For the good of the nation: scientific discourses endorsing the medicalization of childbirth in Peru, 1900-1940

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Abstract

Over the course of the twentieth century, a series of changes occurred in the understanding of childbirth, which went from being a natural reproductive phenomenon belonging to the female, domestic sphere to a professional medical matter handled in an institutional setting. Through procedures like the use of anesthesia, Cesarean sections, ultrasound and other techno-scientific interventions, rapid and significant improvements and changes took place in the health and life of society and of women. The medicalization of childbirth in the early twentieth century was part of a broader process of constructing the state and institutionalizing the patriarchy that was common throughout the region.

Keywords: health; childbirth; medicalization.

Over the course of the twentieth century, a series of changes occurred in the understanding of childbirth, which went from being a natural reproductive phenomenon belonging to the female, domestic sphere to a professional medical matter handled in an institutional setting (Warren, 2015; Vacaflor, 2016; Villavicencio, 1992). Through procedures like the use of anesthesia, Cesarean sections, ultrasound and other techno-scientific interventions, rapid and significant improvements and changes took place in the health and life of society and of women. The medicalization of childbirth in the early twentieth century was part of a broader process of constructing the state and institutionalizing the patriarchy that was common throughout the region, in which women came to be supervised and educated to perform their assigned reproductive role in a satisfactory manner (Pieper, 2009).

In this article we seek to underline some key changes in the process of medicalizing and professionalizing childbirth that were driven by Peru's physicians, who helped position themselves, on the one hand, as bearers of technical knowledge and authority, not only on health but also on political and moral issues; on the other hand, they helped to consolidate the objectification of the female body and turn it into their professional specialty. This authority granted by science allowed them to subordinate mothers (whom they accused of being ignorant on the issues of birth and child-rearing) and to displace midwives (who were characterized as ignorant, dirty, and governed by instinct and traditional practices with no scientific basis). The changes studied were certainly not endogenous to Peru. The whole of Latin America underwent similar experiences, although they were marked by the particular processes whereby each state's policies were constructed, as various authors have noted (Zárate, 2007; Necochea, 2016; Pieper, 2009).

Our hypothesis is that in the early decades of the twentieth century, these changes were driven by patriarchal principles, whose utilitarian concept of women involved the construction of an image of womanhood (emphasizing women's child-bearing role); racial and class prejudice, exacerbated by the process of migration from the countryside to the cities and by industrialization (which led to differential treatment); and by population concerns, influenced by movements like eugenics (which sought a healthier, stronger population so as to promote economic growth). These changes helped create a scientific discourse that was deployed against midwives, faith-healers and herbalists (pitting doctors-Western science-progress versus midwives-the Andean world-backwardness) to consolidate a hierarchical health care system that was patriarchal, urban, and dominated by physicians. As the country became more urban, the medical elite became established and access to physician-dominated health care institutions expanded.

To demonstrate the above hypothesis in this article, we analyze medical theses and scientific articles on childbirth. Unfortunately, we were not able to find sources that provided access to the voices of midwives or women in labor, which prevents us from contrasting the perspectives and interests of doctors with those of the other actors involved. Clearly, the medicalization of childbirth was a negotiated process that could not have occurred without a degree of complicity on the part of women in labor, who benefited from some elements of medicalized birth (Felitti, 2011). It was not merely a top-down process, even though the available historical sources may give that false impression.

Doctors, of course, had a variety of interests as regards childbirth, abortion, population growth, sexuality, contraception, technological innovations, and local laws or *fueros*, among other things. In this article we have attempted, where possible, to show the range of anxieties and interests that increased the attention given to childbirth. Although the medicalization of birth should not be understood only in negative terms, nor as exclusively the result of pressure from university physicians, it does require problematizing, given its impact on the ways childbirth has been understood in people's lives until now. A separate investigation is needed of the relationship and empowerment of doctors in contrast to the subordination and erasure of other actors, such as female birth assistants, midwives and faith healers.

