US experts was sobering. Irene Taeuber, a demographer at the Princeton University Office of Population Research, concluded that "we are all impressed with the immensity of the responsibilities we are assuming, and with the inadequacy of our preparation as professionals to resume those responsibilities."[20] The conference ended on a somewhat optimistic note, with conference Chairman Dr. Samuel Wishik, of the School of Public Health at the University of Pittsburgh, emphasizing that population growth ought to be "sold" by professionals to governments increasingly as both a health and an economic development issue, one that required the broad concourse of different kinds of political and technical specialists.[21]

To PAHO Director Horwitz, however, the complex interlocking of technical and political issues involved in population policies was only one concern. Horwitz was aware of the USAID's efforts to push population limitation onto the political agendas of developing countries through networking with professionals such as the ones who attended the PAHO conference. Opponents of family planning could construe this as a kind of indirect assault on national sovereignty that would lead to a backlash against maternal and child health services, which provided birth control information and contraceptives. Horwitz challenged conference attendees by insisting that the power of

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[19] Davis, Third PASB Conference, 63-64.
[20] Davis, Third PASB Conference, 38.
[21] Davis, Third PASB Conference, 79.

professionals in governments ought to have limits, since there existed "great gaps in knowledge upon which judgment and decision must be founded" in matters relating to contraceptive technologies. Speaking directly to the US government officers in the audience, Horwitz acknowledged the existence of theses linking population growth and underdevelopment, but insisted on "the non-universality of any particular thesis", and on the need for reproductive choices to be left up to "individual families." Ultimately, Horwtiz believed, PAHO's actions as a regional WHO office must not exceed the WHO's mandate to provide family planning information only (1) if governments requested it; (2) if such programs aimed to ameliorate the health of women and children; and (3) if these programs did not interfere with health care systems' curing and preventive work.[22]

Horwitz's tenure as PAHO Director (1958-1975) overlapped with that of the USAID's first Director of the Office of Population, Reimert Ravenholt (1966-1979). Horwitz's persistent advocacy of limited intervention in population limitation activities cost PAHO the financial backing of the USAID in the early 1970s. Ravenholt cut off these funds because of, as he put it, PAHO's "unduly large emphasis on the introduction of maternal and child health activities into family planning programs, rather than the reverse."[23] It was during Ravenholt's directorship that the USAID became the world's largest donor of funds for population limitation activities. Between 1967 and 1973, the USAID channeled some US$ 3 million through Peru's CEPD, a large amount, though still a fraction of the amount the government of India received from the USAID during

[22] Davis, Third PASB Conference, 2-3.
[23] Ravenholt cited in 1973, in Connelly, Fatal Misconception, 263.

the same period.[24] How did the US government come to place such large stock in population limitation work? How did this counterbalance the more conservative approach of the WHO and PAHO?

A crucial player in this unfolding story was William H. Draper, Jr., an investment banker, former US General during the Second World War, and former Secretary of the Army. Draper chaired US President Dwight Eisenhower's Committee to Study the United States Military Assistance Program in 1958. The Draper Committee paid special attention to the impact of population growth on economic development, based on the assumption that this was essential to winning the Cold War against communism, and that rapid population growth slowed down development and promoted political instability. The Draper Report recommended that the United States "encourage those countries in which it is cooperating in economic development programs to formulate programs designed to deal effectively with the problem of excessive population growth."[25]

The report was influential even though Eisenhower did not support US government assistance to population limitation efforts. John F. Kennedy's administration re-visited the Draper thesis through Secretary of State Dean Rusk, who created the role of Population Advisor at the US Department of State, and also played a key role in the establishment of the USAID in 1961. However, it was President Lyndon Johnson who reversed the US policy of non-involvement with population limitation issues in 1965.[26] The first overt sign of change was the State of the Union address of January 4th, 1965. At

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[24] USAID Office of Health and Population, Peru, "History of Family Planning in Peru," (1997: 1). On the Indian family planning program and policies, see Connelly, Fatal Misconception, particularly chapter eight, "A System without a Brain."
[25] Cited in Peter Donaldson, "On the Origins of the United States Government's International Population Policy," Population Studies 44, 3 (1990): 385-399, 389.
[26] Sharpless, "Population Science, Private Foundations and Development Aid."

that time, Johnson vowed to "seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources." Shortly after that, the USAID sent a policy directive to Directors in all countries, indicating that "AID would entertain requests for technical, commodity, and local currency assistance in support of family planning programs initiated by host governments."[27] Johnson followed these actions with his June 25th, 1965, address to the UN on its 20th anniversary, in which he urged all countries (including the US) to "face forthrightly the multiplying problems of our multiplying populations and seek answers to this most profound challenge to the future of the world. Let us act on the fact that less than five dollars invested in population control is worth one hundred dollars invested in economic growth."[28]

Support for this policy shift was wide throughout the US executive and legislative branches. This permitted the functioning of local Population Offices in almost every country where the USAID operated. From 1965 on, the USAID could be found sponsoring, quietly but relentlessly, most family planning initiatives in Latin America with the goal of cutting down national fertility rates.[29] Its funds for family planning assistance rose steadily, from US$ 10 million to nearly US$ 125 million between 1965 and 1972.[30] Such a shift was also responsible for the support the US gave to the

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[27] Marshall Green, "The Evolution of US International Population Policy, 1965-92: A Chronological Account," Population and Development Review 19, 2 (1993): 303-321, 305.
[28] Cited in Green, "The Evolution of US International Population Policy," 306.
[29] Mass, Population Target.
[30] USAID family planning funds decreased slightly in 1974, to US$ $112.5 million, because the Appropriations Committee of the House of Representatives capped population obligations. See part 2, section II, p. 129 of "Implications of Worldwide Population Growth for US Security and Overseas Interests," National Security Study Memorandum 200 (1974). In Documents of the National Security Council, 7th Supplement.

establishment of a new United Nations division, the Trust Fund for Population Activities, in 1967, which became the United Nations Fund for Population Activities (UNFPA) in 1969.

Institutions and individuals in favor of and against population limitation policies came together for a momentous meeting in Caracas, Venezuela, in September of 1967. The US-dominated Organization of American States, the pro-population limitation Population Council, and the PAHO jointly sponsored the first meeting of Latin American government officers with the goal of establishing region-wide population policies. Among the more than two hundred attendees were medical and demographic experts, as well as, more importantly, officers from several Latin American ministries of health, education, and labor, including Peruvian ones. The Caracas Report stated boldly that "the nature of demographic and social phenomena in Latin America make it urgent that special and immediate attention, with a view to effective action, be given to [its] recommendations."[31]

Most importantly, the Caracas report stressed that rapid population growth was a national development problem intimately related to historical patterns of "social evolution and change in Latin America." Addressing this complex problem, therefore, would require the participation of governments, the private sector, universities, the media, and international organizations.[32] Likewise, the Caracas Report made it clear that population policies that focused mostly on the provision of birth control services would

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[31] "Meeting on Population Policies in Relation to Development in Latin America: Recommendations," (hereafter referred to as the Caracas Report) Studies in Family Planning 1, 25 (1967): 1-4, 1. The meeting took place in Caracas from the 11th to the 16th of September of 1967.
[32] Caracas Report, 1.

not suffice. Dealing with rapid population growth as a development problem would require adopting additional policies that expanded foreign trade and improved its terms. Recognizing that most Latin American governments' incomes depended on the export of primary commodities, this recommendation addressed the chronic insolvency of governments, and the difficulties this caused for the delivery of social services.

The Caracas Report urged the adoption of new policies to modernize and broaden educational systems, placing special emphasis on the education of women, that of adults who were already in the workforce, and technical education. These benefits were aimed at adults rather than children. Behind these recommendations was the belief that better-educated adults would not only be more productive, but also more likely to want smaller families, and more likely to act on that desire quickly.[33] Adults (and their children) living in rural areas faced the direst situations of poverty and social neglect throughout Latin America. The Caracas Report acknowledged this and strongly asked for governmental policies to promote higher economic productivity in those areas that not only increased the wealth of large agricultural and mineral concerns, but also the incomes of individuals. Addressing rural poverty could be an important way to curb the massive migrations presently taking place from rural to urban areas in Latin America, which were responsible for increasingly crowded and chaotic cities.[34]

It is important to note the influence of former ECLA Director Raúl Prebisch on the trade, education, and rural development policies recommended by the Caracas Report. In 1964, Prebisch had become Secretary General of the UN's Conference on Trade and

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[33] Caracas Report, 2.
[34] Caracas Report, 3. See also UNICEF, "Children and Youth in National Development in Latin America: Report of the Conference of November 28th-December 11th, 1965, in Santiago, Chile," (1965: 8, 31).

Development (UNCTAD), a post that brought him closer to understanding the social and economic problems shared by developing countries worldwide. In his short treatise Towards a New Trade Policy for Development, Prebisch argued that the problems of developing countries arose in part because of a historical "economic lag of centuries" that would not yield to short-term solutions and that yet required urgent action.[35] Chief among the developing world's financial troubles was the fact that the prices of primary commodity exports expanded slowly, while those of manufactured goods grew rapidly. This created a trade gap for developing countries, as they tended to specialize in the export of raw materials and to import manufactures and capital goods.[36]

Prebisch proposed regional integration as a means for developing countries to leverage their bargaining power in negotiations with developed ones. The formation of economic blocs and the issuance of joint regional policies, such as the Caracas Report, were means to that end. Prebisch also suggested, albeit less successfully, dropping some of the protectionist measures developed countries had in favor of their domestic products, to make it easier for exports from developing countries to compete with them. This is precisely the kind of mechanism the Caracas Report contemplated as it advocated in favor of improved terms of trade for Latin American nations.

The Caracas Report's recommendations to better adult and technical education, as well as to increase rural incomes were also foreshadowed in Prebisch's Towards a New Trade Policy for Development. Regarding the latter, Prebisch was critical of developing

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[35] Raul Prebisch, Towards a New Trade Policy for Development (New York: United Nations, 1964: 89).
[36] See Reynaldo Bajraj, Jorge Bravo, and Georges Tapinos, "Economic Adjustment and Demographic Responses in Latin America: An Overview," In G. Tapinos, A. Mason and J. Bravo (eds.), Demographic Responses to Economic Adjustment in Latin America (Oxford: Oxford University Press, 1997).

countries' tendency to allow the concentration of income in the hands of a few. This, he argued, resulted in superfluous and excessive consumption by urban elites, not in the technology investments that economic development required, nor in the expansion of an internal market where many could consume locally produced goods. Rapid population growth, Prebich argued, could slow down the ability of individuals to acquire educational credentials as well as prevent them from saving some of their incomes. However, he also warned that limiting population growth "cannot in any sense be an alternative to the vigorous development policy advocated in this report."[37]

The Caracas Report agreed with Prebisch's recommendation to see population policies as part of "vigorous development policies", but also took note of the WHO and PAHO advice on the medical value of family planning programs, which ought to be considered "an integral phase (sic) of child protection, maternal and infant care, and especially the fight against cancer." Family planning policies were deemed, moreover, "a means of reducing the rate of induced abortion, which is one of the main causes of maternal deaths." This is why the Caracas Report recommended that "adequate family planning information and medical services be placed within the reach of persons at all social levels," as long as this was done "respecting the inalienable right of families to decide on the number and spacing of their children."[38] The Caracas Report also called for greater education efforts on two fronts. First, school curricula ought to provide better instruction on the phenomenon of human reproduction.[39] Second, higher education institutions should promote training in population issues, particularly for health

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[37] Prebisch, Towards a New Trade Policy for Development, 116.
[38] Caracas Report, 3.
[39] Caracas Report, 2.

personnel. Accomplishing the changes envisioned in region-wide family planning policies would require both financial and technical aid Latin American governments lacked, and the Caracas Report asked the Organization of American States and PAHO for help in these areas.[40]

CEPD Director José Donayre and Minister of Health Javier Arias Stella drafted a population policy to President Belaúnde following the guidelines on health, education, and economic development established in the Caracas Report.[41] In 1967, Peru was well positioned to accept these recommendations. Not only had the country began a pilot program of birth control clinics in Lima under the aegis of the CEPD, but also, as I will show, the capacity of the Peruvian government to make national long-term plans had become increasingly robust since the early 1960s. This made it possible to launch policies that required coordinating the actions of different ministries, such as the Caracas population policy.

It is also important to note that this policy was the result of a regional collective effort to understand and solve problems of poverty, urban chaos, and deficient education that afflicted all Latin American countries to various extents. From the very beginning, Latin American governments treated population policies as intersectorial tools of national development, not as simple policies to reduce birth rates, nor as the province of particular ministries or individuals. That the United States supported this approach is remarkable considering scholars such as Mass, Malpica, Silva, and Connelly tend to emphasize the aggressiveness of the USAID's Office of Population in promoting population limitation

[40] Caracas Report, 4.
[41] Sanders, Planificación Familiar en el Perú; Clinton, Población y Desarrollo en el Perú.

after 1966.[42] My analysis suggests that the US could be more diplomatic and supportive of local initiatives, at least if these initiatives emerged from a cohesive regional bloc, as Prebisch predicted. The policy failed to be enacted in Peru, not because of the US's intransigence, but because the Peruvian military valued family planning only as a part of maternal and child health programs.

Planning Peruvian Families the Army Way, 1968-1975

The military strongman who deposed a democratically elected leader has been a recurring character in the political life of Peru since the birth of the republic. Yet none of these strongmen achieved the intellectual nor the organizational sophistication of the reformist military leaders of the 1950s. In this section, I will analyze how they interpreted the phenomenon of population growth, and what they did about it. The changes began during the regime of General Manuel Odría (1948-1956), who became President following a coup against President José Luis Bustamante y Rivero in 1948. It had been during Bustamante's Presidency that officers such as Minister of War José del Carmen Marín began to envision the creation of an advanced training institute similar to the war colleges of Spain and France, both of which trained Marín.

Peru enjoyed a brief economic bonanza during Odría's rule thanks to the development of the local fishmeal industry and the discovery of copper in the south. In addition, the Korean War (1950-1953) increased foreign demand for Peruvian goods. In 1950, Odría re-invented himself as a civilian candidate for the presidential race, which he won while running unopposed. As explained in the previous chapter, Odría liberalized the

[42] Silva-Colmenares, No… Mas… Hijos!; Mass, Population Target; Malpica, Desarrollismo en el Perú; Connelly, Fatal Misconception.

trade controls that favored mining and agricultural corporations. Deliberately cutting back the governmental planning function, Odría did not even honor Peru's international commitment to conduct a census in 1950.[43]

The year 1950 was also significant because officers like Marín, sidelined from executive posts because of their former allegiance to the deposed Bustamante, went on to establish the Center for Advanced Military Studies (CAEM, in Spanish) within the Ministry of War. The CAEM's main mission was to train officers destined for high command posts to think in terms of long-term strategies of national security through a one-year program in technical and social science education. CAEM's doctrine was based on the "total war" concept, which viewed war as something that required the utilization of all human and material resources of the nation. Concretely, CAEM promoted the idea that strategic natural resources such as oil, minerals, and fisheries ought to be in the hands of the Peruvian government, and not be run, as Odría permitted, by foreign corporations. In addition, CAEM supported the creation of a national strategic planning institute, along with the conduction of regional development projects to better secure frontier areas and relieve rural poverty. CAEM's slogan, "there is no defense without development," described well the Center's philosophy. The Center adopted a critical attitude towards governmental neglect of rural areas and towards the abuses heaped on the poor by Peru's powerful because this created resentment, exacerbated conflicts, and turned the people against agents of the state, such as the military. CAEM's reformist perspective gradually

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[43] President Bustamante announced the projected conduction of this census in 1948. See ACP: "Mensaje del Presidente Constitucional del Perú, Dr. José Luis Bustamante y Rivero, ante el Congreso Nacional," (28 July 1948). On the Odría presidency, see Caravedo, Desarrollo Desigual y Lucha Política en el Perú, 1948-1956; Pareja, Aprismo y Sindicalismo en el Perú; Portocarrero, De Bustamante a Odría.

became hegemonic among Peru's military officers and even popular among political actors opposed to Odría. Just as importantly, CAEM defined a new self-image for Peru's military as the nation's foremost development agent, patriotic and technically able.[44]

During this period, the APRA party (Popular Revolutionary Alliance of the Americas) was still the strongest civilian political force, and the one that counted with the most popular support, something that had not changed since its establishment in the 1920s. The 1962 election gave APRA's Victor Raúl Haya de la Torre the victory, but not by the constitutionally mandated margin. Surprisingly, Haya made a deal with his former nemesis, Manuel Odría, who had also ran for the Presidency. With this agreement, Odría would become President and APRA would control the Vice-Presidency and Congress. By then, however, Peru's armed forces had also changed ideologically. Instead of fearing APRA's radicalism, they resisted APRA's alliance with Odría's conservative forces, as this alliance would likely block what the military thought were necessary national planning and wealth redistribution reforms to guarantee national security. The reformist military trusted more the third way presented by Fernando Belaúnde Terry and his technocratic *Acción Popular* party, which came in second in the election results, after Haya, but ahead of Odría. A coup removed President Manuel Prado from office in July 1962, and General Ricardo Pérez Godoy established a Military Junta.

The military government of 1962-1963 lay the ground for Peru's national strategic planning and coordination function. The Junta created the National System for Economic

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[44] On the CAEM, see Victor Villanueva, El CAEM y la Revolución de las Fuerzas Armadas (Lima: IEP, 1972); Alfred Stepan, "The New Professionalism of Internal Warfare and Military Role Expansion," in Abraham Lowenthal (ed.), Armies and Politics in Latin America (New York: Holmes and Meier, 1976); Rodriguez Beruff, Los Militares y el Poder; Daniel Masterson, "Caudillismo and Institutional Change: Manuel Odría and the Peruvian Armed Forces, 1948-1956," The Americas 40, 4 (1984): 479-489.

and Social Planning and its main technical body, the National Planning Institute (INP, in Spanish).[45] The fact that this was one of the few actions the military government took before calling for new elections is indicative of the high regard Peru's military elite had for national strategic planning. Fernando Belaúnde won the 1963 election, and continued supporting the newly minted organization. On the subject of population, the INP supported ECLA's conclusions about the problems fast population growth could cause, and was transparent in its admission that Peru's demographic growth had been explosive. The introduction of antibiotics and DDT in the 1950s had, according to the INP, halved mortality rates, which previously had been grievously high, especially among undernourished infants when they were exposed to common infectious diseases such as tuberculosis, smallpox, malaria, and poliomyelitis. Total mortality rates dropped from 27.1 per 1,000 in 1940 to 15.4 per 1,000 in 1961; with life expectancy increasing from 36 years in 1940 to 51 in 1961; and with birth rates increasing slightly from 44 per 1,000 in 1940 to 45.4 in 1961. The inevitable future growth of the Peruvian population, however, did not lead to the consideration of any form of population limitation initiative. In fact, the INP's mission was to oversee the conduction of projects to increase and improve the production of goods, services, and employment throughout the country, in order to maintain quality of life even as population size grew, without attempting to slow down its growth directly.[46]

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[45] ACP: Decreto Ley 14220: "Sistema Nacional de Planeamiento Económico y Social," (October 1962).

