

**The Stories of the Forced Sterilizations in Peru: The Power of Women's Voices**

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### **Abstract**

This study explores the extent to which the implementation of the National Program for Reproductive Health and Family Planning by the Peruvian Government had consequences in the lives of women who underwent sterilizations. This study is based on a feminist methodology and used interviews as a method of data collection in order to privilege women's voices and lived experiences from a gender perspective. It addresses notions of biopower and the concept of reproductive health within a framework of intersectionality. Finally, by linking women's testimonies with the theoretical framework, it was possible to identify that specific Peruvian women, in vulnerable and poor conditions, were targeted by the Government because they did not represent the idea of development, and since then, women are dealing with physical, emotional, and social consequences.

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## **Chapter 1: Introduction**

“Peru: Order to indict Fujimori is a milestone in search for justice for victims of forced sterilization” (Amnesty International, 2018).

How could the presumed desire to end poverty through population control measures harm women in vulnerable conditions? According to Hardee et al., “the international family planning movement was built on the foundation of the right of individuals and couples to decide freely and responsibly the number and spacing of their children” (2014, p. 206), which means to have the possibility of obtaining information and of accessing reproductive health services. Some Governments, however, established economic and population policies focused on the instrumental use of women, with the ultimate goal of reducing general poverty levels and accelerating economic growth (Ewig, 2010 / 2012). Furthermore, since the 1960s, many national family planning programs emerged in developing countries with very diverse approaches depending upon their government, economic support, international alliances, and health plans resulting in varied outcomes (Kuang & Brodsky, 2016, p. 33). This thesis focuses on how the implementation of a family planning program, by the Government, that deployed sterilization impacted the lives of some women in Peru.

### **Contextualizing the problem of Forced Sterilization in Peru**

The neoliberal discourses and practices related to gender and development constructed the idea of “Third World women” as recipients of development. Their bodies and their fertility were a target of population control policies framed in the goal of economic development (Ewig, 2006). “The population control discourse is marked by its reduction of ‘Third World’ women to their reproductive organs, and specifically

their wombs, which are pathologized as ‘excessively reproductive’ and requiring intervention” (Wilson, 2015, p. 813).

In the case of Peru, the administration of the former President Fujimori promoted a traditional antinatalist policy, which placed national economic development above women’s human rights (Ballón, 2014; Ewig, 2010 / 2012; Million 2013). President Fujimori’s “Reproductive Health and Family Planning Program” (RHFPP) was established between 1996 and 2000 (Ewig, 2006). This program resulted in a total of 300 000 female and male victims of forced sterilization (FS) (BBC Mundo, 2015).

It is important to address this topic because until now, women who were forcibly sterilized have not received any reparations from the Government. In addition, some people fail to acknowledge that these FS took place and that peoples’ rights were violated. Moreover, to date, former President Fujimori has not been held accountable for these acts. However, he was convicted for crimes related to corruption and human rights violations for his role in killings and kidnappings during the battle against leftist guerrillas in the 1990s. Nevertheless, on December 24<sup>th</sup>, 2017 Fujimori received a presidential pardon in order to be released from jail and not be sentenced in his remaining trials (BBC Mundo, 2017). In October 2018, Peru’s Supreme Court overturned the pardon (Collyns, 2018). In addition, in November 2018, a lawsuit was filed against the former President Alberto Fujimori as well as former officials of his administration for their leading role in the forced sterilizations carried out between 1990 and 2000 (Frances, 2018).

At this point, I find it important to present my positionality on this subject. Even when the FS was a significant problem that affected a lot of Peruvian women, it was present as a rumor— as something that might or might not happened. It is, therefore, not surprising that the first time that I heard about FS was when I was in high school,

when my teacher spoke about Fujimori's government and its human rights violations. At that moment, I could not understand how and why this could happen.

After some years, as I became part of the feminist activist movement in Peru, I got more information about the FS, and it affected me a lot. I could not read an entire testimony because it was very painful. Only when I started to read about reproductive rights and justice could I find words that actually helped me understand the problem and articulate how I felt about it, and how could I approach women who underwent FS. But more importantly, I felt that I had an obligation as a Peruvian woman to contribute to the exposure of this issue. This is why I decided to study this for my thesis.

### **Key objectives of the research**

This research focuses on the FS of women in Peru and will help to fill in some of the gaps of our understanding of how the RHFPP was developed and implemented. More specifically, this research emphasizes women's experiences from the moment they were contacted by health care professionals (HCP) who introduced them to the family planning program, where I will be able to identify processes such as informed consent, personal decisions, and women's struggles with their bodies, relationships, and identities after the tubal ligation (TL). Additionally, I ask to what extent the consequences of FS have impacted women's daily lives.