A utilitarian concept of women: medical practice as the savior of the nation

In the early decades of the twentieth century, there was a widespread idea that Peru's backward status and, in part, its defeat in the Pacific War, were due to the size of its population, which was small in terms of the country's size and resources. Also, it was usually suggested that its underdevelopment was due to a population that was, on the whole, considered weak and racially inferior. High maternal, fetal and infant mortality rates were seen as one of the leading causes of that demographic reality (Necochea, 2016). Using statistics, technological advances and scientific studies, medical discourse began to pressure the state to use its mechanisms of coercion to exert more control over the processes of pregnancy, childbirth and child-rearing, for example, by creating social workers, maternity hospitals, children's hospitals and homes for abandoned children. That is to say, this alliance between medical discourse and the mechanisms of state transformed gender and racial prejudices and population fears into public policies (Necochea, 2016).

To understand the shaping of those policies, particularly in relation to childbirth, it is necessary to consider the existing concept of women's reproductive role in society. As Enrique Seminario (1935, p.1) stated in his thesis: "Many women die performing the most important of all tasks. And, nevertheless, 60% of those deaths are preventable." Two ideas can be seen in this quotation by Seminario. First, the notion of women as child-bearers, with reproduction as their "main function;" and second, the conviction that many of the deaths occurring during pregnancy and childbirth were preventable thanks to technical and scientific knowledge. The notion of women as child-bearers was not new, but it became a topic of concern among physicians in the early decades of the twentieth century, particularly because of the surge in natalism and the perception that social changes (associated with city life and modernity) were leading greater numbers of women to reject their role (Seminario, 1935, p.1).

In the same year, 1935, Dr Carlos Enrique Paz Soldán (1935, p.437-458) declared:

> Thus, an ever-growing legion of 'motherhood shirkers' is being formed in Lima, with various hierarchies, according to their level of education. They come in every variety … The most radical are those who flee their own sex, falling into mannish behavior, incurable deserters of their mission. In them, every impulse toward their natural functions encounters the restraint of a will-power that makes them indifferent

> to motherhood and that which prefaces it … There is a rebellious, satanic legion of women shirking their duty, capable of resorting to all the tricks of erotic sport without its natural consequences, women who often descend imperceptibly into the most extravagant aberrations, when they do not seek a remedy for their accidents, thanks to those willing to break with professional conduct (emphasis in the original).

This long quotation is significant because it highlights the notion that women had an essential function, that of bearing and caring for children, and also because of the religious tone of strong moral condemnation for women who opted not to be mothers, and the discourse in favor of medicalization and control of women's bodies.

The Lima Maternity Hospital

In 1826, a Childbirth School (Escuela de Partos) was created in Lima, with a hospital attached, the Lima Maternity Hospital (Casa de Maternidad de Lima), devoted to prenatal care and childbirth, which had previously happened at home. The promoter and first director of the Childbirth School was the Frenchwoman Benita Cadeau de Fessel. According to specialists such as historian Lissell Quiroz (2012), and doctors in the nineteenth and twentieth century, the founding of the Lima Maternity Hospital marked the beginning of obstetrical science in Peru. According to physician Antenor Seijas (1938, p.16): "As an important historic event we note the founding of the Lima Maternity Hospital (1826) and the Arzobispo Loayza Hospital, so as to show the date when scientific care for pregnant women was first provided."

The founding of the Lima Maternity Hospital allowed the first parameters for labor and delivery care to be established; they centered on two aspects. The first was professionalization, which involved specialized training for women – birth assistants (*obstetras*) – who would devote themselves to attending births. The second was the discourse repudiating midwives, which was incorporated into the birth assistants' training. This discourse explicitly invalidated and devalued the traditional practices of midwives, believing they were not ruled by scientific medical principles. Implicitly, this discourse limited the access of midwives to professional status in the Childbirth School.

Doctors' increased interest in labor and delivery became more obvious in the late nineteenth and early twentieth century, as seen in the number of theses devoted to the topic. Initially, this interest focused on complicated cases and on the viability of using new technologies, such as anesthesia, in childbirth (Campodónico, 1896). The fact that these theses concentrated on what were seen as complicated cases is not coincidental, and reflects a concept that still prevailed in the early twentieth century, that of childbirth as a natural process that did not require the presence of a physician (Chávez, 1883). It was only during the twentieth century that this concept began to change, as we shall now see.

The gradual increase in the presence of physicians

The concern about population growth during this period created a receptive environment, and it coincided with doctors' attempts to broaden their sphere of authority and action

in the social, political and healthcare field. The increasing interest in the processes of pregnancy and childbirth was added to concern over fetal and neonatal mortality, which was closely linked to the population issue, and to the development of technology, rarely seen before in these fields. This concern remained constant throughout the early decades of the twentieth century (Necochea, 2016).