[46] Instituto Nacional de Planificación, "Plan Nacional de Desarrollo Económico y Social del Perú, 1962-1971"; Instituto Nacional de Planificación, Boletín de Noticias 2 (December 1965); Instituto Nacional de Planificación y Oficina Nacional de Estadística y Censos, Estudio sobre la Población Peruana: Características y Evolución (Lima: INP, 1973). On the effects of malaria on the reduction of mortality rates, see Robin Barlow,

Belaúnde's government proved to be a disappointment for the reformist military. Despite the infrastructure-building boom of the early 1960s, peasant and leftist guerrilla uprisings checked his administration.[47] The violent repression of the uprisings not only discredited the President, but also the military, which retreated into a position that was increasingly critical of the social inequalities that had given rise to the uprisings in the first place. In addition, almost from the beginning of his administration, Belaúnde had had to deal with the fact that APRA and the supporters of former President Manuel Odría mounted an effective opposition in Congress. This opposition and Belaúnde's own unwillingness to take on the powerful landed elite prevented Belaúnde's promised agrarian reform. The tipping point was Belaúnde's inability to prevail upon the International Petroleum Co. (a subsidiary of the Rockefeller-controlled Standard Oil) in negotiations over the profits generated by the oil fields in the northern coast. Alienated, a wing of the military, led by General Juan Velasco Alvarado, ousted Belaúnde and instituted the so-called "Revolutionary Government of the Armed Forces" in October of 1968. With great celerity, Velasco nationalized the disputed oil fields. Then, he set out to organize his greatest project, his most controversial one, and the one that failed most spectacularly: the agrarian reform, which began in earnest with the expropriation of the large sugar cane-producing estates in the northern coast.[48]

"The Economic Effects of Malaria Eradication," American Economic Review 57, 2, (1967): 130-148.

[47] Leon Campbell, "The Historiography of the Peruvian Guerrilla Movement, 1960-1965," Latin American Research Review 8, 1 (1973): 45-70.

[48] On the 1968-1980 military governments, see Abraham Lowenthal (ed.), The Peruvian Experiment: Continuity and Change under Military Rule (Princeton: Princeton University Press, 1975); Pease, El Ocaso del Poder Oligárquico; McClintock and Lowenthal, The Peruvian Experiment Reconsidered; Evelyne Huber Stephens, "The Peruvian Military Government, Labor Mobilization, and the Political Strength of the Left," Latin American

Almost as soon as Velasco took over, he cancelled the agreement the Ministry of Health had with UNFPA to adopt a family planning policy and program based on the Caracas Report. In addition, Velasco put an end to the pilot birth control clinics run by the CEPD. The latter sponsored only one last major conference. The *Laboratorio de Demografía y Salud* (Symposium on Demography and Health) was held in Trujillo in December of 1968, with the support of the Panamerican Federation of Medical Faculties and that of the Latin American Demography Center (CELADE). The 61 participants, most of whom were physicians, met to discuss the relations between population growth, economic development, public health, and family planning in the country.[49] Importantly, the USAID, a staunch supporter of meetings of this kind, did not support the Trujillo symposium.

Richard Clinton argues that this was the last broad public discussion of population limitation in Peru during the Velasco era, and that the CEPD had, from that moment on, to limit itself to demographic research and its diffusion to policymakers.[50] That, however, does not mean that Velasco could unilaterally end family planning programs and debates. In fact, Velasco permitted the continuing operation of privately funded clinics like the *Instituto Marcelino*, and the USAID and IPPF-funded clinical training program in family planning at the Arzobispo Loayza Hospital.[51] Moreover, Velasco did not object to the USAID and IPPF-funded Fifth Peruvian Congress of Obstetrics and Gynecology, in late October of 1974. Dr. Richard Derman, Executive Director of Family Planning International Assistance (the international division of the International Planned

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Research Review 18, 2 (1983): 57-93.
[49] Tribuna Médica 5, 218 (2 December 1968): 1-2.
[50] Clinton, Población y Desarrollo en el Perú.
[51] See chapter four for a description of this program.

Parenthood Federation) recounted that "no restrictions were placed on content" and that almost 300 participants openly discussed abortion and sterilization with speakers from Cornell University, the Population Council, the Chilean Family Planning Association, and even with India's Director of Family Planning. The Congress was, in Derman's opinion, "a most dramatic meeting whose long range effects have yet to be felt."[52]

Velasco, however, was unmoved by professionals' demands to increase the availability of family planning services to help curb the national birth rate. Instead of viewing birth control technologies as means to this end, Velasco viewed them almost exclusively as means to space pregnancies. Velasco's skepticism regarding population limitation was not unusual given Peru's intellectual history. The idea that Peru was an underpopulated country with vast regions still to colonize was popular, particularly among military personnel that considered Peru's borders unsecured.[53] Velasco was so worried that Peruvians living in frontier zones would register their children as something other than Peruvians when they could not find a governmental registration office nearby that he eased the procedure and gave municipalities the power to conduct these registrations.[54]

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[52] SSC: PPFAII, box 83, folder 21: "Field trip report from Dr. Richard Derman," (October 1974).

[53] As I argue in chapter two, certain Peruvian intellectuals had promoted this notion at least since the eighteenth century. Princeton University demographer Kingsley Davis denounced vigorously this idea in the 1940s, calling it one of the region's "great myths." See Kingsley Davis, "Latin America's Multiplying Peoples," Foreign Affairs 25 (1946-1947): 643-654, 648.

[54] ACP: Decreto Ley 19394: "Prorrogan por Un Año Término Fijado en Art. 4 de D.L. 18788 sobre Inscripción de Nacimiento," (9 May 1972); Decreto Ley 19987: "Municipios del País Harán Inscripción sobre Nacimientos sin Mediar Declaración," (13 April 1973); Decreto Ley 20223: "Abren Inscripción Extraordinaria del Nacimiento de Peruanos en los Registros del Estado Civil," (20 November 1973).

In addition, Velasco was aware of the fact that migration from rural to urban areas was rising, as both the 1940 and the 1961 censuses showed. On this issue, Velasco adopted the view of Peru's foremost demographer, Alberto Arca Parró. In the 1940s, Arca Parró interpreted autogenous population growth and migration from rural to urban areas as the early signs of a revolution that would catapult Peru from an agricultural to a manufacturing economy.[55] Ironically, Arca Parró had reversed his position by the late 1960s.[56] Yet, when Velasco's 1971 Committee on Population and Work, which Arca Parró chaired, stressed the problems migrants had finding employment in urban areas, and suggested the need for a population policy to better manage the size and distribution of the country's population, Velasco ignored the recommendation.[57]

Peru's National Development Plan of 1971-1975 contained no explicit discussion of population pressures in relation to development. Although it acknowledged shortages of employment opportunities, of schools, and of physicians, the Plan did not consider population growth a cause or contributing factor to any of these shortages. Moreover, although it included demographic data such as the rate of population growth, mortality rates, and current and projected economically-active population rates, the Plan did not concern itself with other important indicators, such as fertility rates, projections of future population size, and projections of future school-age population. The Plan was optimistic about Peru's economic development prospects, stating that the Agrarian Reform would

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[55] Arca Parró, "Census of Peru, 1940"; Arca Parró, El Medio Geográfico y la Población del Perú; George McCutchen McBride and Merle McBride, "Peruvian Avenues of Penetration into Amazonia," Geographical Review 34, 1 (1944): 1-35; Judy Meltzer, "Census-Making, Race and Population in Mid-20th Century Peru," paper presented at the Canadian Political Science Association meeting, Saskatoon 2007.
[56] See chapter four.
[57] See José Donayre Valle's "Prologue," in Varillas and Mostajo, La Situación Poblacional Peruana, xv.

increase productive capacity to such an extent that "it will permit the living standards of the majority of poor people of the country to rise without extreme sacrifices by the middle class."[58]

Although the topic of family planning did not emerge as part of a national development plan or a population policy, it was a carefully regulated aspect of Velasco's maternal and child care program. The main vehicle for the implementation of this program was the Institute of Neonatology and Maternal-Infant Protection (INPROMI, in Spanish), created in 1971.[59] Although the Sanitary Code of 1969 stressed the state's duty to protect pregnant women and infants, it was not until the creation of INPROMI that such work became a priority within the Ministry of Health, thanks to the technical assistance the PAHO and the USAID gave to the INPROMI.[60] In line with the WHO's views in the late 1950s, INPROMI considered pregnant women and infants as at-risk populations, or "the human groups most prone to becoming sick and dying."[61]

Indeed, Peru's National Program for Maternal and Child Health of 1973 indicated that Peru's maternal mortality rate neared 24.5 per 1,000 infants born alive. Hemorrhages, toxemias, lack of hygiene during interventions, and induced abortion explained, in that order, most of the mortality observed. In terms of children's health, over 30 percent of all deaths in Peru occurred among children younger than one. Preventable diseases such as diarrheas, respiratory infections, poliomyelitis, measles,

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[58] Plan Nacional de Desarollo, 1971-1975: Vol. 1, p. 9.
[59] Decreto Ley 18949: "Instituto de Neonatologia y Proteccion Materno-Infantil," (1971).
[60] Decreto Ley 17505: "Código Sanitario," (1969: article 26). PAHO and USAID patronage caused no small amount of friction between the INPROMI and the Ministry of Health, but the closeness of INPROMI Director Luis Suares López to Velasco prevented the conflict from escalating. See interviews with former PAHO Advisor Duncan Pedersen (3 December 2008) and former INPROMI Director René Cervantes (16 December 2008).
[61] INPROMI, "Normas y Procedimientos para la Atención del Recién Nacido," (1972: 1).

diphteria, tetatus, and tuberculosis accounted for most of these fatalities. Still, according to INPROMI, "the real underlying factor" for such high mortality rates was poverty, expressed as a series of widespread social ills, like unemployment, illiteracy, inadequate health services, insufficient housing, and bad sanitation.[62]

At the time of INPROMI's creation, the Ministry of Health's budget consisted of approximately 3.7 percent of the gross national product. This allowed the Ministry to run its 335 hospitals, 388 health centers and 936 rural sanitary posts. In addition, there were 7,818 physicians, 3,722 nurses, and 13,200 nurse-assistants in the public sector, most of whom worked in Lima. More specifically for maternal and infant care, there were about 2,900 beds available in all public gynecology services, as well as 591 gynecologists, 994 university-trained midwives, and 340 pediatricians. The immediate problem INPROMI wished to address was the low frequency of pre-natal check-ups. The number of women who had access to and used these services varied by region. In urban areas such as Lima, some 34.6 percent of pregnant women had regular pre-natal check-ups, whereas in rural areas near Huancavelica the number dropped to a mere 1.3 percent of pregnant women.[63]

INPROMI's goal was to extend pre-natal check-ups to at least 60 percent of all pregnant women by the end of the 1970s, with each woman meeting a physician at least four times during her pregnancy.[64] The assumption was that frequent clinical encounters could prevent potentially fatal complications that might emerge during a pregnancy. In addition, such encounters could be opportunities to impart notions about healthy lifestyles for women and infants, particularly the importance of vaccination and of "responsible

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[62] INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Parte III).
[63] INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Parte III).
[64] INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Parte IV).

parenthood", which will be defined below.[65] To increase its capacity to provide pre-natal check-ups, INPROMI welcomed Velasco's initiatives to make more physicians available in rural areas, such as the Civil Service for Medical Graduates (SECIGRA, in Spanish), the training of all health workers to impart information about healthy pregnancies, and the enlisting of help of community leaders, including teachers, clerics, and folk healers.[66]

It is important to note that, again, regional coordination played a role in the formulation of Peru's national objectives. The meeting of American Chiefs of State of Punta del Este (Uruguay) of 1967 committed all attendees (including then President Belaúnde) to the promotion of maternal-infant health protection programs and that of programs in family education. In addition, the meetings of Health Ministers of the Americas of 1968 (in Buenos Aires, Argentina) and of 1972 (in Santiago, Chile) committed Peru to extend health services to locales of under 2,000 inhabitants, and to reduce maternal and infant mortality rates by 30 percent each by the end of the decade.[67]

The provision of birth control methods was a delicate aspect of Peru's INPROMI-led maternal-infant health program. Following a delivery, the attending physician must "suggest an appropriate inter-parity interval"[68] to the new mother, and let her know "about the availability of contraceptives by prescription," and of the contraceptive effect

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[65] INPROMI, "Normas y Procedimientos para la Atención de la Madre, Capitulo I," (1972, 76); INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Parte V).
[66] On the SECIGRA, see Decreto Supremo 055-71-SA and Resolución Suprema 00034-72-SA/DS: "Regionalización Docente y Asistencial," (March 1972). On the enlisting of help from community leaders, see INPROMI, "Normas y Procedimientos para la Atención de la Madre, Capitulo I," (1972: 75).
[67] INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Introducción).
[68] INPROMI, "Normas y Procedimientos para la Atención de la Madre, Capítulo II," (1972: 29).

of prolonged breastfeeding.[69] This type of intervention could "prevent the risks involved in frequent pregnancies and in pregnancies among very young women, and, especially, prevent induced illegal abortions."[70] Nonetheless, contraceptives and information about them were restricted to specific clinical interactions with physicians. They were not part of the broader maternal and family health education courses INPROMI pioneered. The rationale for these courses was the diffusion of "responsible parenthood," a Catholic concept that emphasized parents' duty to provide spiritual guidance, material support, love, and education for their children, so as to permit their optimal emotional development and incorporation into society.[71]

INPROMI made gynecology departments in hospitals and health centers responsible for the provision of maternal and family health instruction. The courses typically gathered groups of up to twenty women, who received information on what to expect during labor, post-natal self-care, the care of infants, good nutrition habits, sexual intercourse after giving birth, and, of course, responsible parenthood.[72] But Velasco did

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[69] INPROMI, "Normas y Procedimientos para la Atención de la Madre, Capítulo I," (1972: 76).
[70] INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Parte V).
[71] INPROMI, "Normas y Procedimientos para la Atención de la Madre, Capítulo I," (1972: 75). On "responsible parenthood," see Richard Fagley, The Population Explosion and Christian Responsibility (New York: Oxford University Press, 1960: 5); José Luis Idígoras, "La Iglesia y la Regulación Racional y Cristiana de los Nacimientos," El Mensajero del Corazón de Jesús 20, 217-218 (August-September 1964): 219-224; UNICEF, "Children and Youth in National Development in Latin America," 34. On the historical continuity of the idea that parents have responsibilities towards children, see Leslie Tuttle, "Celebrating the Père de Famille: Pronatalism and Fatherhood in Eighteenth-Century France," Journal of Family History 29, 4 (2004): 366-381.
[72] INPROMI, "Normas y Procedimientos para la Atención de la Madre, Capítulo I," (1972: 11, 46). It is ironic that INPROMI used APPF's teaching materials on family health and responsible parenthood as late as 1974 even though Velasco shut down the APPF in 1973. See Archivo del Ministerio de Salud (hereafter "MINSA"): Programa Materno Infantil y de Bienestar Familiar Hospital de INPROMI, "Curso de

not just hope for more responsible parents. He looked forward to politically inspired and mobilizeable parents, particularly in areas where his agrarian reform was already underway.[73] To Velasco, family health education, not population limitation, was to be Peru's path to economic development.[74] "Making people aware of their right to health," INPROMI sentenced, "will make them more willing to organize politically to demand health services. As their demands are progressively addressed, productivity will increase."[75] Given the stock Velasco placed on educating and mobilizing people behind his own nationalist political program, it should then come as no surprise that the Peruvian government bristled at the suggestions put forth at the International Conference on Population of Bucharest in 1974.

From Lima to Bucharest and Back

In April of 1970, the UN's Economic and Social Council approved the Population Commission's recommendation to hold an International Conference on Population in 1974, and to name that year "World Population Year." The United States had been the main proponent of this conference, whose original principal goal had been to set population growth targets that member nations would strive to achieve, with the ultimate purpose of arresting population growth, especially in developing countries. The

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Adiestramiento en Bienestar Familiar, Hospital General Base Chepén (Area Hospitalaria 1 Chepén, Pacasmayo, Región de Salud Nor-Medio," (22-29 August 1974).

[73] INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Parte V).

[74] INPROMI, "Normas y Procedimientos para la Atención de la Madre, Capítulo II," (1972: 236).

[75] INPROMI, "Programa Nacional de Salud Materno-Infantil," (1973: Parte V). Like Odría before him, Velasco made it a priority to construct a political machinery to mobilize political supporters. For an analysis of this strategy, see Manuel Castells, The City and the Grassroots: A Cross-Cultural Theory of Urban Social Movements (Berkeley: University of California Press, 1983: 192).

organizers circulated a Draft Plan of Action, strongly influenced by the US delegation, prior to the August meeting in Bucharest.[76] In this section, I will analyze the Peruvian response to the Draft Plan of Action, as it provided a renewed opportunity for the discussion of population policies as vehicles for national development.

Peru received the conference's Draft Plan of Action and delegated the task of crafting the official national response to the Chief of the Cabinet, who in turn convened a team of experts from the INP, and the Ministries of Health, of Foreign Affairs, and of Labor, all under the direction of the elder Alberto Arca Parró. Among these experts was the Harvard-educated economist and Jesuit priest Juan Julio Wicht. Wicht completed his doctorate in 1972 and became an advisor to the INP Director shortly therafter. To Wicht, the Draft Plan of Action came across as an imposition on the part of experts from developed countries, even though, unlike Velasco, he acknowledged that Peru's rapid demographic growth posed development problems.[77] Curiously, however, the Peruvian delegation chose not to make its position known before the Bucharest meeting, only afterwards.[78] This probably had to do with the anticipated unveiling of the *Plan Inca*, the national planning document that Velasco issued in July of 1974. It would not have been prudent to publicize a view on population growth before knowing where the chief stood, especially because Velasco's administration turned increasingly intolerant of dissent

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[76] W. Parker Mauldin, Nazli Choucri, Frank Notestein, Michael Teitelbaum, "A Report on Bucharest," Studies in Family Planning 5, 12 (1974): 357-395.
[77] AGN: Instituto Nacional de Planificación, "Proyecciones a Largo Plazo de la Poblacion y de la Economia del Perú," 1973. See also Juan Julio Wicht, "La Política de Población en el Perú: La Toma de Conciencia de la Situación Demográfica en el Perú," Acta Médica Peruana 6, 2 (1979): 89-96.
[78] Boletín Especial de la Oficina Nacional de Estadística y Censos 3 (October 1974).

around 1973. Velasco's critics had become more vocal when the Agrarian Reform did not produce the economic and social benefits the government hoped for.[79]

As has been reported elsewhere, most developing countries at the Bucharest meeting rejected the Draft Plan of Action's population targets and demanded respect of national sovereignty in population policy making.[80] Opponents of the Draft Plan moved the discussion away from defining population growth as the problem, and instead claimed that the root cause of most social ills had to do with the poverty that resulted from the unequal distribution of wealth in the world, a position that had been building up among developing countries since the early 1960s, and which became institutionalized with the creation of the UN Conference on Trade and Development in 1964.

At the end of the Bucharest conference, 136 member states (all in attendance except for the Vatican) signed on to a new World Population Plan of Action. This Plan insisted that population problems were derivatives of social and economic ones, and that economic development was, therefore, necessary to tackle population problems effectively.[81] However, the World Plan of Action also stated that "[a]ll couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the

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[79] See for example Dennis Gilbert, "Society, Politics, and the Press: An Interpretation of the Peruvian Press Reform of 1974," Journal of Interamerican Studies and World Affairs 21, 3 (1979): 369-393.

[80] Ralph Townley, "Government and Population: The World Population Conference, 1974," International Journal of Health Services 3, 4: 689-692; J. Mayone Stycos, "Demographic Chic at the UN," Family Planning Perspectives 6, 3 (1974): 160-164; Jason Finkle and Barbara Crane, "The Politics of Bucharest: Population, Development and the New International Economic Order," Population and Development Review 1, 1 (1975): 87-114; Green, "The Evolution of US International Population Policy, 1965-92; Paige Eager, Global Population Policy: From Population Control to Human Rights (Hampshire: Ashgate, 2004: 60-65).