To address these issues, I focus my objectives and analysis on feminist notions of biopolitics, intersectionality, and reproductive health. Together, it is hoped that these objectives will not only provide a comprehensive picture of the implementation of the FS, but also illuminate the impact of the reproductive program on women's lives and their struggle to find justice. In order to do so, the objectives for this research are:

[1] To examine, from the perspectives of women who underwent sterilizations, the process and techniques that the medical staff used to contact them in order to inform

or persuade them to accept the sterilization as a method of family planning. Therefore, I will focus on how these women describe the dynamics between them and the HCP.

[2] To describe how women were introduced to the medical procedure of TL—where it was performed, how the medical treatment was executed, and what they felt and thought before and during the procedure. Throughout this dissertation, I aim to pay special attention to the personal narratives of women who underwent sterilizations.

[3] To identify the main consequences—cultural, economic and personal—that women experienced after the TL, including the changes in the relationship with their husbands and communities. I will analyze if those consequences have influenced or changed the perception that they have about themselves, the HCP and the government.

[4] To explore how women have been participating in the movements of resistance and how they analyze the pardon of former President Fujimori. Moreover, I will describe what they think about justice and social memory.

In order to accomplish these objectives, this feminist engaged scholarship thesis attempts to combine Foucault's notions of biopower and the concept of reproductive health within a framework of intersectionality, to critically analyze women's testimonies and question the role of the State and the HCP in this endeavour. In bridging theories of health, power, and bodies with Feminist Studies, I am able to analyze the embodied and emotional aspects of women dealing with the consequences in their identities, bodies and notions of lives.

In addition, I have designed a qualitative methodology based on interviews, in order to give a space to the participants to express their ideas and feelings. I have conducted ten interviews with women who underwent sterilizations and are currently living in Lima, capital of Peru.

## **Thesis overview**

A central consideration in this dissertation, as it deals with representation, is how certain women were held responsible for the economy of a country based on factors beyond their gender—like citizenship status, class, ability, sexuality, and conformity to traditionally feminine attitudes and behaviours. Throughout the following chapters, I elucidate how the State developed a specific dynamic to force women to have TL, and how women are dealing with all the consequences of this action.

The second chapter, introduces the feminist framework and methodology that will guide all the research. This literature review focuses on the concepts of biopolitics, intersectionality, and reproductive health. The proposed model explores the impact of nation state's biopower in certain strategies that can interfere or create a new paradigm of reproductive health priorities with background factors such as gender, class, and culture. In addition, I present the methods of this research and a brief description of the participants.

Following the connections of the proposed model, I structured the next analytics chapters in a specific manner to connect with the three main aspects of biopower: State, power, and body (Foucault). That is why the third chapter “Setting the context: Peru’s State and Power” focuses on demonstrating that the FS were not an isolated event, it answered to an international wave focused on the reduction of population in Third World countries (Ewig, 2010 / 2012). In addition, we had a very particular scenario in Peru that made the implementation of the “National Program for Reproductive Health and Family Planning” possible without raising too many questions (Ballón, 2014). This led to different ways in which women were controlled by the representatives of the State, who in this case were the HCP, and the connections with the process of asking for consent.

The fourth chapter, “The process of FS and women’s bodies”, focuses on how their bodies were targeted, how their bodies have changed, and the connections of those consequences with their identities and their relationships with their families and husbands, paying more attention to how they are dealing with the pain (Escribens, 2012).

The fifth chapter, “Resilience: women’s voices asking for justice”, is connected to a concept of resilience introduced by Foucault as resistant to the encroachments on women’s bodies and lives (Deveaux, 1994). Here, I want to focus on how victims are showing their own power and their claim for justice, in addition to their own reflection about the Government responsibility.

My final chapter, “Conclusions: Women’s stories and experiences”, offers a brief summary of the principal ideas of the analysis from feminist and intersectional perspectives, highlighting the voice of women who underwent sterilizations. In order to do that, I will remark on the connections between State, power, women’s bodies, and their resilience.

I want to acknowledge that the subjects that I will be exploring may be triggering for many people. In some cases, I will introduce topics as rape, physical and psychological violence, mistreatment and physical pain. I hope the readers take this warning into consideration to decide how to proceed in case these topics might have a negative impact in their emotional well-being.

I want to end this introduction with a quote from Valentina<sup>1</sup>, so the reader can have a more complete idea of the spirit of women who participated in this research. These women have all my respect and gratitude. They also expressed their wishes about this research.

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<sup>1</sup> All the names that I am using are pseudonyms.