The discourse that blamed midwives for deaths during childbirth began to include the discourse about perinatal mortality, portraying mothers as responsible for these deaths. Mothers were accused of being ignorant, slovenly and devoid of scientific education. In 1922, J.M. Barandarián (1922, p.6) wrote:

> infant mortality in Lima and throughout Peru continues to be one of the highest rates … working-class homes, the habits and customs of the inhabitants, the promiscuity in which they live, mixing different sexes and different ages; their poor diet, their utter lack of hygiene … the mothers' ignorance is mostly to blame for this failure, since they did not know how to raise their children, exposed them to contagion and wasted precious time trying remedies suggested by their neighbors, only ending up in the doctor's office when their children were already at death's door.

As Carlos Enrique Paz Soldán (1950, p.18) mentioned in relation to the role of public health: "Societies prosper thanks to this biological sacrifice on the part of women. It is their inexorable law. Therefore, caring for mothers is a social duty of vital importance." It was believed that the solution to women's ignorance about pregnancy, childbirth and child-rearing might lie in the creation of schools for mothers. Future mothers could be trained from girlhood on about the topics of pregnancy, childbirth, nutrition and household economy. According to Carlos Enrique Paz Soldán (1916, p.37):

> the education of mothers, the creation of a solid knowledge of health matters in little girls who will later be called upon to become the axis of home and the source of vitality for the race and the nation, is nowadays the task of the 'schools for mothering and household economy,' hundreds of which now exist in educated countries. In these schools, mothers-to-be receive wide-ranging information on their maternal functions, without the false shame of old-school convent education. And at the same time, that body of knowledge capable of facilitating domestic life with as much economy and comfort as possible (emphasis in the original).

Thus, this effort constructed a scenario that pitted physicians and female birth assistants against midwives and other "informal" health care providers. In general, there was a drive to repress non-professional providers (Chinese herbalists, Andean faith healers, and midwives), who were accused of being ignorant and empirical. As Enrique Seminario (1935, p.6) pointed out: "care is provided, in the overwhelming majority of cases, by midwives, in settings that are inadequate, with no hint of asepsis. Childbirth, under these conditions, is far from being a vision of happiness."

Among the most common complaints of doctors at the time were calls for the Birth School to be transferred to the Faculty of Medicine; for births not to be attended by women who had not been trained in the western medical system, and for care to be offered not only during labor and delivery itself but to begin with marriage. One of the

effects of medicalization was to extend the period of medical oversight. That is to say, new assumptions appeared, such as the belief that it was desirable and beneficial for the health of the child and the mother that medical monitoring begin with marriage (doctors called for a pre-marital health certificate) and pregnancy (not just with labor and delivery). In other words, marriage, pregnancy, childbirth, infant care and child-rearing started to be seen as topics worthy of doctors' attention.

On the other hand, this process of medicalization also led to reforms that were seen at that time as progressive. For example, Barandarián (1922, p.10) maintained the need to give pregnant women more leave and to avoid physical labor in the latter months of pregnancy, since it was associated with lower birth weight: "it is glaringly obvious that muscular work by pregnant women markedly affects the weight of the fetus, to such an extent, that it could be said to be responsible for the problem of infants who are frail at birth." Not only that, but many women came straight from work to give birth, which, according to some doctors, had a negative impact on the development of the fetus and the newborn (p.12). According to Barandarián (1922, p.16), mothers-to-be required a minimum of forty days' rest prior to giving birth. He also recommended a extending the period of paid maternity leave after delivery. Furthermore, he called for the same rights to be given to domestic servants, who were not usually mentioned in workplace safety laws.