[81] UN World Population Plan of Action, Bucharest 1974: Section A, points 1-13.

responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community."[82]

Despite the international validation of its national position, the Peruvian delegation returned home only to continue facing Velasco's unwillingness to turn Peru's official opinion in Bucharest into a specific policy. The *Plan Inca* did not contain stipulations to deal with population growth in any of its sections, which were devoted to other aspects of industrial development and the provision of social services.[83] This was even more alarming to demographers like Wicht following the publication of the results of the 1972 census, which showed that Peru's population had grown to just over fourteen million; that is, it had increased almost by half in the eleven-year intercensal period.[84]

By 1975, a number of military commanders decided that Velasco's personalism and authoritarianism had become obstacles to governance. Minister of Finance General Francisco Morales Bermúdez led a quiet coup in August of that year, and instituted the so-called "Second Phase of the Revolutionary Government of the Armed Forces."[85] Velasco, who had been ill for about one year and had had a leg amputated, did not resist

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[82] UN World Population Plan of Action, Bucharest 1974: Section B, point 14, letter f.
[83] Juan Velasco Alvarado, Plan Inca: Mensaje a la Nación (Lima: Inti-Kallaw, 1974). The Plan contained sections on the use of natural resources, foreign policy, the agrarian reform, domestic industry, tourism, trade, transportation, telecommunications, financial policy, education, scientific research, housing, health, women's issues, freedom of the press, and the administration of justice. See also Carmen Rodriguez de Munoz and Elsa Roca de Salonen, "Law and the Status of Women in Peru," Columbia Human Rights Law Review 8 (1976): 207-228; and Juan Julio Wicht, "La Situación Demográfica del Perú," in Reunión Nacional sobre Población: Problemas Poblacionales Peruanos (Lima: AMIDEP, 1980: 15-93).
[84] INEI, "Historia de los Censos en el Perú."
[85] Francisco Morales Bermúdez and María del Pilar Tello, El Relevo de Pachia, ¿Golpe o Revolución? Hablan los Militares del 68 (Lima: SAGSA, 1983); Francisco Morales Bermúdez, Apuntes sobre Autoritarismo y Democracia (Lima: IBESA, 1989).

the coup, resigned, and kept a low profile until his death in 1977. Morales Bermúdez had been sensitive to the weakness of Peru's financial situation, and was open about the limitations of agrarian reform as an engine of development.[86] He worried, in particular, abut the unavailability of credit and agricultural technology training for people in rural areas, who had benefited from the losses of large landholders. Morales Bermúdez had to lead the country through a severe economic crisis during which he proceeded to slow down the pace of the agrarian reform, and to mend the tense political relations Peru had with the US government as a result of Peru's rapprochement with the Soviet bloc and Cuba during the Velasco years.[87] Finally, in 1978 Morales Bermúdez began the process of returning the country to the authority of civilians. He convened a Constitutional Assembly to draft a new Constitution, which was promulgated in 1979, and called for elections in 1980, thus ending the latest twelve years of military rule in Peru.

It was Morales Bermúdez's government that finally addressed the question of regulating population growth for the sake of economic and social development. Following the Cabinet meetings that established the National Development Plan for 1975-1978, the President charged Lieutenant General Jorge Tamayo de la Flor, Minister of Health, with establishing the basis of what would become the country's population policy. Tamayo gathered a committee that included five high level government officers: Dr. Napoleón Zegarra Araujo, Director of Health Programs, and his advisor, Dr. Hernan Farje Godoy; Alberto Lari Cavagnaro, Director of the Office of International Exchanges;

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[86] Francisco Morales Bermúdez, Exposición del Ministro de Economía y Finanzas (Lima: Ministerio de Economía y Finanzas, 1973); Francisco Morales Bermúdez, Guido Pennano, and Juan Ramírez, Algunos Desarrollos del Sistema Financiero: Crónica de un Colapso Económico: Perú, 1974-1979 (Lima: CIUP, 1980).
[87] José Rodríguez Elizondo, "El Penúltimo Profeta," La República (6 January 2009): 19.

Dr. René Cervantes Begazo, Director of INPROMI; and Mario Castillo Gómez, of the Ministry of Health's Planning Office. In addition, the committee relied on three "permanent advisors": Juan Julio Wicht, Dr. Luz Jefferson Cortez, a gynecologist at the Arzobispo Loayza Hospital, and journalist Luciana Biseo Fuchs.[88] The official documents, however, do not record the important role the PAHO played, through Regional Advisor Dr. Duncan Pedersen, now at Montreal's Douglas Hospital. In fact, it was this eclectic, transnational, and multidisciplinary group of four advisors that actually debated and wrote Peru's first population policy.

Originally from Argentina, Pedersen was finishing his Masters degree in Public Health at Johns Hopkins University when the PAHO's Abraham Horwitz recruited him in the early 1970s, to serve as Regional Advisor in Health and Population for Colombia, Peru, Ecuador and Bolivia. Pedersen had previously assisted the leaders of INPROMI in 1971, when they designed Peru's Maternal and Infant Health Program. As he recalled, the PAHO leaders somewhat resented the aggressive attitude of the United States in the field of family planning, which threatened to turn PAHO-supported maternal and infant health programs into fronts for the distribution of contraceptives. When the Peruvian government requested his assistance once again, Pedersen hoped that a demand-driven approach to the provision of contraceptives would prevail.[89]

Journalist Luciana Biseo had been born in Rome, Italy, but had been writing for Peruvian journals and magazines, and supporting the fledgling Peruvian feminist movement for several years when she was asked to join the Population Policy committee. As Biseo put it, she had some "passionate ideas" about the lives of women in Peru,

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[88] Resolucion Ministerial 000635-76-SA/DS (6 September 1976).
[89] Interview with Duncan Pedersen (Montreal, 3 December 2008).

burdened by a long tradition of *machismo* and misogyny: "I responded quite favorably [to the invitation to join the Committee] because I considered it a good opportunity to bring women's voices to the attention of the government, to let them know of the problems inherent to womanhood, particularly those surrounding sexuality and motherhood."[90]

Gynecologist Luz Jefferson had obtained her medical degrees from San Marcos University and Cayetano Heredia University in Peru, a Masters degree in Public Health from Johns Hopkins University, and a Population Council Fellowship to further her training at the Margaret Sanger Research Bureau in New York.[91] Between her return from the United States in 1965 and Velasco's 1968 coup, Jefferson ran two family planning clinics, a state-sponsored one, and a second, private, one created by the APPF in the Lima district of Breña. She also became the Coordinator for the Population Program of the Peruvian Association of Medical Faculties, which conducted research and training of medical professionals on the links between population growth, maternal health, and the state of the country's medical infrastructure, all the while maintaining her job at the Arzobispo Loayza Hospital and her own private gynecology practice.

The constitution of the commission attracted little public controversy, despite the participation of non-Peruvians. Even though the commissioners did not feel pressured to skew their views in any particular way, they knew that the Catholic Church and Morales Bermudez's cabinet intently followed their proceedings. Wicht participated in the commission as an advisor to the INP but, a priest after all, he provided updates to the Archbishop on a regular basis, and presented to the latter a complete draft of the

[90] Luciana Biseo, e-mail to the author (6 December 2008).
[91] Luz Jefferson, e-mail to the author (16 December 2008).

Population Policy Guidelines before they were made public.[92] Likewise, Luciana Biseo was asked to brief the President's Military Advisory Council on her views on the situation of Peruvian women.[93]

The invitation to form part of the commission had been, to all advisors, an honor. With the authority of a Presidential decree behind it, they had little trouble securing time off their other occupations to participate in the discussions, which took place over approximately two months, in roughly bi-weekly meetings of several hours' duration at INPROMI and at the Ministry of Health. The many drafts included sections on demography, the contemporary socio-economic characteristics of the country, maternal and infant health, and the status of women. On occasion, the commission welcomed ad-hoc advisors on specific topics, such as Ricardo Subiría of Peru's Christian Family Movement.[94] Wicht emerged as the informal leader of the group, and, with Pedersen's help, he put together the final draft of the document in May of 1976.

Most of the commission's discussions were orderly, cordial, and the members' decisions consensual. There were, however, tense moments when the group debated what birth control technologies to legalize. Abortion was universally rejected. Jefferson's moral convictions led her to repudiate the practice, even though, as a gynecologist, she had witnessed the injuries induced illegal abortion caused. Cervantes, the commission's other gynecologist, believed it unnecessary to legalize abortion when the most basic methods of birth control were still unavailable to the majority of Peruvian women.

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[92] Wicht, "La Situación Demográfica del Perú," 57.
[93] Luciana Biseo, e-mail to the author (6 December 2008).
[94] Interview with Ricardo Subiría (6 March 2006).

Biseo's own view was that abortion "is not even a contraceptive."[95] However, gynecologists Jefferson and Cervantes strongly defended the inclusion of sterilization in the country's population policy.[96] Castillo, of the Ministry of Health's Planning Office, in contrast, was completely opposed to the idea. Meanwhile, Pedersen urged caution in this regard, so as to prevent the USAID from turning a balanced population policy into a potentially abusive law.[97] In the end, the commissioners agreed to drop sterilization from the list of approved methods of birth control, largely out of their desire not to antagonize the powerful Catholic Church. "We had already accomplished so much, and did not want to risk having the whole document rejected because of the inclusion of sterilization," reflected Biseo years later: "The way we saw it, we had begun from absolute zero, and yet managed to agree on important points. The rest might happen later, perhaps in a few years. […] Although I felt like I was betraying women, I accepted that this was not the right time to continue fighting."[98]

Peru's Population Policy Guideline embraced what had been the Peruvian position at the Bucharest meeting, affirming that high birth rates in the country were not a cause but a consequence of underdevelopment, and criticizing the attempt to set population limitation targets as racist and driven by the will of powerful countries to violate the sovereignty of weaker ones.[99] In fact, according to the Guideline, Peru's

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[95] Interview with Duncan Pedersen (Montreal, 3 December 2008); Luciana Biseo, e-mail to the author (6 December 2008); and Luz Jefferson, e-mail to the author (16 December 2008).
[96] René Cervantes, e-mail to the author (16 December 2008).
[97] Interview with Duncan Pedersen (Montreal, 3 December 2008).
[98] Luciana Biseo, e-mail to the author (6 December 2008).
[99] Lineamientos de Política de Población en el Perú (hereafter "LPP") (Lima: INP, 1976: Part I, section B, point 5). The Guideline was made public through Decreto Supremo 00625-75-SA (31 August 1976).

problem was not rapid population growth in itself, but rather "the lack of balance between the age groups and that between population size and the resources available to sustain it."[100] The Guideline also adapted other ideas from the Bucharest World Population Plan of Action, including the claim that the current limits to population growth were artificial, and turned a few into very wealthy, polluting, and heavily-consuming countries, while permitting the rest to barely survive in the midst of poverty.

In line with the local studies produced by the INP, the Guideline affirmed that it was the lowering of mortality rates and not the increase in fertility rates that had resulted in fast demographic growth in less developed countries, such as Peru. However, unlike European countries, the lowering of mortality rates in Latin America, the Guideline pointed out, had not been accompanied by greater availability of foodstuffs, more efficient forms of social organization, or widespread sanitation.[101] Instead, the greater availability of antibiotics and disease eradication campaigns had left untouched longstanding backward institutions such as illiteracy, racism, and gender inequality. Rapid and recent demographic growth had also resulted in the fact that 45 percent of Peru's population was under the age of fifteen. The ratio of this segment of the population, which presumably was not an economically active segment, to the adult population that had to work to sustain it, was more than twice as high as that in the United States, Europe and even Argentina.[102]

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[100] LPP, part I, section A, point 1.
[101] These changes were visible in the British case of population growth studied by McKeown. See Thomas McKeown, The Modern Rise of Population (London: E. Arnold, 1976).
[102] LPP, part I, section C, point 10.

Nonetheless, still echoing the demographic optimism of the 1940 census makers, the Guideline affirmed that, while there might be a limit to the indefinite expansion of human population, "we have not yet reached that final natural barrier."[103] Thus, instead of setting quantitative birth rate targets, the Guideline set national qualitative goals based on strengthening of the family, promoting equality of rights between men and women, ensuring freedom and responsibility in parental decisions regarding family size, protecting children, and achieving national security and development. That established, the Guideline acknowledged that population growth worsened problems such as urban chaos and unemployment. It also acknowledged the individually painful experiences of women regarding maternal mortality and malnutrition, worsened by having too many children or by short inter-parity intervals. The document criticized men's views of women as sexual objects, their abusive attitudes, and their lack of commitment to their families.[104]

Future specific population laws must, according to the Guideline, address housing availability, the use of technology for the production of food, the improvement of demographic data gathering, employment generation, environmental pollution, and the distribution of the population in the country's territory. However, the Guideline also indicated that, more immediately, population policymaking required promoting the equality of rights and responsibilities for men and women, including their right to choose birth control methods (all but abortion and sterilization were legalized). Crucially, this right was not cast as an individual right, but rather as the right of a couple, a position that

[103] LPP, part I, section B, point 7.
[104] LPP, part II.

is still commonly accepted in Peru today.[105] The right to choose birth control methods, in turn, demanded extending public medical services, as well as popularizing knowledge about family planning methods, sexual education, and responsible parenthood, which was officially defined as the "free and informed choice by couples to decide the size of its offspring, a choice that not only must consider the partners' responsibilities towards each other, but also towards their children and society."[106]

Jefferson vividly recalls the day their work was made public: "It happened on April 13th, 1976, before President Francisco Morales Bermúdez, ministers and other government officers. It was one of the happiest days of my life because I had worked on such a transcendental document. Juan Wicht presented the Guideline. I did not like all the references made to the importance of the "Revolutionary Government of the Armed Forces", but those were other times. Afterwards I could not stay and celebrate because I was on duty at the hospital." So what did the Revolutionary Government of the Armed Forces actually accomplish with the Guideline once it left the hands of the commissioners and became a national policy?

The Policy in Practice

The Guideline for Population Policy had immediate effects that revitalized private clinical interventions, social science research, and advocacy in favor of family planning. Shortly after the Guideline's promulgation, Miguel Ramos Zambrano, former Director of

[105] Recently, it has re-emerged as Peruvians debate the social legitimacy of emergency contraception, for example. An editorial in the left-leaning newspaper La República stressed that choosing a birth control method "ought to be the decision of a couple and their physician," without the "intromission" of religion. See "AOE Gana Batalla," La República (9 February 2009): 18.
[106] LPP, part III, section B, point 3.4.

the defunct APPF, wrote to President Morales Bermúdez, asking for the return of the APPF's property that Velasco had confiscated.[107] The President acquiesced and, moreover, he allowed the APPF to restart its activities in September of 1976, as the Peruvian Institute for Responsible Parenthood (INPPARES). Later that month, INPROMI invited a USAID-funded consultant to suggest ways in which INPROMI might broaden its supply of birth control methods within the state's maternal and infant care program.[108] In addition, the USAID supported financially the efforts of Peruvian intellectuals of different backgrounds, who began to form civil society organizations to further the study of demography and to promote the enactment of the provisions of the Guideline for Population Policy. These included the Multidisciplinary Association for Research and Teaching in Population (AMIDEP, in 1977), the Peruvian Center for Applied Research (CPIA, 1977), the Association of Professionals for the Promotion of Maternal and Infant Health (APROSAMI, 1978), and the Association for the Social Development of Women (ADIM, 1979). Nonetheless, direct collaboration between the USAID and the Peruvian government in population issues started again only later in 1979, through Primary Health and Population Project 219, to provide family planning services in Ica, in south central Peru.[109]

While family planning research and clinical services began a slow but steady rise, inter-sectorial collaboration within the government to foster legislative changes in gender

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[107] MRZ: Letter from Miguel Ramos Zambrano to President Grl. Francisco Morales Bermúdez (Lima, 8 April 1976).
[108] Terrence Tiffany, "An Organizational Analysis of INPROMI with Recommendations for Family Planning," (October 1976). The American Public Health Association and the USAID supported Tiffany's investigations.
[109] USAID, Office of Health and Population, Peru, "History of Family Planning in Peru," (1997).

equality, population distribution, sexual education, and employment opportunities proceeded more slowly or stalled. In December of 1976, the Peruvian government organized the first official meeting to establish the basis for inter-sectorial cooperation to pursue the objectives set in the Guideline, with funding from the WHO and PAHO. The meeting gathered 62 representatives from the INP, the Ministries of Health, of Housing, and of Education, the Organization of American States, the Catholic Church, the Christian Family Movement, UNICEF, UNFPA, the Midwives Association, the Medical College of Peru, and workers' rights groups. The consensus opinion was that it was important to disseminate the contents of the Guideline through the media, and to develop local authoritative bodies to enact the Guideline's recommendations. However, the commitment of some government officers to honor the Guideline was shallow. Minister of Health, Lieutenant General Jorge Tamayo de la Flor, insisted that no funds or human resources would be devoted to the promotion of birth control outside of the general primary care context, effectively maintaining the old position INPROMI had towards the provision of family planning services. Similarly, Ricardo Morales Basadre, a Jesuit and the President of the Higher Education Council, a dependency of the Ministry of Education, emphasized that the country's educational policy regarding population would be oriented mainly towards the discovery of the structural causes of underdevelopment, with sex education on a lower level.[110]

Finally, in 1977, a new minister of health, Air Force Lieutenant General Humberto Campodónico Hoyos, created the Office of Health and Population within the Ministry of Health. Following through with the recommendations contained in the

[110] Ministerio de Salud e Instituto Nacional de Planificación, Informe Final del Primer Seminario Nacional sobre Política de Población (Lima: INP, 1976).

Guideline, this office was to oversee the implementation of the national population policy while recognizing that "it is every Peruvian couple's right to determine the size of its family, in an informed and free manner", and that family planning must be provided in the context of general health services and not as stand-alone specialized services.[111] Unfortunately, for the remainder of Morales Bermúdez's government, this office was starved of funds. In fact, my research at the Ministry of Health archive indicates that it did not set up objectives nor a national plan to provide family planning services. The INPROMI, which had been, since the scaling back of the CEPD in 1968, the only state agency that provided family planning services, albeit in a very limited way, was shut down in the late 1970s.[112]

The way in which government agencies and individuals proceeded to effect changes in this field was complex. Both the military governments of Velasco and Morales, and the civilian one of Belaúnde, considered that policies to lower fertility rates would be advantageous for the country's development. This was consistent with contemporary analyses of the relationship between population and industrialization. But Velasco's government was different in that he did not see contraception as something that ought to play a role in such policies. While Belaúnde and Morales included medical family planning experts among their population policy makers, Velasco purged his entourage of such experts or limited their influence. There were two reasons for this. First, the promotion of family planning was a low political priority for Velasco, who believed his agrarian reform would spontaneously lead to lower fertility rates. Second, Velasco resented the power the United States had over Peruvian resources. US capital

[111] Resolución Ministerial 0018-77-SA/DS (17 February 1977).
[112] René Cervantes, e-mail to the author (16 December 2008).

controlled Peruvian oil and lands, and Velasco nationalized these properties. US capital also funded birth control organizations, and Velasco eliminated the most prominent among them.