I hope that you will also address this [the problems and consequences of the FS] in another country, about how we are doing here. [...] Many things have happened, and I'm still on my feet. My children tell me: "You need to be strong, mom". (Valentina, December 21, 2018)

## **Chapter 2: Theoretical Framework and Methodology**

I present this theory chapter in four sections to give a better sense of how this study connects with the notion of women's bodies, international intervention, state and resistance. More than just abstractions, I lay out theoretical concepts as an overview of important tools of analysis. To do so, I firstly sketch the general ideas and common points among the feminist theory in order to think about power and resistance. Secondly, I explore biopower's meaning through the relations between state, power and body. Thirdly, I present intersectionality as a fundamental element of feminist thinking, especially in a Peruvian context. Lastly, I reflect on the implications of reproductive rights for women, and introduce select cases of FSs around the world.

The second part of this chapter focuses on the methodology I used to do this research. I will present arguments related to qualitative methodology linked to analysis of women's voices, then I will discuss my reflexivity on the subject. After that, I will explain why I chose interview as a method for data collection. Finally, I will present the characteristics of the participants.

### **Feminist framework**

Nowadays, feminist theory is a productive, extensive, diverse intellectual and political assemblage, due to its nurturance from wide interdisciplinary work and different critical political points of view. Most importantly, when we think of feminist theory we must remember that is not only about women, it is about how relations are intertwined with the power structures according to different contexts and people (Ferguson, 2017). In my view, a feminist framework flourishes best through the alliances of social theories and the incorporation of diverse perspectives that can help develop a critical space to think about the power relations, which can change according

to the context and to the people in vulnerable situations. Resultantly, we can be creative in the possible ways of having justice, love, and freedom as basic possibilities of lives for everyone.

It is evident that we need feminist theory in order to investigate women's problems, so we can understand the social dynamics that have habitually devalued women. Otherwise, the absence of feminist theory may result in making women the focus of the problem (Brown, 2000; Mackinnon, 2009). In that same vein, I consider it important to highlight three characteristics of a feminist analysis that help to have a broader perspective of women's issues. First, feminist theory challenges us to think outside of dualistic relations, which simplifies the complex world by dividing it into opposite variables instead of overlapping relations, which tends to generate hierarchies and to reinforce prevailing power relationships. Second, feminist thinking answers to a fluid process that asks how things come to be, demanding the recognition of power dynamics and the subordinated roles of women that challenge patriarchal thinking that has confidently attributed fixed and universal essences to women. Third, a feminist framework gives us enough tools to analyze women's problems as a result of political decisions, plus it plays a fundamental role in the movements for equality, freedom, and justice (Ferguson, 2017).

Furthermore, the use of a feminist framework answers to the fact that feminism is "a change-oriented scholarly practice" (Ferguson, 2017, p. 273), which means that it encourages our own critical analysis in order to challenge social and power oppression, and victims' forced silences, in order to work toward justice. Plus, within a feminist framework, the development of theories and activism give rise to one another.

Following the characteristics of a feminist analysis, we must consider how feminist theorists are concerned with welfare policies and redistributive rights, in order

to pay attention to the economic and political changes that can have a major impact on feminist interventions, such as the neoliberal politics, which will require us to focus on how women in disadvantaged situations are being affected by these forms of power (Smith, 2008; Young, 1990)

Once we see through the veils of neoliberalism, we can connect how the productions of ‘winners’ and ‘losers’ within this socio-economic system answer to political decisions that keep reinforcing its supremacy through corporate power, the renewal of patriarchy, racist oppression of ethnic and racial minorities, discrimination and violence against women (Smith, 2008). Neoliberalism, not only develops more deeply layers of settler colonialism, but at the same time, it empowers spaces and actions that control women’s bodies under different circumstances.

Under this scenario we can define violence as something that is culturally-formulated. Plus, when we incorporate feminist theory into this approach, we can analyze how identity, power, and social relations interact in order to understand the complex relationship between culture and violence (Leek, 2016). In addition, the notion of structural violence implies that some people are denied political and economic power, and will have to struggle to ask for the possibility of being heard from the periphery (Ross, 2017). On the other hand, when we analyze the power relations that answer to violent contexts and reproduce different consequences for women in vulnerable situations, we also have to consider that the interpretation of this problem can vary according to individuals and their particular social context (Murdock, 2003).

By looking at a broad range of feminist approaches and their connections with justice and violence against women, I seek to present what is currently known as social justice in health care, as a way to have a specific tool that will help to better understand

the voices of women who underwent sterilizations, within a perspective of feminism and justice.

I turn our attention to social justice in health care to present that its primary concern is to provide equal access and health opportunities to all groups. It also focuses on social change to favour inclusivity, finding it important to remove and challenge systematic barriers to fair treatment. From this perspective, there is a need for social change, to do so, we can start by addressing the multiple oppressions faced by individuals, according to their gender, social status, and political affiliations (Mackinnon, 2009).

Specifically, “reproductive justice has generated new theory and practices that explain the phenomena at the intersection of race, class, and gender in reproductive politics to coherently account for events across time and include multiple events” (Ross, 2017, p. 287). We can use this theory to explain and analyze how some reproductive relations are encouraged by certain governments according to their contexts and their specific populations that will probably reflect which individuals are more valued in the society.