López Cornejo (1940, p.5) declared there was a "pressing need for pre- and post-natal rest," and Dr. Enrique Seminario (1935, p.6) criticized the lack of legal workplace protection for pregnant women, noting that employers generally ignored the existing laws, which was of concern, once again, not only for the individual health of the mother and newborn, but because it was in the nation's interest: "collective development and nation-building depends on women." He started from the assumption that women, in their category as mothers, occupied a central role in the effort to achieve economic progress; and that as women were becoming "civilized" (by becoming urbanized and receiving formal education), they were losing strength and endurance for processes like labor and delivery, which, even though they were natural, involved effort and pain. Given that logic, the Peruvian state's vacillating commitment to maintaining institutions intended to care for public health, such as maternity hospitals, was worrying. Thus, Carlos Enrique Paz Soldán (1944, p.67-72) lamented the lack of female birth assistants (there were only 600 in the entire country in 1914, and almost all of them worked in Lima) and called for a National Maternity Service guided by the values of religion, science and social medicine.

This period demonstrates the shift on childbirth culture that took place in Peru and elsewhere; it coincided with women starting to demand to give birth in safe conditions, with as little pain as possible (Felitti, 2011), and with the support of the appropriate specialists and institutions so as to guarantee their welfare.

Abortion as a threat and weakness in the population

In this context of an interaction between the state's natalist drive and growing medical interest in controlling the female body through institutionalized childbirth, abortion became more visible in the public debate. In 1935, *La Reforma Médica* published an article

entitled "Criminal abortions." The text contains the following explanation: "This terrible social scourge is starting to spread in Lima to an alarming extent. On a late-February day, of 17 women admitted in a 24-hour period to the Lima Maternity Hospital, 13 showed unequivocal signs of having undergone criminal abortive practices" (Abortos..., 1935, p.223). Medical discourses in the early decades of the twentieth century show that there was a perception of an "ever-increasing number of abortions" (p.223), which helped explain and solidify the image of the fragility and physical and moral inferiority of modern, urban white women that is present in medical discourses.

In contrast to the physical frailty of modern urban women, rural indigenous women were praised for their physical strength and dedication to their reproductive role. For example, Ricardo Moloche (1908, p.21) stated: "It is well-known that our Indian women give birth easily; oftentimes, in the midst of their working day, they stop because of labor pains from uterine contractions and shortly afterwards, within half an hour, they give birth and wash the child, bundle it up on their backs swaddled in any old piece of cloth, and go swiftly on their way as if nothing had happened." On this point it is interesting to note, as Quiroz (2012) and Necochea (2016) have observed, that medical discourses were tainted with views about class and race. It was thought, for example, that indigenous *campesina* women had a higher pain threshold than middle-class urban women, and that they did not need post-partum rest.

Furthermore, medical discourse was not only fed by the racial views of the time, it also contributed to strengthening them. Seijas (1938, p.13) demonstrates this – a few decades after Moloche – in his remarks on miscarriage being more common thanks to the physical weakness of modern women and to modern industrial urban lifestyle: "due to good pelvic conformation, [indigenous women are] successful in childbirth, despite being unaware of the principles of asepsis and antisepsis, thanks to their natural immunity ... due to their crude and less sensitive physiology ... thus miscarriage must be a rare occurrence among the Incas." The discourse of medicalization of childbirth thus began to take on class and race prejudices, seen in the notion that rural Andean women were stronger and more able to withstand pain that those who lived in the city,[1] assumptions that can be traced up to the present day, affecting the quality of care that rural women receive in health facilities.

Women's moral weakness is incorporated into the medical discourse of concern about the number of abortions identified, mainly in the Lima Maternity Hospital.

> This fact is unfortunately not infrequent. The number of abortions seen in the Maternity Hospital – where care is sought not only by women presenting more or less life-threatening complications – is rising every year ... In this crusade there is an extremely noble concern for the public good which must move people of good will and generous heart to help the state in the unpostponable task of preventing these attempts to shirk motherhood (Abortos..., 1935, p.223).

In the reference to "attempts to shirk motherhood" we see how abortion was interpreted as an attempt on the part of women to escape and reject motherhood, which was considered part of their nature and their main function. Antenor Seijas (1938, p.1), whose 1938 thesis claiming to "wish to find out why women who live in Lima no longer wish to be

mothers," assumed first that motherhood was the meaning of a woman's life: "What is the use of the beauty, attractiveness, and education of the women in Lima if they are to be prematurely withered by ailments in their genital apparatus?" As regards the causes for criminal abortion, he declaimed:

> Spinsterhood, clandestine conception, abandonment, social prejudices, the harshness with which daughters who get pregnant outside marriage are treated at home, the desire to lead a 'life with no ties,' as the unmarried call it, or the wish to avoid premature aging, as married women say, are the most frequent reasons why this class of crime is committed. If we add to that we add the ease with which pregnant women find the remedy that saves them from the difficulty, we have to agree on the unusual frequency with which criminal abortion is being practiced among us (Seijas, 1938, p.54; emphasis in the original).