Yet there were important continuities during this period as well. Both the victories and the setbacks of governmental family planning initiatives depended strongly on the President for all three governments. Belaúnde created the CEPD, Velasco the INPROMI, and Morales the Population Policy Guideline commission. The participation of other institutions in this area, such as Congress, the Catholic Church, or civil society organizations, was negligible during the Belaúnde years, nonexistent during the Velasco administration, and slightly more robust under Morales. Bilateral and multilateral aid organizations, such as the WHO, the PAHO, and the USAID, in almost constant communication with the Peruvian executive, were far more influential policymakers than Peruvian citizens were. Another important continuity in the policymaking field throughout the 1960s and 1970s period is the belief in contraception as the right of a couple, and not that of an individual. The concept of "responsible parenthood" also underscores this point: family planning was not only a right, but also the duty of couples who wanted to do right by their children and their communities.

The 1979 Constitution, stated in its sixth article that "the state supports responsible parenthood," yet the civilian governments that led Peru from 1980 did little to implement the Guideline for Population Policy. Under newly elected President Fernando Belaúnde, the Ministry of Health began providing some family planning services in state hospitals. In addition, Belaúnde renamed the CEPD as the National Council on

Population (CONAPO),[113] which drafted the first National Population Law in 1985. The law, however, was not enforced until 1987, when the National Population Program was established during the presidency of Alan García, once again Peru's President.

Given this picture, it is easy to understand the frustration of the originators of the 1976 Population Policy Guideline. In 1980, Wicht lamented that "almost nothing" had been done to address the complex problems identified in the Guideline.[114] Analysts have often asked what went wrong during the execution phase of the country's 1976 population policy. According to historian Marcos Cueto, the fits-and-starts nature of Peru's policy reveals chronic governmental difficulties to build on previous efforts, a process he has referred to as "a vocation to start over again."[115] Medical practitioners affiliated with the Peruvian Academy of Health concur, citing in addition the pusillanimous and balkanized bureaucracies at the ministries of health and education as complicit in the state's neglecting the development of strategies to address gender equality and sex education.[116] Still others criticize the policy formulation process itself, labeling it as elitist, overly centralized, and unable to elicit popular, business, and NGO support.[117]

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[113] Decreto Supremo 049-80-PM (20 November 1980).
[114] Wicht, "La Situación Demográfica del Perú," 93.
[115] Cueto, "La Vocación por Volver a Empezar."
[116] See the proceedings of the Peruvian Academy of Health's 35th Forum on Sexual and Reproductive Health, in Teobaldo Espejo Núñez, "Estado Actual de la Población Peruana," Revista de la Academia Peruana de Salud 13, 1 (2006): 40-64.
[117] Marshall Wolfe, "Between the Idea and the Reality: Notes on Plan Implementation," International Social Development Review 3 (1971): 32-40; Juan Arroyo, "Introducción," in Arroyo (ed.), La Salud Peruana en el Siglo XXI.

There is little question that the government of Peru bears the responsibility for the weak execution of its own population policy.[118] This inadequacy translates into contemporary sex education of dismal quality, scarce health services for pregnant women in rural areas, and a high maternal mortality rate (as of 2007) of 410 per 100,000 live births. In Latin America, only Bolivia and Haiti have higher maternal mortality rates, and both are countries that are otherwise far less economically prosperous than Peru.[119] The one time that the Peruvian government acknowledged the positive role that family planning could have in addressing health inequalities, maternal mortality among them, was during Alberto Fujimori's presidency from 1995 to 2000, now serving sentences for corruption and human rights violations. However, the implementation of the policy was so abusive that the government soon had to contend with hundreds of accusations of forced sterilizations on poor, indigenous women in rural areas, the very women who should have benefited from the policy change.[120]

Some scholars cite poor execution and ineffectiveness when expressing doubts about whether population policies are still necessary in Latin America. In fact, the record of population policies in the reduction of total fertility rates in the region is mixed.

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[118] This weak executive ability continues even today. See for example Anna-Britt Coe, "De Antinatalista a Ultraconservadora: Restringiendo la Opción Reproductiva en el Perú," Reproductive Health Matters 12, 24 (2004): 55-70.
[119] United Nations Population Fund, "Unleashing the Potential of Urban Growth: State of World Population 2007," (accessed 10 December 2007).
[120] Address to Congress by President Alberto Fujimori (28 July 1995); M.J. Arrunaga, "Existen Metas Mensuales de Esterilizaciones," El Comercio (11 February 1998): 1, A9; A. León, "Ligaduras a Cambio de Comida," La República (7 December 1997): 1, 32-33; "The Peruvian Population Control Program," US House of Representatives; Peru's Ombudsman's Office, Directive Report 01-98 (26 January 1998); Calvin Sims, "Using Gifts as Bait, Peru Sterilizes Poor Women," The New York Times (15 February 1998): Section 1, 1; Centro de la Mujer Peruana Flora Tristán, Silencio y Complicidad: Violencia Contra las Mujeres en los Servicios Públicos de Salud en el Perú (Lima: CLADEM, 1998).

Countries such as Cuba, Panama, the Dominican Republic, Mexico, and Colombia, all of which adopted population policies in the 1960s and early 1970s, reduced their total fertility rates between 40 and 60 percent between the mid-1960s and the early 1990s. Yet, El Salvador and Guatemala, whose population policies date from 1974 and 1975, have not achieved such reductions. Meanwhile, countries such as Chile, Uruguay, and Argentina have almost reached replacement fertility rates (two children per woman) without adopting population policies. Still other countries, including Venezuela, Brazil, Costa Rica and Peru, have also reduced their fertility rates by more than 35 percent either without policies or with policies implemented only in the 1980s.[121] From this, it follows that an official policy is neither a necessary nor a sufficient condition for the lowering of fertility rates. In fact, according to former Population Council Director Paul Demeny, population policies in developing countries have just as often led to the buttressing of a vast and profitable family planning industry, made up of consultants of very kind, providing the same solutions for vastly different social and historical contexts.[122]

Yet, as this chapter shows, population policies can create a favorable environment for the expansion of private family planning efforts and donor assistance. This is exactly what happened in Peru, where the Population Policy Guideline led to the birth of several pro-family planning civil society organizations and even to the re-birth of an agency, INPPARES, that had been demonized and destroyed by Velasco's government when it went by its previous name, APPF. A governmental policy made these initiatives legal and no longer treated them as incompatible with other national development objectives. That

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[121] Carlos Aramburú, "Is Population Policy Necessary? Latin America and the Andean Countries," Population and Development Review 20 (1994 Supplement): 159-178.
[122] Demeny, "Social Science and Population Policy."

all these changes took place during a military government enriches and challenges the historiography of pro-natalist militarism.[123]

During this period, national development came to signify better education and health, more employment, increased incomes, and agricultural and industrial productivity, not just for Peru, but for all Latin American countries. The Latin American health officers who met in Caracas (1967), Buenos Aires (1968) and Santiago (1972) were in agreement that lowering birth rates was to be subordinated to these broader goals, even if it could help accomplish such goals. It is important that these countries sought to formulate health policy goals collectively, yet another indication that, despite their diverse peoples and historical paths, there were at least some commonalities in Latin America's political culture. In this context, the Pan-American Health Organization was not only a source of funds and technical expertise, but also a conduit for international legitimacy. PAHO was present at the 1967 Caracas meeting, and it assisted several health ministries, as well as Peru's commission for the Population Policy Guideline. Its position of respect for national sovereignty, rooted in its WHO-derived mandate, led it to clash with the USAID in the early 1970s over the extent to which maternal and infant health services ought to promote family planning. The role of such a transnational foil to the pretensions of the

[123] See for example Paul Weindling, "Fascism and Population in Comparative European Perspective," Population and Development Review 14 (1988 Supplement): 102-121; David Hoffmann, "Mothers in the Motherland: Stalinist Pronatalism in Its Pan-European Context," Journal of Social History 34, 1 (2000): 35-54; David Kideckel, "The Undead: Nicolae Ceaucescu and Paternalist Politics in Romanian Society and Culture," in John Borneman (ed.), Death Of The Father: An Anthropology Of The End In Political Authority (New York: Berghahn, 2004).

United States during this period has gone relatively unnoticed by scholars who focus on the US's success in promoting population limitation in countries such as India.[124]

At the same time, the respect for sovereignty must not blind us to the Peruvian military's record dealing with family planning services. During Velasco's presidency, the government of Peru was steadfast in its refusal to adopt a population policy with a family planning component, out of the animosity it felt towards the nations (mainly the US) that supported family planning policies as means for developing countries to lower their population growth rates. It is ironic that the same year Velasco came to power, Joseph Stycos asserted confidently that all Latin American government leaders "knew" that reducing the national rates of population growth would have "substantial salutary consequences for the economy."[125] Velasco drastically restricted the provision of birth control methods in state institutions while, paradoxically, rolling out the country's first maternal and infant health program. The notion that birth control might help promote women's health, let alone that it might be a right of women, was alien to Velasco.[126] This vision of birth control was based on a long-held understanding of fertility regulation as inconsistent with an individual rights model, a model that prevailed elsewhere in the 1970s, including the United States. This improved only slightly under Morales Bermúdez's presidency. The latter failed to conduct the intra-governmental reforms in

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[124] Mass, Population Target; Hartmann, Reproductive Rights and Wrongs; Connelly, Fatal Misconception.
[125] Stycos, Human Fertility in Latin America, 4.
[126] The notion of sexual and reproductive rights, and of birth control as one of those rights, was only in its infancy in 1970s Peru. It has only become a prevalent aspect of human rights discussions since the 1994 International Conference on Population and Development of Cairo in 1994. On the growing prominence of the discourse of reproductive and sexual rights, see Larkin, "Global Aspects of Health and Health Policy in Third World Countries"; and Eager, Global Population Policy.

favor of improved labor, education, health, and migration legislation that the Guideline for Population Policy demanded. Moreover, although Morales Bermúdez sponsored the Guideline, the most important achievements for the popularization of the idea that reducing population growth could be beneficial for the country occurred outside the governmental sphere, among intellectuals in NGOs and, as we will see in the next chapter, the Catholic Church.

Chapter Six

Priests and Pills: Catholic Family Planning in Peru, 1967-1976[1]

How did the Catholic Church respond to the conundrum of rapid demographic growth in the second half of the twentieth century? This chapter analyzes a program sponsored by the Catholic Church of Peru, which combined the provision of contraceptive pills with health exams, sexual education, and responsible parenthood training for couples in poor urban areas. This program was based on the belief by Church authorities that the Catholic faith was compatible with the regulation of fertility. At the same time, Catholic leaders were reluctant to treat fertility control as a prerogative of individuals (women or men), emphasizing instead its family and community dimensions.

Increasingly since 1930 the interrelated problems of population growth, mass migrations from rural to urban areas, unemployment, single-parent homes, and high maternal and infant mortality, vexed Latin American societies and the Catholic Church in particular.[2] These problems were consistent with the social dislocations predicted by the demographic transition theory, which proposed qualitative and quantitative changes in populations over time, as societies achieved greater levels of per capita income, urbanization, industrialization, and education.[3] Proponents of the demographic transition theory in Latin America suggested that, thanks to Western biomedicine, mortality rates in the region declined rapidly after the Second World War, bringing about population

[1] A shortened version of this chapter appeared in Latin American Research Review 43, 2 (2008): 34-56.
[2] Wicht, "La Política de Población en el Perú."
[3] On the demographic transition theory, see chapter one.

growth, but not yet industrial, urban or educational improvements, nor a mental shift in favor of smaller families or the voluntary use of contraception.[4]

In addition to this, Latin American governments had to cope with the increased interest of advanced industrial nations, the United States in particular, in reducing the size of the population of Latin American countries. This interest became a call for a concerted international effort to curb rapid population growth in less developed countries, a call that became intense in the early 1960s.[5] Financial support for population limitation programs went hand in hand with policies such as John F. Kennedy's 1961 Alliance for Progress, intended to counter the threat of communist agitation emanating most clearly from Cuba. In short, the formula went, high rates of population growth negatively affected the region's economic and social development and thus threatened its political stability, which in turn favored communist inroads and the welfare of the US. Crass as it sounds, fewer children equaled fewer potential malcontents.[6]

As we will see, the Catholic Church did not completely agree with this assessment. Throughout this period the Church's main concern in this respect was the stability of the family. In the twentieth century, several Latin American Catholic authorities and intellectuals went from embracing to questioning the importance of population growth. However, the problems these Catholics emphasized were not the political instability of these countries, nor their inability to augment their wealth. Rather, the problems the Church emphasized had to do with the effects of poverty on the stability

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[4] Guzmán et al, The Fertility Transition in Latin America; Chesnais, The Demographic Transition.
[5] See chapter five.
[6] "Implications of Worldwide Population Growth for US Security and Overseas Interests," National Security Study Memorandum 200.

of families, and with the unfairness inherent in the fact that some countries were wealthy while others were impoverished. It was the promotion of solidarity between nations, and of welfare for families, that galvanized the Peruvian Catholic Church in pursuit of a means to give men and women more control over their fertility.

The family based on a heterosexual marriage is still the model that the Catholic Church upholds as the ideal unit in which children ought to be raised, and in which decisions regarding offspring size ought to be made.[7] This insistence on the heterosexual household as the proper locus for fertility is key. It disqualified non-heterosexual marriage, and the making of individual decisions regarding reproduction without considering one's spouse. In addition, the conflicts between the Catholic Church and Gnosticism in the second and third centuries, which decoupled marriage from procreation, led to a strong Catholic reaction in favor of the procreative function of marriage, a condemnation of abortion, as well as a critique of non-procreative uses of sexuality, including masturbation, coitus interruptus, and the regulation of fertility through periodic abstinence from sex.[8]

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[7] The original model is the New Testament's "Holy Family" made up of Jesus and his parents, Joseph and Mary. Pope Pius XI's encyclical Castii Connubii (30 December 1930), and Pope Paul VI's Humanae Vitae (25 July 1968) reaffirmed the value of this model. The same preference is manifest in the contemporary literature of the lay Catholic organizations that encourage periodic abstinence from sexual intercourse as means to regulate fertility in Peru, such as the Center for Family Promotion and Natural Fertility Regulation (CEPROFARENA, in Spanish). See Luis Giusti and Paulina Giusti, CEPROFARENA: Veinte Años al Servicio de la Familia y de la Vida (Lima: CEPROFARENA, 1996).

[8] Noonan refers to this as the "central theory on procreative purpose" of marriage, a concept developed early on in the history of Catholicism by Augustine, Bishop of Hippo, in the fourth century. Beginning in the sixteenth century, however, the growth of educated urban middle classes, rivaling clerics in intellectual sophistication, led to greater confidence by Catholic theologians in the ability of lay people to make moral judgments. As a result, the former became less inclined to publicly insist on procreation as the

The longstanding importance of heterosexual marriage for the Catholic Church, as a sacrament, a source of companionship, and the context for having and raising children, has put the Catholic Church at odds with scholars writing from a tradition that equates family planning with individual choices. Historian Linda Gordon, for example, called birth control "an individual human right" and the process leading up to its public acceptance a "struggle for self-determination by women", while criticizing the Catholic opposition to birth control methods as stemming from "anti-sexual and anti-woman attitudes."[9] At the heart of this position is the belief that the respect for human rights can only be guaranteed by secular authorities, with religion playing a role that is counterproductive to the satisfaction of rights, including sexual and reproductive ones.[10]

The above argument has long underlay the separation of church and state in Western democracies. Some scholars, such as sociologist Kingsley Davis, have gone as far as to cast Catholicism as an enemy of democracy: "Catholicism attempts to control so many aspects of life, to encourage so much fixity of status and submission to authority, and to remain so independent of secular authority that it invariably clashes with the

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exclusive lawful purpose of married intercourse. As Noonan notes, this may also have been related to the priesthood's unwillingness to alienate well-off Catholic patrons, who favored coitus interruptus, at a time when Protestantism was on the rise in Europe and was already dominant in North America. See John Noonan, Jr., Contraception: A History of Its Treatment by the Catholic Theologians and Canonists (New York: New American Library, 1965: 237, 409, 519); and David, "Abortion in Europe, 1920-91." On the widespread use of coitus interruptus in Europe, see Schneider and Schneider, Festival of the Poor; and Kate Fisher and Simon Szreter, "'They Prefer Withdrawal': The Choice of Birth Control in Britain, 1918-1950," Journal of Interdisciplinary History 34, 2 (2003): 263-291.

[9] Gordon, Woman's Body, Woman's Right, xv, 4, 337).

[10] Jean Franco, "Defrocking the Vatican: Feminism's Secular Project," Sonia Alvarez, Evelina Dagnino and Arturo Escobar (eds.), Cultures of Politics, Politics of Cultures: Revisioning Latin American Social Movements (Boulder: Westview, 1998).

liberalism, individualism, freedom, mobility, and sovereignty of the democratic nation."[11] In the United States, scholars have often interpreted the Catholic Church's position against most birth control methods as an intrusion in the realm of civic life.[12] Epidemiologist Phyllis Piotrow, for example, blamed the "inflexibility of the Catholic Church" for the US government's inability to widely promote the use of birth control methods in the 1960s.[13] Recent findings by historian Leslie Woodcock Tentler indicate that, in fact, the anti-contraceptive culture among priests in the US was strong for many decades before Pope Paul VI issued the 1968 Humanae Vitae encyclical, banning contraception for Catholics.[14]

However, the US model cannot be invoked to explain the history of Catholicism elsewhere. Recent studies indicates that the range of attitudes towards family planning among the Catholic priesthood varied widely between and within places like Ecuador, Mexico, Ireland and Quebec, from overt support for parishioners using birth control methods to banishment from the Church.[15] Likewise, the attitudes of Catholics worldwide

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[11] Kingsley Davis, "Political Ambivalence in Latin America," Journal of Legal and Political Sociology 1 (1943): 127-150, 143.
[12] Peter Donaldson, "American Catholicism and the International Family Planning Movement," Population Studies 42 (1988): 367-373.
[13] Piotrow, World Population Crisis, 90). See also Paula Viterbo, "I Got Rhythm: Gershwin and Birth Control in the 1930s," Endeavour 28, 1 (2004): 30-35.
[14] Leslie Woodcock Tentler, Catholics and Contraception: An American History (Ithaca: Cornell University Press, 2004).
[15] Rice-Wray, "The Provoked Abortion"; Gloria Acero and María Dalle Rive, Medicina Indígena: Cacha-Chimborazo (Quito: Abya-Yala, 1992); Diane Gervais and Danielle Gauvreau, "Women, Priests, and Physicians: Family Limitation in Quebec, 1940-1970," Journal of Interdisciplinary History 34, 2 (2003): 293-314; Leann McCormmick, "'The Scarlet Woman in the Flesh': The Establishment of a Family Planning Service in Northern Ireland, 1950-1974," Social History of Medicine 21. 2 (2008): 345-360.

regarding the control of their fertility has tended to be favorable, particularly among the wealthier and better educated, regardless of Church opposition.[16]

The Catholic Church in Latin America played, particularly during the 1960s and 1970s, a more complex role than US writers have heretofore assumed in debates about the acceptability of contraception. As Stycos, Hall, and Sobrinho have pointed out, during this period the Catholic Church was not as opposed to discussing the problems brought on by rapid population growth as leftist activists and nationalist military officers in the region were.[17] At the same time, the Church tended to agree with these nationalist and leftist leaders' assessment that population growth was neither the gravest problem besetting Latin America, nor one that could be solved simply by increasing the supply of contraceptives.[18] Yet, this is exactly what certain US Catholics believed. Dr. John Rock, co-creator of the contraceptive pill, for example, touted the pill as an ideal solution to curb population growth among the "backward peoples" of the so-called Third World.[19] Instead, Latin American Catholic authorities and intellectuals insisted time and again on the importance of educating parents-to-be as to their duties to their potential children. This "responsible parenthood," a topic to which I will return, included providing children

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[16] Gavin Jones and Dorothy Nortman, "Roman Catholic Fertility and Family Planning: A Comparative Review of the Research Literature," Studies in Family Planning 1, 34 (1968): 1-27.
[17] Stycos, Human Fertility in Latin America, 4); Hall, "Population Growth"; Sobrinho, Estado e Populaçao, 79).
[18] Daphne Patai, "A Nun's Tale: Practicing Liberation Theology," Massachusetts Review 27, 3-4 (1986): 531-556; Kathleen Tobin, "International Birth Control Politics: The Evolution of a Catholic Contraceptive Debate in Latin America," Journal for the Study of Religions and Ideologies 1, 2 (2002): 66-80.
[19] John Rock, The Time Has Come: A Catholic Doctor's Proposals to End the Battle over Birth Control (London: Longmans, 1963: 4). See also Margaret Marsh and Wanda Ronner, The Fertility Doctor: John Rock and the Reproductive Revolution (Johns Hopkins University Press, 2008).

with material goods, an education, and spiritual values. These tasks did not exclude "restricted or limited procreation in view of the total responsibilities of parenthood."[20]

In this chapter, I argue that the promotion of responsible parenthood led to the Peruvian Catholic Church's support for the limitation of fertility by married couples. That this resulted in the ecclesiastic embrace of a technology such as the contraceptive pill is consistent with a pragmatic and historically localized attitude by Peruvian lay Catholics, clerics, and theologians. This chapter will first discuss the emergence of lay Catholic activism in early twentieth century Peru, as the basis for the movement that both supported and challenged the Peruvian Catholic Church's involvement in the provision of contraceptives in the 1960s. The chapter will then discuss the intersection of this movement with the US lay Catholic movement that turned its financial, missionary, and technical attention to the developing world in the late 1950s. Finally, I will analyze the origins and consequences of the Catholic family planning program in Peru.