With this explanation in mind, we can now reflect on how reproductive justice is interconnected with human rights. According to Ross, there are three principal aspects of this relationship. First, the right to choose to have a child; second, the right to use any kind of birth control; and third, the right to have an environment free from violence to parent children. Now, it is essential to clarify that reproductive justice is not the same as reproductive health or a reproductive rights framework. It is a concept built to amplify the notion and relations of intersectional forms of oppression against Black women’s integrity, and to fight reproductive dignity (Ross, 2017).

Moreover, this concept emerges out of the distinct historical realities of diverse communities, which developed an amplified framework to introduce notions of gender, cultural and power perspectives. This means there is no correct nor single way to apply the concept of reproductive justice. Moreover, its analysis offers a scope for intervention and invention, while also establishing parameters for how it can be applied based on the criteria of its dynamic potential, including: intersectionality, the connection between the local and the global, the link between the individual and community, based on human rights framework, and focused on government and corporate responsibility. It fights all forms of imposed population control and puts marginalized communities at the centre of the analysis (Ross, 2017). All of these characteristics draw on social, political and economic notions of how people interact with each other and with their government. Yet, the concept of reproductive justice has rarely been applied to the context of Latin America with a feminist framework where we can analyze the identification of women as “domestic subjects” placed in the private sphere, and the predominant gendered traditions related to motherhood, even how women define their own bodies (Murdock, 2003).

According to Deveaux, feminist theory helps us to approach the body paradigm, which refers to the power that sovereign authority has on people, according to their gender and social status (1994). This will dictate the ways in which people can be treated, reflecting the value that the government has for their lives, bodies, desires, culture and hopes. So, we should always have into consideration that a person has a particular meaning for the nation-state that will have consequences in the decision-making process related to their bodies, identities and communities. In this case, some questions raise like: What is the value of a woman in poor conditions for the state? What does womenhood mean for Peruvian society? What is the priority of women for

the nation-state? Moreover, with these frameworks we can analyze the different forms of disciplinary control of women's bodies, which are the focus of different kinds of surveillance.

### **Biopower**

The body it is no longer perceived as something just material, instead it carries profound meanings and connections according to what it represents for governments. To establish such relationships, I seek to lay down a set of criteria regarding the connection between the state, power, and the body in the incorporation of governmentality and biopolitics. With this, we can have a better sense of the role that reproductive health plays in biopower, where not all human beings receive the same treatment, taking into consideration that the dynamics of race, gender, and class are perceived and elaborated as the principal factors of global divisions (Zhang, 2014) but, at the same time, how within this dynamic, resistance keeps growing.

In order to understand biopower, we have to analyze the basic biological features of the human species as a set of mechanisms that became objects of control in answer to a general political strategy of power (Foucault, 2009; Mills, 2012). This means, that now our bodies follow the rules established by governments, not necessarily for our own development, but to increase its political and economic power.

Most significantly, according to Deveaux (1994), Foucault uses the term biopower to explain three principal characteristics of the current dynamic between the state and people. First, the control of the sovereign's power over its subjects, where the state's focus is on prohibition and where juridical authority is replaced by new interests in the birth rate, education, discipline, health, and the longevity of its population. Second, the *normalizing society*, where people struggle not for *political rights* but for *life rights*, such as the right to one's body, health, and the fulfillment of basics needs.

Lastly, the concept of docile bodies is presented as an aspect of modern power, where sexuality is key to the exercise of biopower. That is why the power is organized around the management of life rather than the threat of death (1994).

In short, when I use biopower analysis within a feminist framework, I would like to think in the different kinds of “innovations which facilitate increased state control of reproduction of what Foucault calls the ‘socializations of procreation’” (Deveaux, 1994, p. 229). With this perspective, we can focus on how women’s bodies are targeted in all of the processes of reproductive rights and the end-goal of these efforts. On the other hand, it is essential to connect biopower to the development of capitalism, as a tool that inserted bodies into the machinery of production, which from a broader perspective means the control of populations. At the same time, we can establish that biopolitics “far from being centralized or totalitarian, operates through ‘*techniques* of power present at every level of the social body and utilized by very diverse institutions,’ right down to self-governance by the individual” (Mills, 2012, p. 258).

The states with robust sovereignty and paternalist norms transform their government’s techniques over population into strict rules of state security, by changing traditional ideas about national identity into new modes of who is valuable and who is the enemy of the state’s development. Under this context that follows neoliberal characteristics, certain logics seem to be global, therefore accepted, such as the idea that individual rights are less significant than self-sacrifice in the name of community (Mills, 2012; Ong, 2006)

In particular, the norms and hierarchies that gain in importance in relation to power dynamics answer to the political focus on the development of the government of life (Marks, 2006), which means that even the decisions that are considered personal and private to individuals are somehow manipulated or controlled by the government’s

notion of life. In that same vein, “biopolitics is not an unqualified attempt to care for the wealth and well-being of people, but the specific endeavor to promote the life and well-being of the population under power’s control” (Foucault 2003, p. 254) that also seeks to protect the population from others rather than threaten its possibility to flourish, proliferate and expand, which is why biopolitics uses racism as a mechanism of the state power (Mavelli, 2017).