As this last quotation shows, this type of abortion was associated with two factors in particular: poverty (the inability to support children) and moral weakness. Changes in the expectations associated with modernity (the shame/stigma of becoming pregnant while single) permitted the creation of a link between poverty, abandonment by a partner and abortion.

On the other hand, physicians were concerned about the apparent "ease" with which care could be obtained for abortions and post-abortions, which helped create a discourse that accused mainly midwives and female birth assistants of being accomplices to criminal abortion and positioned physicians as key actors in the prevention of abortions and deaths during pregnancy and childbirth.

Lastly, abortion was condemned for preventing women from performing their roles as mothers, but principally for being a factor in depopulation: "While, strictly speaking, there is no guarantee that there is absolute depopulation in Peru, there are reasons to note that we are facing relative depopulation, since the total number of inhabitants is not rising at the expected rate for a young nation that has abundant elements for sustaining life" (Seijas, 1938, p.1). As we see in this quotation, abortion created anxiety not necessarily about the psychological or physical effects on women as individuals, but because it revealed a change or questioning of women's reproductive role in the modern age, which had an effect on the "public interest;" in other words, the negative impact on birth rates. Thus, physicians proclaimed themselves as the solution to the country's population problems.

Cesareans and pathological childbirth

From the 1930s on, the notion of "normal birth," as opposed to one with complications, begins appearing more frequently in medical writing. So does the idea that "normal births" – meaning births that, in principle, did not need a physician – were increasingly diminishing. Seminario (1935, p.84) writes: "It might almost be said that cases in which the phenomena of gestation unfold normally are increasingly rare; and even though the disorders presenting in the majority of pregnancies are transitory, mild and of no consequence to the woman's later life, they are nonetheless deviations from what we should consider typical, normal gestation."

This phenomenon was associated with modernity, urbanization and the new spaces women were entering (such as factory jobs or other work outside the home). While pregnant women were not yet considered patients, the idea was beginning to be suggested. As Seminario put it (1935, p.90): "A woman in the state of gestation is not ill and it would, therefore, be inappropriate to speak of the therapeutics of pregnancy, but it is clear that the procreative function makes women less resistant and thus more vulnerable to all kinds of pathogenic influences." In other words, pregnant women were in a vulnerable state, prone to diseases.

Within this logic of the weakness and vulnerability of urban women during pregnancy and childbirth, procedures like Cesarean sections began to be used more frequently, although reluctantly. According to Ricardo Moloche (1908), the first Cesarean was performed in Peru in 1866, in the Lima Maternity Hospital. In 1900, a second Cesarean was carried out by Alberto Barton at the Santa Ana Hospital. After that, the number of Cesareans began to grow, in a limited way. In 1924, 24 abdominal Cesarean sections were recorded, while in 1935, 30 were recorded at the Lima Maternity Hospital. It was in the 1930s that the number began to grow significantly. However, even though the number of Cesareans was greater, medical theses for those years still described it as an exceptional procedure. As Enrique Seminario (1935, p.99) stated in his thesis on maternal mortality: "The Cesarean operation seems to have been the treatment considered safest by our obstetricians, since it has been employed 35 times [in cases of placenta previa]. Cesareans cannot in any way be considered the method of choice in treating this occurrence, but only an exceptional method."

The physician who was the author of this work, Enrique Seminario, was not in favor of Cesarean sections save under exceptional circumstances, and only when trained professionals were present to perform them (which was not usually the case), in hospitals with the proper technology. As he put it:

> It is my belief that the Lima Maternity Hospital does not have the appropriate conditions for performing an abdominal Cesarean … none of the statistics books that I have studied mention blood transfusions being given to pregnant women prior to undergoing abdominal Cesareans for placenta previa. Under those conditions, it is obvious that surgical mortality, with this dystocia, must be considerable, since the patients were not fit to undergo the traumas of anesthesia and the accompanying surgery (Seminario, 1935, p.100).