Catholic Activism in Peru

Peru had been a Catholic country, with substantial manifestations of popular religiosity and devotion, since the colonial period.[21] However, the first widespread lay Catholic movement, with the explicit aim of not only living one's faith but also promoting Catholic beliefs and driving them into the heart of political and social institutions, began only with the Eucharistic Congress of 1935, which gave rise to the

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[20] Fagley, The Population Explosion and Christian Responsibility, 5-6.

[21] Consider for example, the emergence of three major devotionals between the sixteenth and eighteenth centuries: the cult of St. Rose of Lima, Patron Saint of the Americas, of St. Martin of Porras, and that of the *Señor de los Milagros*, whose processions draw tens of thousands of purple-clad faithful through the streets of Lima every October.

Acción Católica Peruana (ACP) the same year.[22] Led by Bishops Mariano Holguín in Arequipa, in southern Peru, and Pedro Pascual Farfán, in Lima, the ACP began publishing journals such as Acción Católica Peruana and Sígueme in the 1930s and 1940s, and establishing sections for women, workers, and youth.[23]

From early on its history, the ACP was deeply concerned with the social conditions that affected the patriarchal family model. The most important of these were the availability of civil divorces and employment for women.[24] The ACP advocated a clear divide between men's and women's realms of action, moral, intellectual, and physical capabilities. Hardliners such as Fr. Manuel Noriega insisted that men were most adept at managing a family's public affairs since they were "willful, logical, unforgiving, strong, courageous, independent, and bold." Conversely, he praised women's skills running a family's private matters because women were, by nature, "pious, intuitive, patient, forgiving, gracious, docile, and resigned to their fate." The equality of men and women was, therefore, nothing but "socialist pap." Still, even someone like Noriega conceded that women who were not able to find husbands to support them (or those who became widows) ought to receive social support in order to participate in the job market.[25] Several members of the ACP had been concerned with the subject of women earning incomes since the early 1930s. To them, it was not a problem with a quick and

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[22] The ACP was the national chapter of the worldwide Catholic Action, a worldwide movement of lay Catholics established by Pope Pious XI in 1922. On Catholic Action, ee Yves M.J. Congar, Lay People in the Church: A Study for a Theology of the Laity (Westminster: Newman, 1962).
[23] Jeffrey Klaiber, "The Catholic Lay Movement in Peru: 1867-1959," The Americas 40, 2 (1983): 149-170; Jeffrey Klaiber, The Catholic Church in Peru, 1821-1985: A Social History (Washington DC: Catholic University Press, 1992: 47).
[24] See, for example, Acción Católica Peruana (24 January 1932, and 10 January 1943).
[25] Manuel Noriega, "Feminidad y Feminismo," Sígueme 9, 45 (September 1944): 6.

easy solution. Reluctantly, ACP members admitted that extending political, economic and civil rights to women might improve their lot enough that they would not feel obliged to abandon their main role as domestic administrators.[26]

It is important to note that the ACP's promotion of civil rights and social safety nets was part of a broader Catholic drive to spread the Catholic Social Doctrine. Social Doctrine documents were different from most other pronouncements of the Catholic Church in their level of public engagement. These documents urged social and political reforms, rather than formal or doctrinal modifications. Tellingly, some of these documents were addressed to "all men of good will", and not just to Catholics.[27] The first among these Social Doctrine documents was Pope Leo XIII's 1891 Rerum Novarum encyclical, which laid out the rights and responsibilities of capital and labor to each other and to the broader community, followed by Pius XI's 1931 Quadragesimo Anno, which condemned corporate greed and the unaccountability of political and economic power.[28]

Shortly before Quadragesimo Anno, Pope Pious XI issued the Castii Connubii encyclical. This was the first Catholic statement concerning the use of contraception by married couples. Castii Connubii condemned abortion and eugenics laws that prevented marriage for those deemed unfit. More important for this discussion, Castii Connubii maintained that, although procreation was the main purpose of sexual relations within marriage, "the cultivating of mutual love and the quieting of concupiscence" were its secondary ends, even if sex sometimes did not lead to procreation, due to "natural reasons

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[26] Acción Católica Peruana (26 November 1933): 191.
[27] George Weigel, "The Church's Social Doctrine in the Twenty-First Century," Logos: A Journal of Catholic Thought and Culture 6, 2 (2003): 15-36, 16.
[28] Archivo de la Conferencia Episcopal Peruana (hereafter "CEP"): Leo XIII, Rerum Novarum (15 May 1891); Pius XI, Quadragesimo Anno (15 May 1931).

either of time or of certain defects."[29] By sanctioning these "natural reasons" and "defects", the Catholic Church for the first time allowed non-procreative sex. Moreover, the encyclical placed great emphasis on the spiritual education of children, and considered it irresponsible for parents to have more children than they could care for and educate.[30] Castii Connubii also partook of the spirit of the Catholic Social Doctrine. If families were too poor to care for their children, it argued, governments should intervene on their behalf: "Those who have the care of the State and of the public good cannot neglect the needs of married people and their families, without bringing great harm upon the State and on the common welfare. Hence, in making the laws and in disposing of public funds they must do their utmost to relieve the needs of the poor, considering such a task as one of the most important of their administrative duties."[31]

Indeed, this was the kind of policy that ACP members favored. Irene Silva de Santolalla was representative of the drive to uphold the Catholic Social Doctrine while preserving Peruvian women's domestic role. A self-taught politician and mother of four, Silva had been a member of the ACP since the 1930s, as well as Vice-President of the eugenicist National League of Hygiene and Social Prophylaxis. In 1938, with the support of Cardinal Juan Gualberto Guevara, she began to promote the idea of a marriage and family education institution, through a radio program and newspaper articles printed in Peru and Argentina. When women acquired the right to vote and be elected to public office in 1956, Silva was the first woman to be elected to the Peruvian Senate. In March

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[29] CEP: Pius XI, Castii Connubii, point 59. These "natural reasons" and "defects" could include infertility, the post-menopausal period and the infertile portion of a woman's menstrual cycle.
[30] CEP: Pius XI, Castii Connubii, points 10, 13, 16, 17, 24, 37, 80, 85, 89, and 90.
[31] CEP: Pius XI, Castii Connubii, point 121.

of 1957, she successfully introduced the Family Education Hour bill in Congress, which made family education mandatory in high schools.[32]

As Silva put it, the goal of the family education hour was to fight "the pernicious influence of modern societies, based on the worship of money, unprincipled social climbing, power without mercy, and disorderliness."[33] Although family education was to be taught in schools, to young girls in particular, its practical locus was the home life, where women were to reclaim the right and duty to steer the moral education of their children. Like other ACP members, Silva did not believe in the moral or intellectual equality of men and women. However, she supported women's rights to seek employment when they could find enough economic support from their husbands or the state. She also supported the extension of social services that would allow women to dedicate more time to their so-called natural duty of raising children, including maternity leaves, improved housing, and higher salaries for working class men.[34]

While the ACP's activism stressed the importance of women's authority in the home, it failed to address the matter of fertility control. In fact, the Peruvian Catholic Church's first formal pronouncement in this regard emerged many years after Castii Connubi, in 1947. At that time, Cardinal Juan Gualberto Guevara named and condemned the "enemies of the Christian home": divorce, "Malthusianism" (the use of

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[32] Silva, Intentando la Solución de ¡El Gran Problema! See also ACP: Ley 12818: "Creando la 'Hora de Educación Familiar' en los Centros Docentes que se Indican," (15 March 1957).
[33] Silva, Intentando la Solución de ¡El Gran Problema!, 15. The word "disorderliness" is my translation of "organización sin jerarquías", which connotes a blurring of boundaries between the social roles of men and women.
[34] Silva, Intentando la Solución de ¡El Gran Problema!, 33.

contraceptives), abortion, and the sterilization of the feeble-minded.[35] Even after that, the Peruvian Catholic Church tempered its objections to contraception following Pope Pious XII's support for the rhythm method of birth control in 1951.[36]

The Peruvian lay Catholic movement publicly embraced Pious XII's position only in December of 1954, during the Fifth National Eucharistic and Marian Congress, a meeting of lay and ordained Catholics. The Congress had attracted a group of Catholic physicians, who organized a satellite conference. During this meeting, Dr. Froilán Villamón upheld the value of the rhythm method, and reviled the use of contraceptives, in the form of chemical or surgical sterilization, coitus interruptus, spermicidal substances, and barrier methods. He also vilified abortions when not performed by a physician to save a woman's life, as well as the existence of birth control organizations. Still, Villamón recognized that often people did not wish to have children because they could not support them financially. Because of that, he reasoned, and in line with the Catholic Social Doctrine, reducing contraceptive use would only be accomplished through policies to improve wages and the quality of life of the poor, and through the guidance of the physician, who "must maintain, not infrequently, the value and inviolability of human life with intelligence, the heart, and facts."[37]

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[35] Juan Gualberto Guevara, "La Constitución Cristiana de la Familia: Resumen de una Carta Pastoral," Gaceta Eclesiástica (Arzobispado de Arequipa) 1, 2 (March-April 1947): 30-31, 31. See also "¿Demasiados Niños?" Caretas 260, 13 (1 February 1963): 11-14.
[36] Pious XII's position in favor of the rhythm method for married couples became clear following an address to the Italian Catholic Union of Midwives on the 29th of October, 1951. See Jones and Nortman, "Roman Catholic Fertility and Family Planning."
[37] Froilán Villamón Haltenhof, "El Derecho de Nacer y la Conservación de la Especie," Revista Peruana de Obstetricia 3, 1 (1955): 7-26, 7.

By the 1950s, transnational actors and their local allies were already sowing the seeds of what would become population reduction campaigns in developing nations.[38] Catholics the world over were concerned about the allegedly excessive freedom that new contraceptive technologies placed in the hands of individuals, as well as with the contraceptives' side effects. More distinctly for Latin America, Catholic leaders worried about the possibility that governments, under financial pressure from foreign agencies, would use their power to indiscriminately push birth control on people who had little opportunity to reflect on what it would mean for their lives, i.e., mostly the poor.[39]

In response to these concerns, Pope John XXIII set up a Pontifical Commission on Population, Family and Birth in 1963, as Vatican Council II was in session, to advise the Pope about the effects of contraception on the lives of Catholics.[40] Vatican Council II, a meeting of Bishops from around the world, was in session from 1962 to 1965. The topic that occupied this reunion was the manner in which the Church ought to engage with Catholics' changing expectations, particularly those arising from the maintenance and deepening of social injustices. It was the defining moment of John XXIII's papacy, one that, in accordance with the Social Doctrine tradition, had been and would continue to be critical of the widening socioeconomic gaps between rich and poor nations, nuclear proliferation, and the violation of human rights.[41]

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[38] See chapters four and five.
[39] Felipe McGregor, "Posición de la Iglesia sobre la Regulación de los Nacimientos." Tribuna Médica 2, 92 (June 1966): 1-15.
[40] On the Vatican Council II, see Melissa Wilde, Vatican II: A Sociological Analysis of Religious Change (Princeton: Princeton University Press, 2007).
[41] CEP: John XXIII, Mater et Magistra (15 May 1961); John XXIII, Pacem in Terris (11 April 1963); John XXIII, Gaudium et Spes (7 December 1965).

The Pontifical Commission on Population, Family and Birth's original membership was limited to social scientists and theologians; but in 1965, after John XXIII passed away, new Pope Paul VI saw it fit to include physicians and Catholic couples in the commission as well. The new members included Patrick and Patricia Crowley of Chicago, the presiding couple of the US Christian Family Movement (CFM). By the early 1960s, the CFM was the world's largest organization of Catholic married couples, hence the relevance of the Crowleys' participation. Contrary to the Vatican's demand for secrecy, the Crowleys actively sought out the opinions of fellow CFM members regarding the use of periodic abstinence methods of birth control, and shared the results of their inquiries with the commission. For several members of this group, that survey was their first chance to hear how difficult Catholic couples found the practice of periodic abstinence, and how much these couples yearned for alternatives.[42]

Despite some indications that the Pontifical Commission might endorse the use of contraceptives, Paul VI's July 1968 encyclical De Humanae Vitae restated the injunction against birth control methods, while demanding that couples have only those children they could raise lovingly and provide for.[43] To understand the reception of the encyclical in Peru, we must refer to the politically engaged Catholic laity in the country. The fulfillment of the Catholic Social Doctrine was of great import to the Peruvian Catholic Church following the Second World War.[44] Irene Silva de Santaolalla's work in Congress was one of its more conservative manifestations. The disapproval of the excesses of

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[42] Marks, Sexual Chemistry; Robert Blair Kaiser, The Encyclical that Never Was: The Story of the Commission on Population, Family and Birth, 1964-1966 (London: Sheed and Ward, 1987).
[43] CEP: Paul VI, Humanae Vitae (25 July 1968).
[44] Jeffrey Klaiber, "Prophets and Populists: Liberation Theology, 1968-1988," The Americas 46, 1 (July 1989): 1-15; Klaiber, "The Catholic Lay Movement in Peru."

capitalism in the form of a preferential option for the poor, a critique most poignantly articulated by Pedro Arrupe, the General of the Jesuit Order, was another, more radical, manifestation. This was at the heart of the critique elaborated by liberation theologians, who adopted some tenets of dependency theory to affirm that poverty in Latin America was tied to capitalist expansion, which rendered the so-called peripheral nations chronically underdeveloped as wealthier capitalist countries drained resources and surplus capital away from them and towards the capitalist centers.[45]

In March of 1968, a group of Peruvian priests issued a declaration denouncing the chronic conditions of injustice that "tormented the country." In particular, the priests criticized the unequal system of land tenure, the poor quality of education, the lack of regard for workers' rights, and "the large imperialist consortia" that controlled Peru's natural resources "under conditions that harm the nation's interests and dignity."[46] The declaration is significant because it was supported by the Cardinal himself, Juan Landázuri Ricketts, and by priests who later became involved in the Church's family

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[45] On liberation theology, see Gustavo Gutierrez, Teología de la Liberación: Perspectivas (Lima: CEP, 1971); Michael Dodson, "Liberation Theology and Christian Radicalism in Contemporary Latin America," Journal of Latin American Studies 11, 1 (1979): 203-222; Mary Charles Murray, "The Development of Liberation Theology," Renaissance and Modern Studies 36 (1993): 108-121; Enrique Dussel, "A Note on Liberation Theology" in Leslie Bethell (ed.), Ideas and Ideologies in Twentieth Century Latin America (Cambridge: Cambridge University Press, 1996); Philip Berryman, "Church and Revolution: Reflections on Liberation Theology," NACLA 30, 5 (March-April 1997): 10-15. For a critical take on the contributions of liberation theology to contemporary Catholicism, see Carol Drogus, "The Rise and Decline of Liberation Theology: Churches, Faith and Political Change in Latin America," Comparative Politics 27, 4 (1995): 465-477. On dependency theory, see Peter Klaren and Thomas Bossert (eds.), The Promise of Development: Theories of Change in Latin America (Boulder: Westview, 1986). For a critical take on Dependency Theory, see Robert Packenham, The Dependency Movement: Scholarship and Politics in Development Studies (Cambridge: Harvard University Press, 1992).

[46] "Declaración de Sacerdotes Peruanos," Oiga 265, 6 (22 March 1968): 17, 33-34: 17.

planning program, the Jesuits Enrique Bartra and Luis Bambarén, then Auxiliary Archbishop of Lima.[47]

A month earlier, the Peruvian Bishops Conference had acknowledged that rapid demographic growth was a social problem. Moreover, the bishops shared "the anguish of numerous families whose homes and conjugal lives are seriously troubled" by having too many children. Nevertheless, they also indicated that birth control programs alone should not take the place of development initiatives. In fact, the bishops claimed that demographic growth could become beneficial for the country, if accompanied by a rational exploitation of its natural resources and educational improvements. In addition, the bishops reviled the potential for foreign aid to become contingent on the implementation of population limitation campaigns, and rejected any attempt to limit population growth if it affected the ability of parents to make free decisions about the size of their families.[48] The Jesuit Enrique Bartra had criticized population reduction initiatives in Peru in 1965 and instead argued for the "intensification of institutional, social and mental changes in the Peruvian population" to make better use of the nation's natural resources.[49]

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[47] Harold Griffiths, "Ya en el Perú se Respira el Clima Posconciliar," Oiga 266, 6 (29 March 1968): 12-13.
[48] CEP: "Declaración del Episcopado Peruano sobre el Crecimiento Demográfico," (Lima, 27 January 1968).
[49] Enrique Bartra, "Forum sobre Control de la Natalidad," Revista de la Facultad de Farmacia y Bioquímica 27, 98 (1965): 182-183. It was declarations like this that buttressed McQuillan's argument regarding the similarities between Catholic and Marxist thought in relation to population growth. To both, population growth was an epiphenomenon caused by fundamental problems of inequality and insufficient planning that capitalism could not solve. See Kevin McQuillan, "Common Themes in Catholic and Marxist Thought on Population and Development," Population and Development Review 5, 4 (1979): 689-698.

How did this politically charged Catholic Peruvian environment react to Humanae Vitae? Not surprisingly, as von Geusau has documented, Western economists and demographers, as well as the mostly US-based population limitation establishment, criticized Paul VI's encyclical. A few Peruvian medical professionals and newspapers voiced their disagreement. The August 7th, 1968 editorial of Acción in Lima accused the Pope of wanting "a society composed of poor families, horrified by the fear of a new conception, a world of misery and under-nourishment." A psychiatrist warned that "limit[ing] sex relations to infertile periods would have psychotic effects." Interestingly, "groups of Chilean, Brazilian, and Peruvian theologians" made pronouncements indicating that "the Encyclical could be fallible as a matter of fact, and that the personal conscience of the married couple was the final authority on the subject."[50] For the most part, however, Peruvian priests and theologians remained silent, at least at first.