This kind of racism differs from traditional notions that ascribed negative qualities to certain ethnic groups and portrayed them as inferior. Instead, the modern biopolitical racism it is a form of government, designed to manage a population, adding an irrational prejudice, socio-political discrimination, and promoting an ideological motive in a political doctrine. This is a clearly biopolitical governmental rationality that introduces the idea of what must live and what must die under the domain of life, that is under the state power’s control (Mavelli, 2017; Rasmussen, 2011).

When we think about the notion of body in biopower, we have to understand that its object is the population rather than the individual body. It is the diversity of human beings, as a biological species, that are subject to conditions like propagation, births and mortality, health, illness, disease, life expectancy, longevity, risk and security, and management. So, looking more closely, biopower develops distinctive techniques to function with different relevant bodies of knowledge such as demography, studies of fertility, morbidity, public health and hygiene in order to establish its pyramid of power that will guide its sovereignty (Newman & Giardina, 2014; Sinnerbrink, 2005).

In addition, there are multiple layers of engagement related to who is a citizen under the surveillance of the state power that follow notions of ethnicity, cultural, and linguistic differences. These will help to establish what group of individuals could be

identified as people who do not fit under the state paradigm. Plus, the embodiment of identity for those “applying” for citizenship is beyond geographic and biological characteristics, instead it is related to socio-historical experience, political economy, and colonialism (Creary, 2018).

Further, in all the spectrum of body, we must analyze how within the category of women, there are certain women placed above others on the social ladder. Moreover, the mistreatment of power to intensify abuses and to entrench conditions of vulnerability is the perfect structure that biopolitics recommends to enforce its own power (Sifris, 2016). A clear example of this is involuntary sterilizations, where political and social structures work together to target certain women, in order to punish them for their vulnerability without caring for their own decisions over their own bodies. That is why “in order to understand women’s health concerns, policymakers and social scientists must take the social context into account” (Capurchande, Coene, Roelens, & Meulemans, 2017, p. 2).

As the debate above shows, certain types of women are more likely to be subject to undergo sterilizations performed by the state. Thus, in order to identify the nature and power dynamic of FSs inherent in the carrying out of these procedures, we have to understand that this action it is not only a form of discrimination and violence against women, but is a form of intersectional discrimination (Sifris, 2016) that comes from the state but is reinforced through different representatives, such as the medical health care professionals, the health system, the police force, and so on.

At this point, when we talk about reproductive issues, we can analyze how sexual politics help to obtain access to the life of an individual body and to the lives of the entire population (Ludwig, 2016). According to Foucault, sexuality is one of the main concerns of the state because it governs its citizens’ sexuality, reproductive

activities, birth, and marriages practices (Foucault, 1990). At the same time, the population accepts this mandate or is coerced at some level to obey this kind of performativity.

In addition, when we place the body in a context of power dynamics, we can analyze it from the perspective of the biopolitics of populations, where we can identify a body as disciplined and useful for the state. “In which the state’s attention turns to the reproductive capacities of bodies” (Deveaux, 1994, p. 224). Yet, the importance of gender and biopolitics into the consolidation of a nation-state has a significant role, taking into consideration the historical relationships among medicine, politics, and women’s bodies. In this scenario, the body becomes a political field congested with power relations.

It is interesting to note, however, that the effects of power on bodies under the conditions of biopower also can include the notion of resistance, as Foucault expressed: “where there is a power, there is resistance” (Deveaux, 1994, p. 223). This power paradigm is helpful for a feminist framework where we can analyze how women answer to the diverse sources of subordination and the different ways and techniques that women have developed to engage in resistance every day of their lives. By exploring these concepts, we can understand the relations between gender, power and subordination that are transformed into different roles of power in women’s lives, in their social, political, and personal relationships (Deveaux, 1994).

We must recall that a feminist framework highlights the importance of describing women not as passive victims uniformly dominated, but as active agents with different voices and stories that have agency to fight back against oppression. In addition, Foucault says that “no one can take up a position outside it and try to eliminate it altogether. If a person is trying to change a situation, that person is participating in an

exercise of power, a relation of power, an event of power” (McWhorter, 2004, p. 42). However, this scenario can make us wonder how certain places, spaces, policies and practices in contemporary society encourage and celebrate some bodies while, at the same time, erasing and denying others (Sifris, 2016).