Technical advances like Cesarean sections, with trained surgeons, transfusions and more medical equipment, were used as arguments to downgrade the role of female birth assistants in maternity hospital and birthing care, and to transfer their responsibilities to physicians.

Research done by Aragón Peralta shows that, in 1940, only 214 of the 16,950 births at the Bellavista Maternity Hospital were by Cesarean section (1.35%) – quite a few more than in 1907, when only two of the 17,401 births at the Lima Maternity Hospital were Cesareans. Figures listed by Aragón Peralta show that the Cesarean rate from 1910-1940 grew from 0.35% at the beginning of the twentieth century to 2% by mid-century. According to

Aragón Peralta (1942, p.6): "given the incidence rates obtained, we may say that abdominal Cesarean operations only became a reality as a therapeutic method for pathological birth in the Bellavista Maternity Hospital from 1924 on."

Like Seminario, Aragón Peralta believed that Cesareans should only be used in highly exceptional cases, when the life of the mother or child was at risk (that is, in "complicated births"). Among the reasons for choosing a Cesarean were the following: narrow pelvis, placenta previa, eclampsia and the size of the fetus. As to post-surgical morbidity, although he found rates were lower compared to earlier periods, he pointed out that the absence of medical monitoring, the presence of midwives and the lack of training among the female birth assistants was a central cause of death: "the determining factors for the higher mortality rate [were] women arriving at the hospital facility for emergency care, in the worst conditions, without having undergone routine obstetrical examinations throughout pregnancy, out of laziness and lack of education on their part, and attended rather by empirical persons in most cases" (Aragón Peralta, 1942, p.29).

Likewise, this physician denounced home births, positioning the hospital as the place where women should give birth. According to Aragón Peralta (1942, p.33): "home births should be avoided, at least by women in our country, and pregnant women should undergo obligatory examinations at prenatal clinics."

He underlined the need to

> awake maternal awareness in our pregnant women so that, either voluntarily or involuntarily, they will attend prenatal clinics, where, thanks to regular examinations, any dystocias that might present can be detected in time, or in cases where, thanks to past history, there is a suspicion that a woman might present dystocia, she can be closely monitored. These prenatal clinics must be closely linked to the obstetric centers, so that, one month before their due date, those pregnant women can be sent to a special service for 'labor dystocia,' where they would be put on a hygienic-physiological, mental and dietary regime, thus raising their general pre-operative state, which would also affect the health of the fetus (Aragón Peralta, 1942, p.49).

Another interesting shift linked to this last one was the fact that pregnant women came to be seen as patients. In 1940, Dr. Luis Alberto Pérez reflected that : "during this period, a series of more or less striking phenomena are occurring, leading to the fact that in most cases it is impossible to draw a line between the normal and the pathological" (Pérez, 1940, p.35). That is, pregnancy as a type of pathology or "special moment that required medical care." As the doctor says:

> Indeed, in the period of pregnancy, calculated at between 270 and 280 days, a series of anatomical and physical changes take place in all the organs and reproductive apparatus, which, while considered normal by most authors, there are also specialists who do not consider these changes so physiological; and even though pregnancy is a natural function in women, for which their bodies are built … [due to] the major changes that occur in almost all the organs and systems of the pregnant woman, she enters a special state that we can call equidistant from physiological and pathological states, since it is never fully either one of them (Pérez, 1940, p.17).

In other words, pregnancy required specialized medical monitoring and care.

Pérez stressed the rise in premature births (associated with industrialization and modernity in urban life), and the need for these to be attended by specialists. He called for the creation of more prenatal clinics throughout the country, under the supervision of specialized physicians who could monitor progress during labor in various areas of the city and the country. According to Pérez (1940, p.73): "As soon as possible, prenatal medical clinics must be established in districts where women can attend regularly."

Physicians and birth assistants: between expectations and need

A study on the reality of labor and delivery care in Peru undertaken by the physician Félix López Cornejo in 1940 called for increased involvement of university physicians in labor and neonatal care by creating more prenatal care centers and spaces for clinical and social care for pregnant women to offer medical examinations, monitor the progress of pregnancy, provide early diagnosis and treatment for hereditary diseases (with syphilis being the main concern), diagnosis for the fetus, diagnosis of the many causes of dystocia, instructions on hygiene during pregnancy, spreading information about obstetrical hygiene, and the value of breastfeeding. Echoing calls made over the previous two decades, he defended "education on fetal care" as the basis for "a future full of progress, health and wellness" (López Cornejo, 1940, p.3). He believed there should be protection on social and economic aspects also, which should be shouldered either by the state or by the companies where expectant mothers worked.