The Second General Conference of Latin American Bishops took place in Medellín, Colombia, in September of 1968. Paul VI addressed the bishops at the opening of the conference and defended what had become his most divisive encyclical. Humanae Vitae, he held, did not endorse a "blind race towards overpopulation" nor diminished the responsibilities of couples towards their children. In addition, Paul VI said that the encyclical did not forbid "an honest and reasonable limitation of births, nor legitimate medical therapies, or the progress of scientific research."[51] In the end, the Latin American bishops endorsed Humanae Vitae and, in line with the social doctrinal developments accumulating since the late nineteenth century, the conclusions of Vatican Council II, and

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[50] See pages 10 and 11 in Leo Alting von Geusau, "International Reaction to the Encyclical Humana Vitae," Studies in Family Planning 1, 50 (1970): 8-12.
[51] CEP: Segunda Conferencia General del Episcopado Latinoamericano (Medellín: Paulinas, September 1968: 17).

the Liberation Theology critique, they added a series of reflections. First, the bishops acknowledged the shift from rural to urban societies in Latin America, along with changes in family structure away from patriarchal families towards families with greater emotional intimacy and a more even distribution of responsibilities. Second, the bishops denounced that the process of development had led to material abundance for a few families, greater insecurity for others, and economic marginality for the rest. Third, even though population growth was not the only important demographic variable to consider, the bishops indicated that population growth in Latin America exacerbated economic, social and ethical problems, such as low marriage rates, single-parent families, out-of-wedlock births, and housing shortages.[52]

Faced with this situation, the Medellín bishops expressed their solidarity with families burdened with too many children, while calling for educational reforms to instill a sense of responsible parenthood among the young and more compassion towards struggling families. The situation of poverty and neglect in which many Latin American families lived, the bishops suggested, constituted an act of violence that was inherently unjust and sinful. According to the bishops, the injustices to correct in Latin America had a transnational dimension, related to the terms of foreign trade that made raw materials cheaper than manufactured products. Because of that, the producers of raw materials, such as most Latin American countries, remained subordinated to industrialized nations that produced more manufactured items. At the same time, the bishops accused, foreign

[52] See the chapter on "Familia" in CEP: Segunda Conferencia General del Episcopado Latinoamericano.

companies operating in Latin American countries often used subterfuges to evade taxes and send most of their dividends abroad, without reinvesting them in the region.[53]

Thus, by the late 1960s the Peruvian Catholic Church affirmed that population growth caused unjust suffering for many families. Yet the Church also posed two challenges. To demographic transition theorists, who believed in the power of industrialization to overcome, eventually, the social dislocations it caused, the Church responded by endorsing the critique of dependency theory: industrialization exacerbated social inequalities, instead of reducing them. To advocates of population control campaigns, the Church warned that such campaigns risked trampling the right of couples to make free decisions about their fertility.

These views were remarkably consistent with those of the political elite that seized power in 1968. As previously discussed, General Juan Velasco Alvarado mistrusted the United States. In 1973, he shut down the *Asociación Peruana de Protección Familiar*, then Perú's largest network of family planning clinics, because of its reliance on funds from the Planned Parenthood Federation of America. In addition, at the 1974 United Nations International Conference on Population in Bucharest, the Peruvian delegation sided with the coalition of Third World countries that rejected the US-supported Population Draft Plan of Action. The position of these countries was that the root causes of underdevelopment would be better tackled not through population reduction policies but through radical initiatives to even the terms of foreign trade that were currently stacked in favor of industrialized nations. Lower fertility rates, Velasco insisted, could be accomplished gradually through increased funding for education and

[53] CEP: Segunda Conferencia General del Episcopado Latinoamericano, 41-47.

the rationalization of urban development. Velasco's assertion of national sovereignty over natural resources, and his insistence on lowering fertility through planning and education indicate a significant degree of convergence between the military reformers and the Peruvian Catholic Church. But how could this convergence translate into action on the part of the Church?

Dr. Kerrins and His Mission to Peru

Dr. Joseph Kerrins was greatly responsible for the early stage of the Peruvian Catholic Church's family planning program. Born in 1928, Kerrins had been a New England Catholic almost his whole life. He attended Providence College, run by the Dominican order, and, after serving in the US Coast Guard, enrolled at Tufts University Medical School, graduating in 1954. By the early 1960s, Kerrins and his wife, Helen, were active in organizations such as the Christian Family Movement and the Anti-Defamation League. In addition, Kerrins started the Family Life Clinic and Marriage Institute to teach the rhythm method to Catholic couples in Attleboro, Massachusetts, where he was the chief of obstetrics and gynecology at the Sturdy Memorial Hospital.[54]

Aware that missionary work would mean giving up his lucrative private practice, Kerrins increasingly saw such activism as an extension of his volunteer work in New England. In 1966 he contacted the Association for International Development, a Catholic charity based in Patterson, New Jersey. Since its foundation in the early 1960s, AID-Patterson had specialized in supporting Catholic professionals seeking to do volunteer

[54] Papers of Dr. Joseph Kerrins (hereafter "KP"): "Their Choice: 'Ring of Misery,'" The Attleboro Sun (14 January 1967: 6); interview with Joseph Kerrins, St. Petersburg, Florida (3 March 2005).

work in the developing world. In this respect, AID-Patterson had four main functions: (1) it ran training sessions so volunteers could learn about the challenges of living and working abroad; (2) it helped raise funds to provide for the living expenses of the volunteers; (3) it provided the volunteers with a network of local supporters who could assist them as they settled; and (4) it coordinated with the Catholic authorities in the communities where the volunteers would work. India, African and Latin American countries were some of the destinations of AID-Patterson volunteers.[55] The profile of the AID-Patterson volunteer was that of a man between 21 and 45 years of age, ready to work anywhere in the world "for the fulfillment of God's Design in human society." Candidates' traits included professional competence, spiritual formation, and an ability to train others.[56]

US Catholics had begun to organize volunteer corps for service overseas after Pope John XXIII's 1961 request for lay volunteers to assist local Catholic churches in poor countries. To the US volunteers, this was not only a chance to assuage an acute priest shortage, but also an opportunity "to help combat the Communist menace" through good works that would earn them new allies.[57] Their zeal was awesome, and their paternalistic attitude intense. As George Wolf, of the National Catholic Welfare Council put it,

> "You ask how might these young Americans be received? I might say, who cares, when we look at it in the light of whether St. Francis Xavier was wanted in Japan

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[55] Larry Dodge, Becoming Global Citizens (Cumberland, WI: Forum Publications, 2003).
[56] American Catholic Research Center and University Archives, Catholic University of America, Records of the National Catholic Welfare Council (hereafter "NCWC": Series 4, sub-series 4.2, box 186, folder 4: "AID brochure (November 1963)."
[57] NCWC: Series 5, sub-series 5.2, box 194, folder 30: "Len Peterson, 'Papal Volunteers for Latin America,' IFNAID 3, 1 (May-June 1961)."

> […] The important thing is that Christ wants us in these places. […] Americans cannot show their love of these people through our local State Department people, through our dollars, through our films on horror, sex, etc. We can only do it in the real form that a parent has for his child – through personal contact, suffering, joys and the like."[58]

Part of the reason for the convergence between anti-communism and the activism of US Catholics lay in the Cold War. Pope John XXIII's call for volunteers coincided with John F. Kennedy's creation of the Alliance for Progress in 1961. Not only did the Alliance for Progress exclude Socialist Cuba: it also called for US Catholic volunteer agencies to play a role in the delivery of Alliance for Progress aid to Latin America. The National Catholic Welfare Conference became one of the largest voluntary overseas relief agencies in the US when Kennedy advised that the US International Cooperation Administration and its foreign aid missions use the services of voluntary agencies to carry out the American foreign aid program.[59] Thus, for US volunteers, the Pope's demand to assist local Churches was in line with their nation's demand to steer the poor away from communism. As Gerald Mische, co-founder and assistant director of AID-Patterson, put it, "Christianity must come up with a positive solution to the socio-economic problems of the people in Latin America or the Church will be left out of the picture."[60]

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[58] NCWC: Series 5, sub-series 5.2, box 194, folder 30: "George Wolf, 'The Peace Corps,' IFNAID 3, 1 (May-June 1961)."
[59] NCWC: Series 5, sub-series 5.2, box 194, folder 30: "NCWC News Service, 'Relief Expert Notes Call for Cooperation between Private Groups and Government in Foreign Aid Law,' (9 November 1961)."
[60] NCWC: Series 5, sub-series 5.2, box 194, folder 30: "NCWC News Service (Domestic), 'Laymen Must Work to Promote Solutions to Latin Social Ills,' (27 November 1961)."

Although local Catholic authorities had a say in determining how to use the talents of the AID-Patterson volunteers, soon, the highly skilled, motivated, and zealous US volunteers began to bristle under the control of the Latin American Catholic authorities. The former did not wish to be "just another local priest helper operation."[61] As a result, AID-Patterson increasingly encouraged the volunteers to find projects that best suited their dispositions and skills before committing to volunteer work. To help them with this, AID-Patterson began to sponsor a summer training program at Seton Hall University, known as the Summer Institute for International Service, in 1962.[62] Here, potential volunteers learned about non-Western cultures, languages and societies, from personalities such as anthropologist Margaret Mead and William Doherty (of the American Institute for Free Labor Development).[63] In fact, when Dr. Joseph Kerrins and his family moved to Lima, they received help from Sal Piazza, an AID-Patterson volunteer who was working for the American Institute for Free Labor Development, the international arm of the AFL-CIO, which promoted the formation of non-socialist trade unions.[64]

AID-Patterson put Kerrins in contact with Father John Coss, a Catholic priest in the order of the Sons of Mary. The Sons of Mary first went to Peru in April of 1961, also in part responding to the need "to combat the Communism that was rampant at that

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[61] NCWC: Series 4, sub-series 4.2, box 186, folder 3: Gerald Mische (AID) to Rev. John Considine, MM, Latin American Bureau, NCWC (11 March 1962).
[62] ACWC: Series 4, sub-series 4.2, box 186, folder 3: James Lamb, AID Director, to Rev. John Considine, MM, Latin American Bureau, NCWC (14 March 1962). See also interview with James Dette, former AID-Patterson volunteer (Montreal, 30 May 2006).
[63] ACWC. Series 4, sub-series 4.2, box 186, folder 4: James Lamb, AID Director, to AID membership, (August 1963).
[64] Interview with Sal Piazza, former AID-Patterson volunteer (Montreal, 17 June 2006).

time."[65] Peruvian Cardinal Juan Landázuri asked the Sons of Mary to take over the parish of Santa Magdalena Sofía Barat in the Lima neighborhood of El Agustino. Coss was named parish priest in October 1965, and found himself back in the US and meeting Kerrins in the summer of 1966.

During a preliminary trip to Peru later that year, Kerrins met Brother Francisco Tanega, another Sons of Mary priest and a medical doctor. Tanega ran clinics in several poor neighborhoods in Lima between 1961 and 1969. Speaking of the female patients in those clinics, Kerrins recalled that "there seemed to be no doubt in their minds they wanted me to help them to stop having so many babies."[66] Br. Tanega, Fr. Coss, Fr. Roger Reedy (another Son of Mary) and Joseph Kerrins then designed a program that would permit birth limitation within acceptable Catholic teachings. The contraceptive pill, effective, non-invasive and, in 1967, deemed likely by the Pope's Pontifical Commission on Population, Family and Birth to become a part of the Catholic family planning toolbox, seemed like a good choice at the time.[67]

The contraceptive pill did not form a barrier between the sperm and ovum, as other birth control methods did (including condoms, spermicidal jellies and foams, cervical caps, and diaphragms). Rather, the hormones in the pill interrupted the maturation of ova in the ovaries. This was not the only remarkable chemical feature of the pill. Some Catholic physicians used oral contraceptives to make ovulation cycles more predictable among women who wanted to use the rhythm method. These physicians

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[65] Letter from Fr. John Coss to the author (29 November 2006). See also Susan Fitzpatrick Behrens, Of Divine Import: The Maryknoll Missionaries in Peru, 1943-2000 (Ph.D. dissertation, University of California, San Diego, 2001).
[66] KP: "Letter from Joseph Kerrins to Cardinal Juan Landázuri," (Lima, 28 December 1967).
[67] E-mail from Br. Francisco Tanega to the author (17 April 1006).

believed that a woman's spontaneous infertile period was similar to the pill-induced infertile period, because both were caused by hormonal fluctuations. The only clinical and moral difference was, in their view, the longer duration and higher predictability of the pill-induced infertile period.[68] Kerrins himself had used G.D. Searle's Ovulen since 1964 in his own private practice for this very purpose.[69]

More importantly, in line with the long-standing Catholic concern for family integrity, Kerrins and the Sons of Mary believed that the ultimate goal of the program should be to improve marriages and make better Catholic families, and they did not think contraception alone could accomplish that. Therefore, they devised an educational component for the program. As members of the Christian Family Movement in Massachusetts, Joseph and Helen Kerrins had conducted seminars to coach married couples towards the improvement of conjugal love, sexuality, communication, and their relationship to their children. The seminars consisted of eleven sessions on these different subjects, and the Kerrinses suggested using their seminar curriculum as the blueprint for the educational program.[70]

Fr. Coss and Br. Tanega submitted a proposal to Cardinal Juan Landázuri, outlining the clinical and educational components of the program and emphasizing that the pills (conspicuously referred to as "anovulatories" instead of "contraceptives") would be provided for a period of 18 to 24 months at the most. This period was based on the observations Br. Tanega had made about how long poor urban women breastfed their

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[68] Rock, The Time Has Come; WHO, "Clinical Aspects of Oral Gestogens."
[69] KP: Joseph Kerrins to Cardinal Juan Landázuri (Lima, 28 December 1967).
[70] KP: Joseph Kerrins and Helen Kerrins, "Responsible Parenthood Program in the Barriadas of Lima," Report to the Association for International Development, April-December 1967.

infants, and on the belief that breastfeeding women should be fully dedicated to nurturing an infant. The corollary of that belief was that it was morally legitimate to prevent a new conception during the lactation period. Cardinal Landázuri gave his permission for this program to operate in El Agustino, although he labeled the program as experimental at first.[71]

The months leading to the departure of the Kerrinses generated a significant amount of planning headaches for Joe and Helen Kerrins. At the same time, their willingness to help the poor and to sacrifice the comforts of suburban life made them newsworthy. The Attleboro Sun designated reporters to cover life in Peru for the Kerrinses and their ten children.[72] In September of 1966 Joe and Helen took an exploratory trip to Peru and firmed up their commitment to spend eighteen months working among impoverished "*barriada*" dwellers in Lima.[73]

Migration from rural to urban areas had accelerated in Peru since the 1930s. New arrivals in Lima, however, often had to contend with housing costs that were out of their reach, when housing was available at all. Even for city residents, housing conditions deteriorated for almost everyone but the wealthy, and poor tenants rarely succeeded in making owners and authorities act on the rising problems of uncollected garbage, delinquency, and malfunctioning municipal services such as water, sewage and electricity. The decision of where to settle, for new arrivals, and of where to re-settle, for fed-up urban dwellers, was not easy. A substantial amount of strategizing and leadership

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[71] E-mail from Br. Francisco Tanega to the author (17 April 2006).
[72] KP: Yolande Murphy, "Humanitarian Obligation in Peru," The Attleboro Sun (8 September 1967: 3); and Yolande Murphy, "What he Witnessed is Beyond Imagination," The Attleboro Sun (9 March 1968, 3).
[73] KP: William J. McIntire, M.M., "Responsible Parenthood in Lima," America 118 (October 1968): 380-382.

was required to locate vacant space, negotiate with the owners before or after settlers had taken over the space, and then try to organize communities to lobby for the extension of city services to newly colonized spaces.[74] The aspect of these communities in formation in the 1960s, known then and now as "*barriadas*" or "*pueblos jóvenes*", was for outsiders one of rampant chaos made worse by poverty. El Agustino was one such *pueblo joven*.[75]

Joe Kerrins's range of reactions to life in El Agustino varied widely, from annoyance at the "horde of dirty, lean kids in rags" who followed him when he worked, to optimism following his first successes: "I'm swamped. The poor in the *barriada* of Agustino seem to be very anxious to do something to try to limit the size of their families."[76] Most notable among Kerrins's reactions was his critique of wealth inequalities within Peru and between Peru and the US:

> "If your neighbor has an abundance of bread and you have none, you have a right to some of his. […] Everywhere we look we see dogs, walls and barred windows to prevent the poor from taking any of the possessions of the rich. One wonders what the poor, not just in Peru but in the world, will do when they finally find out how much we have in the States. Will we be able to build high enough walls and strong enough bars for our windows and train enough ferocious dogs?"[77]

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[74] Abelardo Sanchez, Raúl Guerrero, Julio Calderón and Luis Olivera, Tugurización en Lima Metropolitana (Lima: DESCO, 1979); Peter Lloyd, The "Young Towns" of Lima: Aspects of Urbanization in Peru (Cambridge: Cambridge University Press, 1980); Henry Dietz, Poverty and Problem-Solving under Military Rule: The Urban Poor in Lima, Peru (Austin: University of Texas Press, 1980); Golte and Adams, Los Caballos de Troya de los Invasores.
[75] Roy, "Aspectos Saltantes del Estudio de Fecundidad en El Agustino."
[76] KP: Joseph Kerrins letter to Gene and Joanne (9 June 1967); and Joseph Kerrins letter (16 April 1967).
[77] KP: Joseph Kerrins letter (18 February 1967).