By tapping into the notions of state, power, and body, we can understand how the targeting of women for FS reflects the power structures and the inferior position that women continue to be placed by the state. “In fact, the power dynamics between the State and the individual are significantly magnified when gender is factored into the equation” (Sifris, 2016, p. 55). Moreover, the male state —where decisions are made from androcentric frameworks— keeps referring to women as objects and defining them as the property of society.

Without a doubt, from the perspective of biopower, the self becomes the object of political power in order to ensure a behaviour that supports the nation-state’s goals and to isolate the bodies that do not follow what was established as “normal”. Rather than focus on the individual, “biopolitics emphasized using the measurements of human vitality, the value of life, and the well- being of the population as a means to efficient governing” (Hohle, 2010, p. 40). That is why, it focuses on the functions of the bodies and links them with a global project, like public health. Most significantly, sovereign power no longer builds its supremacy through threats of death, instead of that its focus is on the normalization of life. Being its principle objective, the regulation and modification of health, reproductive practices, customs, and habits of the social body (Heiner, 2009).

### **Intersectionality**

The term can refer to the moment in which racism, sexism, and classism collide to form a matrix of domination, at the same time that structures the forms of

subordination based on racialized status, class, gender, and sexuality. Furthermore, it helps to understand multiple oppressions experienced by women of colour and women in marginalized conditions due to their personal characteristics (Falcón, 2012; Nash, 2008). Through intersectionality, we can theorize how identity and selfhood is constructed and how the multiplicity of social, historical and cultural discourses are connected to them, in order to analyze how different groups of people are affected by social problems or how they can react to them (Mattson 2014; Valkonen & Wallenius-Korkalo, 2016).

In addition, intersectionality is an analytical and political framework that groups together practices developed in the context of black feminism. It points out how different identities can intertwine systems of oppression that are mutually reinforced, where the diverse forms of inequalities are not treated as separable or as subordinate (May, 2015), instead they are examined as a dynamic that have different kinds of expressions.

It makes sense, from an intersectional approach, to talk about how we conceptualize racism, sexism and classism in terms of how gender is racialized and how this answer to a capitalist patriarchy structure (May, 2015). In addition, the terms of race<sup>2</sup> status, sex and class are introduced to invoke intersecting power hierarchies between social dynamics. In doing so, we also have to incorporate the notions of colonialism, imperialism, heteropatriarchy, and nationalism with their own arguments related to the nature of power that connects with intersectionality (Collins, 2017).

Most importantly, these concepts can help us to understand that when the political system tries to naturalize and normalize the violence, it is an effort to make it invisible and, at the same time, to reinforce the hegemonic political domination over

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<sup>2</sup> I introduce the notion of race following Foucault's theory, but acknowledging that race is a social construction and not biological category.

certain people. That is why “[r]acism, sexism and class exploitation constitute distinctive and intersecting systems of oppression that rely both on political domination and on violence as an important tool of organization” (Collins, 2017, p. 1465).

On the other hand, as intersectionality was developed in a context of struggles for social justice, it offers the opportunity to question and challenge dominant logics and structures, to forge collective models for social transformation. Something that Audre Lorde characterizes as “divide and conquer” thinking (Lorde, 1984), with the objective to not replicate or reinforce the inequalities, erasures, and alterations perpetuated by the nation-state (May, 2015).

Intersectionality proposes an interdisciplinary orientation that draws on multiple spheres of knowing, from the political scale of lived experience to the macropolitical scale of structural power. In other words, “intersectionality is political, philosophical, and pedagogical in nature” (May, 2015, p. 21). It invites us to think from different spaces and to seek justice by identifying and addressing the privilege and oppression. In addition, we can use intersectionality to disrupt conventional frames, in order to ask new questions about power, inequality, and marginalization. So we can develop a more inclusive framework that incorporate different notions of knowing, power and memory (Bedolla, 2007).

Intersectionality theory considers the dynamics by which racialized status, class and gender are socially constructed categories that can change according to specific markers of the context, and how they operate within the diffusion of power relations (Hancock, 2007; “Intersectionality,” 2007). In the case of Peru, characteristics like the place where you live, how you talk, where you study, your traditions and / or how many children you have can define intersectional status and the value that you have for the government. In other words, rather than focus on the power relationships and the

inequalities between those in power and those on the margins, intersectionality offers the option to map and analyze the relative ways in which identity politics can create power and continue to establish a particular dynamic to answer the desires of people at the center (Hancock, 2016).

Under the framework of intersectionality and health, we do not need to focus on the individual factors such as biology, socioeconomic status, sex, gender, and race, but in the relationships and interactions between such factors, and across multiple levels of society. With this, we can begin to understand how health is shaped across and within population groups according their own characteristics. With this approach, we can achieve two crucial goals. First, it brings attention to the population group's differences that usually are identified as homogeneous groups, like women, men, migrants, Indigenous peoples, and minorities. Second, with an intersectionality informed analysis, we can point out health inequalities all around in the health care system, in order to map more effective directions in policy development (Kapilashrami & Hankivsky, 2018).