According to López Cornejo, in order to improve conditions for labor, more control over birth assistants was needed, to ensure that their work was limited to normal births. However, "the complications of pregnancy, labor dystocia, artificial childbirth and diseases transferred from mother to child, are accidents that can only be treated by a doctor" (López Cornejo, 1940, p.29). Given that so-called normal births were steadily decreasing, this implied that medical intervention in childbirth care should also grow proportionately.

Although care by birth assistants rather than midwives was seen as the preferred option in normal births, the medicalization of childbirth also contributed to consolidating a discourse that criticized their training and work. The medical discourse was not only directed at midwives but also at birth assistants trained in the Childbirth School and other actors like the religious orders, which had played an active role in Peruvian public health since colonial times. As J.M. Barandarián points out,

> framed within a colonial regime, with harsh religious discipline, and a convent-like atmosphere of repentance and mysticism, for many years, the Lima Maternity Hospital has fulfilled the simple function of treating women in labor … the nuns and the people educated by them, who are in charge of caring for the patients, look upon the state of pregnancy with horror and aversion (Barandarián, 1922, p.II).

As for the situation of the female birth assistants, López Cornejo also stressed the problems associated with the public health system, such as the state's failure to support it. According to the author, due to a logic that had been operating for some time, this lack of

support and in general the poor conditions in which birth assistants worked meant that many of them did their job badly – they made mistakes when writing up medical histories and attached little importance to certain anomalies (Pérez, 1940) – and they carried out clandestine abortions since they were not able to "survive on their wages ... thus many of them are obliged to cross the respectable boundaries of their professional work, and to enter the forbidden terrain of abortion" (López Cornejo, 1940, p.47).

Consequently, in the hierarchy of the medical system, female birth assistants were ranked higher than midwives, but below doctors. In fact, medical defense of the use of Cesarean sections and the ability to differentiate between normal and pathological births shows an opposition to and critique of the work of the birth assistants, which conflicted with the need to count on their services throughout the country.

The description given by López Cornejo himself of the number and situation of the birth assistants in the country shows the importance of and need for trained birth assistants in labor and delivery care on a national level, a state of affairs that continues to this day. At the outset, in 1940, the number of birth assistants was very low: there were only 263 practicing in the country, of whom only 32 were qualified birth assistants hired and paid by the government nationwide. Secondly, most of the birth assistants were concentrated in Lima and El Callao; in a city like Iquitos – the largest and most important one in the eastern part of the country – there was only one, and in eight departments, there was not a single one. Given the statistics drawn up by the author himself, it is clear that most women in Peru, until the mid-twentieth century, continued and would continue to receive care from midwives, regardless of physicians' expectations (López Cornejo, 1940, p.44).

Based on those statistics, it was unthinkable to get rid of midwives, as many doctors wished. Economic, social, cultural and healthcare realities meant home births with a midwife were necessary. The case of the Andean *campesino* population was even more dramatic, since:

> meanwhile, in the interior of the country, our largely indigenous population in 'the Ande' is still in the same dire situation as centuries ago, receiving no care during childbirth. While it is true that they have never had obstetrical care and could only rely on nature, which set about adapting the body to the harsh conditions of life in the country at altitude, thanks to which Peruvian Indian women possess a special constitution, tough and not too sensitive, with good pelvic conformation that contributes to physiological birth; nevertheless, we cannot fail to admit that nowadays, as in the past, there are tragedies of labor dystocia, and multiple complications during pregnancy and post-partum, which have consequences for Peru as a whole, since in these cases indigenous mothers are alone with their misfortune (López Cornejo, 1940, p.44; emphasis in the original).

Thus, as part of the medicalization of childbirth, the racial discourse was superimposed on the medical one and onto pregnancy complications, independently of the natural physical superiority of Andean women.