Signing off his letters to friends in the US as "yours in a prayer of action"[78], Kerrins rolled up his sleeves and got to work. The Rules Committee of the Peruvian Faculty of Medicine gave him a broadly worded temporary permit to assist in "sanitary work, health posts, nutrition clinics and other problems that directly affect the inhabitants of the *barriada* of El Agustino."[79] Likewise, Kerrins bore a letter of support and introduction from the Bishop of Fall River, Massachusetts.[80] Significantly, though, Kerrins did not have the support of the US government, even though the latter was already funding the Peruvian government's fledgling family planning clinics.[81] Instead, Jonathan Fine, the Human Resource Development Officer of the US Agency for International Development in Peru, told Kerrins that "[a]lthough it may be too late for you to reconsider your plans for coming to Peru," he still hoped Kerrins would "realize how politically sensitive family planning programs were, and how dangerous it was for American citizens to become openly identified with such work." Fine urged Kerrins to keep in close contact, as the Peruvian press routinely "misinterpreted the motives of those working in this field and raised the false specter of 'Yankee Imperialism.'"[82]

The clinical part of the program was set up first because Kerrins believed it unlikely that couples would attend the marriage workshops without the incentive of providing birth control. The Peruvian *Centro de Estudios de Población y Desarrollo* (CEPD) supplied Kerrins with Ovulen-21, a contraceptive pill, at no cost, to be sold at

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[78] KP: Joseph Kerrins to Gene and Joanne (9 June 1967).
[79] KP: Dean J. Campos Rey de Castro, Facultad de Medicina de la Universidad Nacional Mayor de San Marcos, to Joseph Kerrins (Lima, 2 December 1966).
[80] KP: Letter from James Connolly, Bishop of Fall River, to Joseph Kerrins (6 January 1967).
[81] See chapter five.
[82] KP: Jonathan Fine, M.D., Human Resources Development Officer, US Agency for International Development, to Joseph Kerrins (Lima, 25 January 1967).

very low cost to the women who enrolled in the program.[83] The reasoning was that free contraceptives would give users the impression that the technology was worthless when, in actuality, it was a means to attract people to the educational program. The first workers in the clinic of El Agustino, which officially opened in April of 1967, were all volunteers: Kerrins, a nurse, and a social worker who Kerrins met through contacts with the Sons of Mary and AID-Patterson.[84]

On any given day, Kerrins would drive to pick up his assistants and then head for the clinic. He set up his equipment in the parish's function room, using a private area as the exam room and a desk to welcome patients. The clinic provided a range of gynecology services, including screenings for cervical cancer and tuberculosis, in addition to the pill. The social worker would note each woman's name, address, number of pregnancies, children living and dead, age, and reason for coming. Then Kerrins would take her medical history and give her a physical exam. If she wanted to be on the pill, the physician showed her how to take it and discussed possible side effects. The social worker would repeat the instructions before giving her the first month's supply. If breastfeeding, the social worker would also give the user a supplement of minerals and vitamins. Then the user made an appointment for the following week, in case any problems arose. Finally, the social worker gave the user a consent form that the user's husband was obligated to sign, and that the user was expected to bring to her next appointment. Kerrins estimated that the early team of volunteers saw an average of forty

[83] Ironically, the pills had been donated by the USAID to the CEPD. Thus, the USAID indirectly supported Kerrins's project after all.
[84] Interview with Joseph Kerrins (St. Petersburg, Florida, 3 March 2005).

women seeking the pill every day. The work took about five hours, including travel time.[85]

Soon, priests from other parishes began to approach Kerrins and the Sons of Mary to ask that similar clinics be established in their parishes. By June 1967 there were four more clinics in *pueblos jóvenes*: one in Dos de Mayo, another in El Montón, and two in Comas. The early adopters were parishes managed by foreign priests, in particular those belonging to the Oblate, Columban and St. James missionary orders.[86] The workload became too burdensome for a group of volunteers, and Kerrins applied for and received a grant of US$ 5,000 from the CEPD to hire two social workers and a nurse to assist him. Kerrins himself did not benefit from this grant. AID-Patterson paid him a living allowance during his time in Peru. By August, some of the clinics were so popular they had to be open twice a week, and Kerrins received a US$ 6,000 grant from the Pathfinder Fund.[87]

By 1965 the pill had become a very profitable drug in the US, pleasing its creator, G.D. Searle.[88] Not surprisingly, other pharmaceutical companies attempted to bring to market a contraceptive pill of their own. Warner-Lambert was one of them, and it had one product in need of human trials. This pill was a combination of quinestrol, an estrogen that was stored in and released progressively from fatty tissue and that, as a result, had a long-lasting effect, and quingestanol acetate, a progestagen. The novelty of the formula

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[85] KP: Joseph Kerrins, "A Responsible Parenthood Program in the Barriadas of Lima," Report to the Association for International Development (August 1968). See also interview with Joseph Kerrins (St. Petersburg, Florida, 3 March 2005).
[86] For a list of Lima parishes and the people responsible for them, see CEP: Secretariado del Episcopado Nacional del Perú, Anuario Eclesiastico del Perú, 1969.
[87] KP: Kerrins, "A Responsible Parenthood Program."
[88] Tone, Devices and Desires, 233.

consisted in the fact that it needed to be taken only once a month to have a contraceptive effect.[89] The substance, known as "Q1-Q2", was simultaneously tested in Mexico, Chile and Peru, and its advocates baldly promoted it as a solution to the problem of fast population growth in the Third World.[90] Warner-Lambert approached Kerrins in August 1967, during the program's fastest period of expansion, and thus its period of greatest financial need, and offered a US$ 10,000 grant, in addition to the medication itself, for free, in exchange for a report of its acceptability among the urban poor and Kerrins accepted.[91]

Accepting Warner-Lambert's help turned out to be a costly bargain for Kerrins. His advocacy of methods other than periodic abstinence had already raised eyebrows among members of Peru's lay Catholic movement. Warner-Lambert's offer turned these doubters into enemies. To them, Kerrins was no well-meaning Catholic volunteer, but the employee of a US corporation that profited by preventing Peruvians from being born.[92] Ironically, these critics came mainly from the Peruvian Christian Family Movement (MFC), among whom Kerrins had also his closest allies when he began the educational component of the program in August of 1967. As in the US, Peru's MFC was made up

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[89] W. D. Odell and M. E. Molitch, "The Pharmacology of Contraceptive Agents," Annual Review of Pharmacology 14 (1974): 413-434.
[90] Manuel Maqueo-Topete, Edel Berman, Javier Soberón and Juan José Calderón, "A Pill-a-Month Contraceptive," Fertility and Sterility 20, 6 (1969): 884-891; Boris Rubio Lotvin and Edel Berman, "Once-a-Month Oral Contraceptive: Quinestrol and Quingestanol," Obstetrics and Gynecology 35, 6 (1970): 933-936; Enrique Guiloff, Edel Berman, Alfredo Montiglio, Raul Osorio and Charles Lloyd, "Clinical Study of a Once-a-Month Oral Contraceptive: Quinestrol-Quingestanol," Fertility and Sterility 21, 2 (1970): 110-118; see also Winterhalter Uriarte, "Un Nuevo Contraceptivo Oral."
[91] KP: Kerrins and Kerrins, "Responsible Parenthood Program in the Barriadas of Lima."
[92] Archivo del Movimiento Familiar Cristiano, Lima (hereafter "MFC"): Federico and Laura Hurtado, Presidents of the Archdiocesan Team of the Peruvian Christian Family Movement, to Cardinal Juan Landázuri (Lima, 9 May 1974).

mostly of middle-class Catholic married couples who promoted not social activism but an inwards-looking reflection about the quality of one's married life and the maintenance of traditional gender roles of men in the public sphere and women in the domestic one.[93] Yet, a few couples in the MFC were persuaded by Kerrins's position and by the support of the Catholic hierarchy for this program. These couples translated the Kerrinses' curriculum from English into Spanish. After taking the course themselves, these MFC couples in turn began conducting the workshops on conjugal love and responsible parenthood in parishes in *pueblos jóvenes*. Their experience teaching about conjugal love in an environment of material squalor and violence was both challenging and inspiring; some made friends with the couples they met in the workshops and with the priests who hosted them.[94]

In late 1967 the program faced a crisis. It revolved around whether or not Cardinal Landázuri had given appropriate consent to open additional clinics besides the experimental one in El Agustino. During the course of the controversy, it became known that Kerrins was being supported by Warner-Lambert. "The Cardinal exploded!!!" Kerrins wrote.[95] Believing Landázuri to be "very nationalistic and anti-gringo", Kerrins rushed to assure him that it had never been Kerrins's intention to offend the Church.[96] Kerrins also emphasized the importance of his educational initiatives, and offered to close

[93] MFC: Francisco Zarama and Consuelo Zarama (eds.), Este es el MFC: Décima Reunión de la Asamblea General del Movimiento Familiar Cristiano en América Latina (Panama, 1979).
[94] Interview with Mrs. Consuelo Castillo, former member of the MFC (Lima, 22 June 2006).
[95] KP: Joseph Kerrins to John and Pat (6 January 1968).
[96] KP: Joseph Kerrins to Father G (13 February 1968).

all clinics to appease the Cardinal.[97] Mastering his own irritation over the scandal, Landázuri commissioned Fr. Enrique Bartra, a Jesuit theologian, to evaluate the moral appropriateness of the program, in order to decide whether or not to phase out the clinics. By early 1968, with Bartra appointed as the Cardinal's representative to the management of the program, the crisis was over. At that time, approximately 699 women were taking oral contraceptives in eight parish clinics, and by June of 1968, when Kerrins departed, the number had grown to 1,200 women.[98]

Kerrins had recently returned to the US when Humanae Vitae was issued. Stunned by the news, he called the Pope's decision "an unjust imposition" and claimed that "the society in which the Peruvians live – uneducated, uncultured, poverty-ridden – has not attained a level of Christianity at which they could be expected to follow an edict which would worsen for them the major problem they have so recently began to combat."[99] Kerrins, however, had underestimated how committed the highest officers of the Peruvian Catholic Church were to this program.

After De Humanae Vitae

Cardinal Landázuri was aware of the increase in the number of birth control clinics in Lima, sponsored by both the government and the *Asociación Peruana de Protección Familiar*. Unlike those, the parish clinics were committed to the promotion of Catholic values through the educational program. Moreover, as shown above, there was

[97] KP: Joseph Kerrins to Cardinal Juan Landázuri (Lima, 28 December 1967).
[98] KP: Kerrins and Kerrins, "Responsible Parenthood Program in the Barriadas of Lima"; see also Joseph Kerrins letter (9 June 1968).
[99] KP: "Gynecologist Hopeful Encyclical Won't Disrupt Family Planning," Attleboro Sun (3 August 1968: 1).

an important sector of the Catholic hierarchy that took seriously the legitimacy of a couple's right to determine how many children they should have. This sector was sympathetic to the continuation of the program, and it included the Auxiliary Archbishop of Lima, Luis Bambarén; the Bishop of the province of Callao, Augusto Durand; and the Jesuits Enrique Bartra and Juan Julio Wicht.

To consolidate the program in the *pueblos jóvenes* where it already operated, the Cardinal turned its administration over to the Peruvian lay Christian Family Movement (MFC), which in turn split the program into clinical and educational branches. While the latter stayed firmly in control of the MFC, the former began to be managed by paid medical professionals. With its new structure in place, the program earned the endorsement of the National Office for the Development of Pueblos Jóvenes (ONDEPJOV). The latter was an agency created by General Velasco Alvarado in December of 1968 to coordinate social policies for residents of *pueblos jóvenes*, and to mobilize support for the regime among them. ONDEPJOV went as far as to recommend that the government's family planning policy be modeled on the Catholic Church's program, a recommendation that Velasco did not follow.[100]

Throughout the changes, the Catholic Church's program still aimed to strengthen couples and families "to be active and organic components of the people of God"; to provide relief for "the anguish of numerous families caused by the lack of balance between demographic growth and the development of our country"; to broaden the knowledge that "rational family growth leads to dignified progress for mankind"; and to develop the concept of responsible parenthood. Nevertheless, in clear allusion to the Q1-

[100] MFC: "Recommendaciones del Organismo Nacional de Desarrollo de Pueblos Jovenes (Lima, 8 April 1969)."

Q2 affair, the program also aimed to provide "pills that have passed all experimental stages and are authorized by Peruvian health authorities."[101]

Faced with the increasing popularity of the clinics, the leaders of the MFC sought to enlist the help of more MFC couples to deliver the educational curriculum in the *pueblos jóvenes*. This was not easy. Several leading members of the MFC had become vehemently opposed to the use of oral contraceptives after Humanae Vitae, and were critical of the foreign funding the program received. According to them, the project had "helped the [US]AID once again enter the country and begin birth control activities for political reasons in a dangerous manner. They will even be capable of continuing support for the Educational Plan to accomplish that goal."[102] The critics were not wrong about the funding sources. The bulk of the project's financing in 1969-1970 (1.4 million Peruvian soles, or approximately US$ 33,000) came from the *Centro de Estudios de Población y Desarrollo*, which channeled donations from the USAID. Another US$ 16,000 consisted of a donation from the Pathfinder Fund.[103]

By early 1970, educational program director Pedro Pazos estimated the medical program had approximately 2,500 users, and believed that they would grow to 3,300 within six months. According to him, the program needed 111 new MFC couples to train *pueblo joven* couples, yet only 26 MFC couples had completed the course up to that

[101] KP: Helí Cancino Izaguirre, Guillermo Tagliabue, Oscar Castillo, and Armando Tovar, "Promoción Conyugal, Familiar y de Investigación del MFC en Barrios Marginales (June 1968)."
[102] MFC: "Reunión del equipo central arquidiocesano del MFC (Lima, 14 January 1970)."
[103] MFC: Pedro and Magdalena Pazos Gamio, Directors, to Juan and Renata Idoña, Archdiocesan Presidents, MFC (Lima, 18 February 1970).

point. Of those couples, only nine worked actively in *pueblos jóvenes*.[104] Pazos's pleas for greater MFC involvement were unsuccessful. This indecisiveness led Pazos to seek more administrative autonomy. As a result, two new organizations emerged between 1970 and 1971. The *Programa de Apoyo Laico Familiar* (PALF) took charge of clinical operations, while the *Centro de Capacitación y Promoción Familiar* (CCPF) focused on offering courses on responsible parenthood and leadership training for *pueblo joven* couples. By August of 1970 the clinical program had over 4,000 users of the pill in 14 parish clinics in Lima, Callao, Huacho, Ica, Ancash, and Tacna. It employed twelve obstetrician-gynecologists, a psychologist, and several nurse-assistants. Meanwhile, the educational program, still lagging, had enrolled a little over 1,000 people to complete the curriculum.[105] By June of 1973, there were 19 parish clinics and over 5,500 users of the pill.[106] The PALF assured its US sponsors that in one year they could have 4,480 additional acceptors, as long as their budget were increased to 5.1 million soles, approximately US$ 118,000. Harold Crow, Family Planning International Assistance officer, endorsing the PALF's request, told the chief of the USAID's Family Planning Division that "[i]n the Peruvian context, the PALF program has always impressed me."[107]

Fr. Enrique Bartra, the Jesuit advisor to the PALF, went from cautiously criticizing the program to enriching the theological justification for the provision of oral

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[104] MFC: Pedro and Magdalena Pazos Gamio, Directors, to Armando and Nelly Tovar, Archdiocesan Presidents, MFC (Lima, 5 January 1970).
[105] Pedro Pazos, Heli Cancino, Guillermo Tagliabue, Carlos Flores-Guerra and Enrique Bartra, "Programas de Orientación Cristiana en Relación con la Regulación de la Natalidad en el Perú," Obstetricia y Ginecología 16, 2 (1970): 153-168.
[106] SSC: PPFAII, box 83, folder 22: Memorandum from Harold Crow to John Robbins, Planned Parenthood Federation of America (12 October 1973).
[107] SSC: PPFAII, box 83, folder 22: Harold Crow to Jake Harshbarger, Family Planning Services Division, Office of Population, USAID (13 August 1973).

contraceptives for up to 24 months. He began by stating that women's monthly ovulating cycles were suspended after giving birth, and that maintaining, and even inducing, this "natural ovarian resting period" was morally justified because there are tight biological, psychological, and spiritual links between mother and child during pregnancy, which continued through the breastfeeding period. Bartra deemed these links "essential for the formation of the human being", and claimed they could be upset by the sudden arrival of another baby.[108] Bartra also emphasized that the duration of the breastfeeding period could not be precisely determined because it was not only a biologically but also a culturally determined phenomenon. In any event, "the breastfeeding mother appears to have the right to ovarian rest during that whole period, as long as it may be."[109] Even if a woman who recently gave birth did not breastfeed, Bartra went on, she still had the right to ovarian rest, but in that case it was necessary to set limits to this period. To come up with an estimate, Bartra cited chronicles from Peru's colonial period, the Bible, a survey conducted by the PALF in a *pueblo joven*, and even the Koran, and suggested that, in Peru, the normal rest period lasted between 18 and 24 months, the same duration Kerrins and the Sons of Mary had used as a reference. Bartra also noted that many *barriada* women would like to breastfeed, if only to save money on formula, but could not because of their poor health, arising from malnutrition and worsened by poor hygiene and by having given birth numerous times in unsanitary conditions. At the same time, Bartra's thesis reveals a rigid view of women's roles as the natural caretakers of infants. Nowhere in his theological justification are men portrayed as potential nurturers.

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[108] Enrique Bartra, "Fundamentación Moral del Tratamiento Anovulatorio después del Parto," Revista Teológica Limense 7, 3 (1973): 425-431, 426.
[109] Bartra, "Fundamentación Moral," 427.

With Bartra as spiritual advisor, the program began to emphasize the training of couples in methods of periodic abstinence as part of the educational component, so they would be ready to put those methods in practice after the 24-month regime of pills. Bartra's arguments in favor of the program matched the attitude of Cardinal Landázuri himself. Fr. Pedro Richards, the spiritual advisor of the MFC in Latin America, wrote to Landázuri in December of 1976 from Uruguay, criticizing the program and claiming that "while, throughout the continent, there are those who courageously fight for what is prescribed in Humanae Vitae, the Lima experiment seems subservient to the *pildoristas* [pill-pushers]." Landázuri replied that this project had his approval. Citing Bartra's work, Landázuri agued that "Humanae Vitae does not forbid a reasonable regulation of fertility nor legitimate therapies. The restricted use of anovulatories allowed through the program does not infringe on the terms of the Encyclical, according to the judgment of authorized experts in morality." Moreover, the project itself was continuously "improving its medical aspects, according to advances in natural methods." Downplaying Richards's knowledge of Peruvian realities, Landázuri referred to him as "a priest just passing through Lima," then delivered a sharp rebuke: "As Cardinal and Bishop I strongly reject these and other expressions in your letter which, in addition to being insulting, are untrue. I cannot allow you nor anyone else to doubt my fidelity to the Holy Father, the doctrine or the directives of the Church!"[110] Richards's criticism was unusual. Fr. Luis Bambarén, assistant Archbishop of Lima and Chair of the Commission on Social Action of the Peruvian Bishops' Conference, had made the program public at a meeting of Latin American Bishops in Chile in 1970. Cautious interest and not condemnation were the

[110] MFC: Cardinal Juan Landázuri to Fr. Pedro Richards (Lima, 3 February 1977).

most common reactions from his peers, although there is no evidence that other Bishops pursued similar projects.[111]

Despite Bartra's and Landázuri's best intentions, however, clinicians involved in the project did not always comply with the guidelines set by the MFC in 1969.[112] According to those guidelines, each parish priest had the ultimate power to decide whether a given woman was eligible to receive contraceptives in his parish. Physicians must notify the medical director and the parish priest if they considered there were valid reasons why a woman should stay on the pill beyond 24 months. Physicians must also inform the women of their duty to participate in the educational program with their husbands. In reality, physicians were reluctant to end the supply of contraceptives under different conditions. Physicians did so, for example, when a woman had been on the pill for over 24 months but had not yet, with her husband, completed the educational program, which consisted of talks given over several weeks.[113] Physicians also made exceptions when they estimated that a new pregnancy would be too risky for a woman, given her physical state. If women asked physicians for contraceptives other than the pill, physicians referred those women to hospital outpatient clinics.[114] When women who had been on the pill nevertheless became pregnant and had abortions, physicians allowed them to restart the 24-month regime of oral contraceptives. Most exceptions were made to the rule that husbands had to give their written consent for their wives to go on the pill

[111] MFC: "Reunión del Concejo del MFC (Lima, 6 February 1970)."
[112] MFC: Pedro Pazos, Program Director, to Drs. Heli Cancino and Guillermo Tagliabue, Co-Directors of the Medical Program (Lima, 25 November 1969).
[113] Interview with Dr. Jorge Ascenzo, former PALF employee (Lima, 19 July 2004).
[114] Interview with Dr. Hugo Oblitas, former PALF employee (Lima, 19 July 2004).

because a good number of *pueblo joven* women were not married to the fathers of their children.[115]