Within this perspective, the intersectional approach improves the understanding of the health system because it not only focuses on who is left behind but why and how. This information it is essential, especially in the application of this framework to global health dynamics due to it requires greater attention to intergroup and intragroup differences (Kapilashrami & Hankivsky, 2018).

On the other hand, taking into consideration that the notion of reproduction is grounded in women's bodies, as the only way to increase the population for the national family, their biological possibilities are considered as part of nation-state. The value that they can receive, however, not only depends on their ability of reproduction, it also depends on the specificity of their bodies, and if the nation-state considers that women's notion of modernity matches with the goals of the nation. In this sense, family planning

becomes important in regulating population groups identified by racial status, social class, and national status, which creates a scenario where some women are encouraged to reproduce and others are routinely discouraged or prohibited from having children (Collins, 1998; Deutscher, 2010).

Moreover, when we think about racism, we should have in mind that contextual forces do not operate in isolation, they interact with others like sexism and classism, even in the production of health inequalities. Intersectionality helps us to identify the underlying power structures that produce inequalities resulting from the accumulation of diverse interactions between dimensions of social identity and social forces, not just independent risk factors (Green, Evans, & Subramanian, 2017).

Of special interest, research shows that racism works through different micro and macro level processes that structure health outcomes (Bastos, Harnois, & Paradies, 2018). This means that the health system answers to a racist structure that discriminates against certain people. Moreover, the strong connections between racism and health care have consequences not only at the individual level experiences. At the social level, we can find this divisions in the lacking of high quality of healthcare facilities and professionals, that develop racially patterned barriers to high-quality care (Bastos et al., 2018).

As we can see, there is a complex system of power, that also includes gender as a crucial factor mediated by additional forces. Plus, this system institutes an oppressive organization between social relations that privileges primarily men over women (Gkiouleka, Huijts, Beckfield, & Bamba, 2018), that at the same time builds other forms of oppression.

**Peru: cultural and social background.** For this research, I consider it important to have a little perspective about Peru and its cultural and social background.

At this point, I introduce the notion of development as a tool that can help us understand how the nation-state drew the line between what and who could be considered as developed and underdeveloped. Moreover, we should also highlight some aspects of intersectionality taking into consideration that, according to UNESCO, culture and development cannot be separated. “Development involves the capabilities that allow groups, communities, and nations to plan their futures in an integral and integrated way. Thus, culture can be seen as a cross-cutting factor in economic, social and environmental development” (Acuña & Urizar-Garfias, 2005, p. 21).

I present three characteristics to give a better sense of Peru’s context. First, our national identity is forged by our cultural heritage as the tangible and intangible assets that our ancestors have left to us over the centuries, that also include new or mixed point of views under the influence of the colonialism. This enables us to know who we are and where we have come from. In addition, it is supposed that the state has the responsibility to protect these assets so that they can be admired, valued, and used in a sustainable way by today’s citizens and maintained for future generations (Acuña & Urizar-Garfias, 2005). Second, Peru is home to many cultures that have very different relationships, often conflicting, but sometimes also revealing points of convergence and reciprocal learning (Nureña, 2009). Third, there is a structural discrimination present in Peruvian society, plus the indigenous populations has already incorporated cultural and social elements of European origins; therefore, what can be consider as indigenous should not be seen as ‘pure’, but as culturally ‘mestizo’. In addition, the cultural behaviour associated with indigenous peoples are being gradually and constantly abandoned. This is promoted by the state through an educational system where indigenous labels are not promoted as the source of a positive identity (Callirgos, 2018).

## **Reproductive health**

I explore the reproductive health approach, in order to talk about three things: first, how sexual rights are connected to a human rights framework; second, the principal struggles of introducing this concept to the neoliberal system, and thirdly, a brief overview of some international cases of FS.

First of all, to give a better sense of what is sexual health, we should have in mind that this includes the rights to equality and non-discrimination, the access to highest standard of health, to decide the number and spacing of one's children, to have access to information and education, and others. In addition, sexual rights protect all people's rights to express their sexuality and enjoy sexual health, within a framework of protection against discrimination (World Health Organization, Reproductive Health and Research, & World Health Organization, 2015). In other words, these rights are not only focussed on increasing the access to services, but also to encouraging the freedom to make informed decisions related to health, well-being, and human development in a context where humans rights are interlinked and guaranteed, such as freedom from violence and fear, access to justice, and personal autonomy (Orza et al., 2017).