This description likewise underlines a socio-economic reality in the nation, in which a Quechua-speaking *campesino* population, living off traditional agriculture intended for domestic consumption, existed alongside a working-class or professional urban population,

while a growing population of migrants were moving from the country to the cities. At the same time, it shows the indifference about the problem of medical care for childbirth in Peru, which was supposed to be handled by the state from 1940 on (López Cornejo, 1940); an indifference that is reflected in the ongoing inequities still seen in labor and delivery care in the country.

The desire for labor to be attended by physicians and birth assistants in hospitals or clinics was still far from becoming a reality in Peru in the mid-twentieth century. As Carlos Enrique Paz Soldán (1935, p.444) stated: "50% of the population of Lima, the capital of the Republic, cannot be born in maternity hospitals for the simple reason that they do not exist." Some years later, he again pointed out: "Reliable calculations authorize me to declare that a quarter of a million births is the figure for the country. However, of those 250,000 births, only 40,000, at most, receive the professional care that these births require. There are more than 200,000 Peruvians springing up in neglect, in poverty, in conditions that threaten their health" (Paz Soldán, 1950, p.70).

To remedy this situation, in 1942, the position of birth assistant was created in each province, among the staff positions in the national budget. This measure has not yielded the desired results, due to the lack of sufficient numbers of properly trained professionals (Paz Soldán, 1950, p.70). Although the growth in hospitalization rates for childbirth accelerated from the 1950s on, this was also a response to another phenomenon that was transforming Peru: the massive migrations from the country to the cities and populism in politics, rather than to a rise in the availability of care, hospitals or trained obstetrical staff who followed the technical and scientific advances of the era.

Final considerations

Over the course of the twentieth century, a series of changes occurred in childbirth practices. From being seen as a natural event that should be cared for at home by a midwife and the family, birthing came to be seen as a process that required specialized care and the use of sophisticated technologies in a clinic or hospital. This change in the view of childbirth was part of a broader process of medicalization that took place in different arenas in people's lives. That is, situations that were formerly handled or resolved through practices that partook of shared knowledge in society, became pathological situations that required medical solutions.

In the early decades of the twentieth century, the process of medicalization was driven by various assumptions and fears. One of these assumptions was the idea that in order to achieve economic progress, population growth was necessary and possible. In other words, that the population of Peru was too small for its territory and resources. Also, that much of the population was undisciplined, weak and prone to diseases. This could be dealt with by reducing infant mortality rates and by encouraging women to have more children, and to care for them appropriately.

Another assumption was that women's essential role was the bearing and rearing of children. Even though women were praised in their role as mothers, they were considered ignorant about central aspects of the process of pregnancy, labor and child-rearing.

Therefore, physicians, who were mostly concentrated in Lima and the country's main cities, began calling for more intervention and the creation of schools for mothers. On this point, it is also interesting to note the association of race and class seen in medical discourses, which held that while upper-middle-class urban women were more fragile and needed protection, Andean *campesina* women had a higher pain threshold.

The development of new medical technologies to deal with miscarriage or the need for a Cesarean contributed significantly to creating hierarchical power relations between physicians, birth assistants, midwives and women. The concern about a supposed "rise" in the number of abortions led to anxiety and condemnation by the medical community, both on moral grounds, linked to Catholicism, and for demographic reasons, namely, the need to increase the population so as to have a more developed economy. However, it was also used as a justification for censuring the practices of midwives, who were blamed, and for critiquing the professional skills of the birth assistants.

Finally, the possibility that greater medical intervention in childbirth might lower both maternal and infant mortality rates helped justify the need to replace the informal, empiric actors who had been assisting at births, for example midwives. The discourse against midwives was repetitive. It was based on their lack of formal training, lack of hygiene and their Andean origin. That is, the high fetal and infant mortality rates could be dealt with, if greater medical monitoring was allowed in the processes of pregnancy, childbirth and child-rearing.

Even though nowadays the process of medicalizing childbirth has prevailed, and medical and obstetric services have successfully reached the majority of the population, significantly reducing maternal mortality and broadening the options available to many women; nevertheless, the change in power relations among the actors requires problematization and analysis, since it is based on authority, gender, race, and class, as seen currently in the different types of violence women experience in healthcare establishments (Sadler et al., 2016), and in the growing demand to "humanize childbirth" (Diniz et al., 2015) both in Peru and around the world.

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NOTES

[1] In terms of racial mixing (*mestizaje*), and the positive/negative view of it, see Cosamalón (2017).

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