By the mid-70s, the program faced a new crisis. The troubles began with a bold declaration by the Peruvian Bishops' Conference about the challenges contemporary society posed to the family. The bishops stressed that unemployment, single-parent homes, high imprisonment rates, the eroticization of everyday life (evident in movie titles and salacious newspaper cover photographs), and, most significantly, the inability of parents to provide for many offspring, threatened Catholic family values. The bishops cautiously admitted the need to consider governmental population policies to address the latter point. At the same time, they refused to reduce the demographic problem to "a debate over the legitimacy of the use of contraceptives." Such reductionism, the bishops contended, was typical of the "'happy families' who live with their backs turned to the unhappiness of other families and the injustices of society."[116]

The swipe at the "happy families" angered some of the wealthier leaders of the MFC, who pointed out the existence of divisions among the Peruvian clergy. These MFC critics claimed that, since the bishops of Huancayo, Yauyos, Abancay and Cajamarca found the Catholic family planning program unacceptable, "there is disorientation and confusion in the consciences of lay members of the Church, because priests do not speak with one voice." In addition, the critics complained that the arguments in favor of population limitation to stave off future food scarcity were weak. Peru, according to them, had "infinite unexploited riches awaiting the science and technology of the Peruvian worker to begin to be productive." In their view, wealthy nations held back food

[115] Interview with Ms. Martha de Laudi, former PALF employee (Lima, 14 April 2006).
[116] CEP: "Familia y Población," Iglesia en el Perú 17 (April 1974): 1-8: 5.

production to maintain their own profits at the expense of the suffering of Third World countries. Moreover, the critics believed the pill made men see women as more sexually available. Finally, they were suspicious of the support the clinical side of the program received from the Planned Parenthood Federation of America (PPFA), because the MFC leaders did not know how those funds were used. With irony, the critics noted how the medical program used PPFA funds, even though General Velasco cancelled the activities of the *Asociación Peruana de Protección Familiar* in 1973, precisely because of its reliance on PPFA funds.[117]

In response, Cardinal Landázuri had a meeting with his auxiliary bishops, the MFC leaders and a group of parish priests. The meeting was favorable to the continuation of the program, and therefore Landázuri had no choice but to divest it from the MFC, although he hoped some of its members would still help out individually. Landázuri was disappointed: "I am sorry to have to make this decision, and I trust the members of the MFC will reflect on the reasons that have made me do so." The Cardinal believed that, through this program, the MFC supported the Archdiocese's social mission, "in accordance with the demands of our time, through an authentic and effective commitment to the poor and the oppressed."[118]

Even after this, the program continued for several years. However, after 1976 it began to decline for a set of interrelated reasons. General Velasco died in 1977, shortly after being quietly removed from power by General Francisco Morales Bermúdez, who cooled down the pace of the social changes introduced by Velasco, including the agrarian

[117] MFC: Federico and Laura Hurtado, Presidents of the Archdiocesan Team of the MFC, to Cardinal Juan Landázuri Ricketts (Lima, 9 May 1974).
[118] MFC: Cardinal Juan Landázuri to Federico and Laura Hurtado, Presidents of the Archdiocesan Team of the MFC (Lima, 5 June 1974).

reform. As for demographic growth, Morales Bermúdez called for a committee to draft the country's first population policy guideline in 1976, which legalized the use of all contraceptives, save for sterilization.[119] As a result, foreign donors increasingly chose to finance organizations that used a broader range of contraceptives than the Catholic program did. Still, the program continued to request funds from Family Planning International Assistance at least until 1979. By then, the program had developed a financial self-sustainability plan, based on the sale of magazines and pamphlets, individual and institutional donations, charging for services to private organizations, in-kind support from the Catholic Church and volunteers, and increasing the cost of client services.[120] Moreover, the program was based in 22 parishes in Lima, Huancayo, Callao, Huaraz, Ica, Huarochiri, Trujillo, and La Oroya.[121] In the late 1970s, however, the Catholic Church itself began to lean more heavily on periodic abstinence methods and on responsible parenthood education, instead of the promotion of the pill. As a result, the clinical program slowly wilted until its final demise sometime in the early 1990s.[122]

Conclusion

The Peruvian Catholic Church family planning program went by two names. Kerrins and the Sons of Mary dubbed it the "Responsible Parenthood Program in the Barriadas of Lima." The Cardinal and the Peruvian MFC went with "Project for Conjugal and Family Promotion in Peripheral Neighborhoods." The names suggest the objectives

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[119] See chapter five.
[120] SSC: PPFA II, box 83, folder 23: "ATLF request for renewal of funds to FPIA, 1978." See also box 83, folder 25: "ADIFAM request for renewal of funds to FPIA, 1978."
[121] SSC: PPFA II, box 83, folder 24: "ATLF request for renewal of funds to FPIA, 1979."
[122] Interview with Dr. Guillermo Tagliabue, former PALF employee (Lima, 17 July 2004).

of the program's founders and supporters: parental responsibility and freedom to determine how many children to have, and the improvement of families as Catholic communities. The initiative was based on a longstanding commitment to the Catholic Social Doctrine, present since the late nineteenth century. The suffering caused by having too many children became connected to this commitment early in the 1960s. However, Catholic authorities in Peru did not see fertility control only as a means to limit births, or only as an individual right. Their family planning program was part of a broader education plan to promote the duties of responsible Catholic parents for the betterment of families and the nation. This again, harkened back to an old Catholic project that made familial harmony of paramount importance. Although, as Irene Silva's legislative work suggests, before the 1960s the furthering of familial harmony was most often understood as a female duty, by the 1960s responsible parenthood education and the betterment of families had become both a male and female obligation.

For priests, particularly those working in poor parishes on a daily basis, the most persuasive aspect of the program was not its relation to US funds or the discourse of nationalistic development in Latin America. Rather, it was the way the program combined a popular demand for smaller families with a duty to transform Catholics through consciousness-raising and education. To these priests, responsible parenthood meant not just conceiving children, but providing moral values, material support, love, and education for those children.[123] None but an observant Catholic married couple, they believed, was better prepared to fulfill these requirements. Likewise, no organization was

[123] José Luis Idígoras, S.J. "La Iglesia y la Regulación Racional y Cristiana de los Nacimientos," El Mensajero del Corazón de Jesús 20, 217-218 (August-September 1964): 219-224.

entitled to decide for this couple the number of children they ought to have. The most the Church could do was provide guidance so couples made this decision in a conscientious and free manner.

At the same time, this program unfolded within the context of the Cold War and a resurgence of Peruvian nationalism. Social forces such as the increasing relevance of the discourse of development, the nationalistic reaction to the influence of the US and its very zealous Catholic volunteers, and the introduction of new contraceptives, also affected the direction and content of the program. A preference for smaller families can help explain why, from the outset, more people partook in the clinical part of the program than in the educational one. Approximately only one *pueblo joven* woman out of four who went on the pill also completed the educational curriculum. But it is not the only factor that explains the large discrepancy. The clinical program grew so much and so fast that volunteers could not run it, even during Kerrins's tenure. The program needed paid professionals and a division of labor between field clinical workers and managers. This growing workforce depended largely on foreign funds. Particularly after 1968, US foreign policy towards population growth in the developing world was oriented to the quiet but relentless support of national governments that wanted to lower birth rates. The sheer amount of funds and resources the US made available to those working on family planning in the 1960s and 1970s throughout in Latin America was partly responsible for the greater development of the medical program relative to the educational one in our case.

Nevertheless, these attempts to affect family planning policies and practice were not welcomed by everyone. Peruvian nationalism in the 1960s affected this story in

multiple ways. There was strong criticism of the program on the part of certain members of the MFC in Lima, who perceived sinister links between the promotion of family planning and the corporate greed of pharmaceutical companies, the over-sexualization of women, and the economic subordination of some nations to others. The latter link was particularly relevant for General Velasco's regime. His hostility towards the Planned Parenthood Federation of America's presence in Peru and his alignment with the nations that attacked the 1974 World Population Draft Plan of Action are representative of his conviction that population could be turned into an asset for the nation's development.

A third level of analysis is also discernable, beyond the Catholic Church's insistence on both spouses' involvement in fertility decisions, and beyond the disagreements between Velasco's pro-natalism and the US's population reduction efforts. Although this must remain speculative in the absence of more direct evidence from the women and men who attended the parish clinics, it stands to reason that the clinics would not have been as popular had there not existed some degree of active demand for contraception on the part of dwellers of *pueblos jóvenes*. The medical services provided by the Catholic parish clinics not only included the pill but also physical check-ups, vitamin supplements, and cervical cancer and tuberculosis screenings. Particularly for women living in *pueblos jóvenes*, the prospect of free health services and family planning must have been alluring, as indeed the number of users suggests.

On a more practical level, it is clear that not all national Catholic churches adopted a hard line against birth control following Humanae Vitae, which is what some

students of the Catholic Church in the United States, for example, suggest.[124] In Latin America, the 1960s Catholic Church was as committed to denouncing social injustice as it was to being faithful to the Vatican. In Peru, this double commitment led the Catholic Church to foster an approach to family planning that did not embrace the connection between birth control and industrialization, nor the connection between birth control and women's expanded autonomy from the domestic sphere. This is an important revision of the portrayal of Catholic leaders as uniformly opposed to birth control. In fact, they embraced birth control, but on different terms. Negotiating such terms required theological creativity, such as that displayed by the Sons of Mary and Bartra, along with the recognition that popular demands have legitimacy and deserve support, such as that provided by Landázuri. This also suggests that the contemporary polarization between civil society and the Catholic Church in Latin America on issues such as emergency contraception need not seem hopeless, as long as Catholic leaders in the region can, once again, tap into the well of theological creativity and courageous leadership that was one of the hallmarks of their Church in the 1960s, and that surely has not been extinguished.

[124] Gordon, Woman's Body, Woman's Right; Donaldson, "American Catholicism and the International Family Planning Movement."

Chapter Seven

Summary and Conclusion

What is the nature of the power of biomedical science? Neither imposed nor unconditionally accepted, the history of the medical control of fertility Peru presents biomedical power as something of a tenuous accomplishment. It is tenuous in its negotiated and contested history, which different experts, government agencies, religious leaders, and lay people have shaped, in addition to medical professionals. Yet, fragility should not be equated with ineffectiveness, for biomedical power has also contributed to important social changes in the country, including the emergence of biologized ways of understanding the link between fertility and national progress and the availability of cheap and effective contraceptives.

This project's view of medical power as fragile yet productive does not support the protagonism the demographic transition theory awards to medical science, at least in Latin America. Demographic transition theory credits medical technologies and institutions not only with reducing population growth, but also with jumpstarting debates linking population to economic development, and with changing pro-natalist mentalities. For all its sophistication, demographic transition theory can be enriched by paying attention to more than the last forty years of Latin America's history. The medical concern with population as an improvable national resource and a couple's obligation, both of which already existed in the nineteenth century, colors the whole of Peru's engagement with contraceptives. Demographic transition theorists have fruitfully incorporated long-term histories to explain population changes in European nations. This

dissertation shows that the same can and ought to be done to better understand current population debates and realities in Peru and, indeed, all of Latin America.

In the late nineteenth century, an emerging group of medical professionals embraced and developed an ideological construct that circulated among physicians at least since the mid-eighteenth century: Peru as a nation needed more inhabitants to take full advantage of the new opportunities provided by its participation as an exporter of raw materials in a transnational economic system. Caring for the reproductive potential of the nation was a task for all: men and women, the wealthy and the poor, and whites and Indians. While mothers were the keystones of all initiatives, they alone would not be able to increase the quality and the quantity of population, and thus fathers and, especially, the medical profession must too participate. For the most part, this was an urban story, particularly a Lima story. It could not be otherwise, as the main ideologues were experts based in the capital. Moreover, it was Lima that experienced before any other city in the country the heady new affluence of the early twentieth century, as well as the concomitant challenges of rapid urban growth and poverty.

A notable trait of this early medical pro-natalism was its prejudice against non-white Peruvians, particularly indigenous peoples. As we have seen, this prejudice reproduced colonial assumptions about the cultural and even biological inferiority of indigenous Peruvians. According to this view, indigenous men could, through significant work and submission to the nation's elite political leadership, join in the project of national aggrandizement, albeit as the junior associates of whites. Importantly, physicians of this period had little to say regarding how indigenous women could also participate in this project. Late nineteenth century medical pro-natalism already held indigenous

women from rural areas at arm's length: neither contributors to the nation, nor subjects of rights. Today, these are the Peruvians who receive the worst health care in the country.

Yet, also between the late nineteenth and early twentieth centuries, women and men of diverse ethnic backgrounds and economic conditions intervened in the processes of birthing and contracepting, deciding when, why, and with whom to have children. Abortion is a good example of how agency and structure determine this bio-social event. It serves also as a reminder of the challenges physicians faced in their attempts to heal and persuade Peruvians that caring for bodies was best left up to professionals. In addition, abortions conducted by physicians are interesting because they illustrate how these procedures could be linked to more and not less fertility. In the late nineteenth century, when the dilation and curettage procedure became popular among Peruvian physicians, what the latter valued most was not the D & C's power to end a pregnancy, but rather its power to remove infected tissues that somehow prevented conception and pregnancy.

The incidence of maternal mortality as a result of abortions procured in unsafe circumstances was one of the main reasons for the medical support of contraception in Peru between the 1940s and the 1970s. To this end, Peruvian physicians, social scientists, nurses, social workers, and community-based distributors became allies with foreign population limitation organizations and government agencies, forming a wide-ranging and coordinated movement. Undoubtedly, the United States wished for strong programs to limit population growth throughout Latin America. Since 1965, the US Department of State, through the USAID, monitored family planning initiatives in Peru. It gave its support to some, such as the *Asociación Peruana para la Protección Familiar* (APPF),

was indifferent to some, such as Dr. Walter Llaque's rhythm method training program, and was wary of yet others. Dr. Joseph Kerrins experienced this firsthand when he started the Catholic Church's program using the contraceptive pill.

The USAID's attitudes towards these different initiatives were a function of how much control the US had over them, and of the contraceptive technologies used. The more control the USAID could exert, and the wider the selection of contraceptives offered, the more supportive the USAID became. Of course, US interest and support are one thing; actual influence is another. The USAID, the International Planned Parenthood Federation, and the Population Council always worked through Peruvian experts and government intermediaries. Together, they had to persuade Peruvian women and men of the value of modern contraceptives, particularly the IUD. There is a strong similarity between the treatment by medical experts of the late nineteenth century of indigenous women as barely human, and the way in which IUD promoters assumed poor women in Peru were beyond civilizing. Ironically, for all their efforts and the expenses they incurred, the rhythm method is, in present day Peru, the means of fertility control that women use most frequently.[1] This is another reminder of just how tenuous the medical control of fertility can be.

Peruvian health workers were not simply about to do the bidding of their United States allies. The preference for the IUD on the part of US advocates of population limitation happened to match the interest of Peruvian experts in protecting the lives of women from risky pregnancies and in preventing families from becoming poorer. Rarely did Peruvian physicians and policy makers emphasize the curtailment of population

[1] Gustavo Rodríguez and Sandro Venturo, Ampay Mujer! Lo Mínimo que Debemos Saber sobre las Peruanas de Hoy (Lima: Aguilar, 2009).

growth as one of their main objectives. In fact, recall experts such as Dr. José Burgos in chapter four, who, far from supporting replacement-level fertility rates, believed that three or four children spaced every three years made most sense. The goal of this kind of fertility control was mainly to decelerate individual parity rates to preserve women's health and families' financial wellbeing. Thus, it was more important to medical workers to promote a mentality shift among Peruvians to make them care more for the children they had. This is an important thread connecting organizations such as the APPF, and the Catholic Church-run Project for Conjugal and Family Promotion in Peripheral Neighborhoods. Both are emblematic of the hegemonic influence of "responsible parenthood" among Peruvian medical professionals working in the field of fertility control in the second half of the twentieth century.

The notion of "responsible parenthood" is also important because it points to a continuity between the early and the late twentieth centuries regarding the value of heterosexual couples raising children. Medical experts throughout the twentieth century have deemed caring for children a couple's obligation to the nation. Throughout this period, medical experts have been consistently harsh towards men's lack of commitment to their families and their violence against of women, and towards women who do not comply with medical advice. The promotion of birth control by health care workers must be seen as part and parcel of their emphasis on creating responsible parents, not only as a vindication of individual rights, nor only as the result of attitudinal changes that took place only in the 1960s, as demographic transition theory suggests.

When the Peruvian government made family planning its responsibility in the 1970s, it endorsed a far-reaching and radical policy: the 1976 Population Policy

Guideline. It is important to acknowledge that it was a military government and not a civilian one that supported the institutionalization of population policies with family planning components for the first time in the country. It is also important to acknowledge the Cold War pressures, the thirst for development, the enduring myth of Peru as a country with vast underexploited riches, and the refusal to docilely acquiesce to the prescriptions of the United States that are embedded in such document. Finally, it is important to realize how far reality still lies from policy. The 1980-1985 Belaúnde government failed to implement most of the Guideline's prescriptions. In 1987, President Alan García finally succeeded in creating a law and national organization to enforce the Guideline. Even so, the shortcomings of Peruvian sex education and the system for the provision of birth control methods were evident. The one time that the Peruvian government took on the task of extending the provision family planning services for all Peruvians was during Alberto Fujimori's presidency from 1995 to 2000. However, implementation of the policy was so disastrous that it led to the forced sterilization of several poor, indigenous women in rural areas between 1996 and 1998, the very ones who have been on the margins of citizenship at least since the late nineteenth century.

Thus, despite the advances the Peruvian government made in the late twentieth century in terms of improving access to health care in rural areas, the availability and quality of family planning services still leaves much to be desired. The state's failure to fully address the sexual and reproductive health needs of its population reaches an absurd extreme in the case of therapeutic abortions. Although these have been legal since 1924, there is not yet a definition of what kinds of pregnancy complications could cause a woman a "permanent and grave injury", warranting a therapeutic abortion. Where did

things go wrong for family planning in Peru? In the mid-1960s, several private organizations provided these services for moderate prices, along with other maternal care services. Within a decade, these organizations had ceased to exist or had been greatly weakened. In their stead, the Peruvian government had taken their place or projected to take their place. To some extent, private family planning organizations actively sought out this outcome. The state's taking responsibility for something they did validated their efforts and sacrifices. Physicians' preoccupation with governmental approval has been common in Peru since the early twentieth century's creation of the country's Directorship of Public Health. Unfortunately, this preoccupation leads even very intelligent people to overlook how ineffective and inefficient the Peruvian governmental bureaucracies are.

Cheap and effective family planning services lost momentum when the Peruvian state took them on as a governmental function. Is privatization the answer? To some extent, perhaps, but this is not viable in the short term, and it would take a more detailed reflection about the balancing of profits and individual (not couple), rights to contraception than I can here provide. Moreover, privatization will do nothing to solve problems such as the regulation of therapeutic abortions, or the need to perform clinical trials on new contraceptive technologies. At the very least, however, Peruvians and their foreign allies can contribute to the broadening of this debate beyond the medical and governmental circles where it has lain for too long. Non-governmental organizations created by demographers, feminists, Catholic activists, and physicians have done some of this work since 1976. Considering the ineffectiveness of the Peruvian government in this field, the proliferation of organizations such as Manuela Ramos and Promsex is not only necessary, but one of the few hopeful signs recent Peruvian history affords. Part of

improving the quality of and access to family planning services in Peru will require the greater diffusion of the initiatives these organizations conduct. To paraphrase an Argentinean physician of note, creating two, three, many Manuelas, is the goal.[2]

[2] Ernesto Guevara, "Mensaje a los Pueblos del Mundo a Través de la Tricontinental," Obras 1957-1967, Tomo II (La Habana: Casa de las Américas, 1970). Guevara is also simply known as "El Che."

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