These rights, also strengthen individual agency to pursue a healthy and pleasurable sexual life without fear of unwanted situations that can be a violation of their bodies and desires. In addition, it is important to highlight the factors of cultural and international boundaries that are associated with reproductive and gender health (Cowell, 2010), like some beliefs and behaviours that follow cultural patterns and can have consequences in women's lives: fertility obligations, not being allowed to say no, the connection between religion and the use of contraceptives, etc.

At this point it is interesting to explore three questions based on the implications of the analysis of paradigms of medical ethics, human rights and the quality of care.

First, how important are the conceptualizations of health? second, does it have consequences for social relations? and third, what role does the agency of citizens play in topics related to reproductive health?

One of the main points about health is the way it is conceptualized because it can determine the actions and politics taken and developed to protect and promote it (Miranda & Yamin, 2005). In that way, the actors responsible for these actions and politics should always consider the variety of people that will have to deal with their consequences or enjoy the positive effects of their decisions. Second, a human rights framework places health within social relations and institutions that have certain power to advance or undermine social justice. Under this scenario, HCP are responsible to assure that health care is available, accessible, of adequate quality, and free from discrimination (Committee on Economic, Social and Cultural Rights, 2000). Third, even though the ethical treatment of patients and the assurance of quality of care are important parts of the right to health, the human rights' paradigm aims to develop a context where people can empower themselves. In order to recognize that they are not patients with a given diagnosis nor as consumers of health services, who should receive quality, but as citizens with rights that are capable of making demands that go beyond packages of services (Miranda & Yamin, 2005). Therefore, it is completely understandable that the human rights perspective focuses on socially marginalized groups, who are normally excluded from their own health decisions and, especially, silenced about their desired on reproductive rights. Plus, they are not only excluded from these decisions but also from the possibility of participating as full citizens of society. A clear example of this perspective is the execution of FSSs, that undermine the capacity for choice and dignity of women who live in vulnerable situations (Miranda & Yamin, 2005).

One of the most repetitive tension that evolves with reproductive rights is its connotations as a fraught subject. In different cultures, matters related to sexual and reproductive life of individuals, especially females, generate conflicts or awkwardness. This reactions are bounded to the valorization of reproduction, where normally the sexuality of women is controlled, but at the same time it means that the reproductive body (women) should be protected and nurtured, because they are valuable as producers of lives (Basu, 2014).

Moreover, the central challenges that face the reproductive health movement are conceptual, political and controversial, instead of medical or technical. Because they analyze the traditional assumptions about the roles of women in society, and challenge traditional assumptions about sex and gender, questioning the personal freedom of choice whether religious, political or cultural (Pellegrom et al., 2014). As we can see, women's reproductive health is a very sensitive issue, and it tends to overlap with a wide spectrum of social justice such as women's social, economic, and political status (Wang, 2016). In addition, since this concept is not very well known, it is important for people to continue to see family planning as a free-standing issue that is linked to individuals' human rights.

Following the previous statements, in 1994 the International Conference on Population and Development (ICPD) is considered to be the turning point in redefining reproductive health. One of the principles of the conference was the focus on women's issues, with the objective to make them more visible at the international level and, at the same time, impel political commitment, which was a shift in comparison to earlier decades when much of the world's attention focused on slowing down the population growth rates especially in the Global South. In addition, in the ICPD's Programme of Action, reproductive health is identified a state of complete physical, mental and social

well-being and not merely the absence of disease or sickness, in all matters relating to the reproductive system and to its functions and processes. Therefore, reproductive health implies the capability to reproduce and the freedom to decide if, when and how often to do so. Importantly, it highlights the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice (Wang, 2016).

With this notion, there has been three major distinctive perspectives over the past decades that have evolved regarding women's reproductive health, and that have added new supplementary versions of women's reproductive health. First, the demographic perspective, grounded in neo-Malthusian thought, that focused on contraceptive effectiveness with the goal of reducing population size, particularly in developing countries with very little concern about women's reproductive health. Second, the aim to identify patterns of diseases and disorders among certain groups of people that answered to the traditional public health model that is mostly concerned with improving the health of population by preventive medicine, health education, and the monitoring of environmental hazards. Finally, the gender equality approach that viewed women's reproductive health in line with gender relations in the society (Wang, 2016). As we can see, there has been a path, where reproductive rights have gained different perspectives and knowledge that keep struggling to be linked with social and political decisions.

Whereas the reproductive rights approach claims to grant choices to individuals, it is important to acknowledge the centrality of gendered and racialized constructions of population control discourse and practice in order to understand how the violence of population control against women in the Global South, minoritized populations in the Global North, and against black and ethnic minority women has been sustained and

perpetuated. At the same time, the neoliberal framework that focus on instrumentalizing gender equality has not been questioned in its relation with reproduction and demands for reproductive justice, making visible the structural forces –economic, political and social– which deny women control over their bodies and over wider processes of reproduction (Wilson, 2017).

In order to exemplify how the notion of reproductive health has been acquired in different contexts at diverse periods of time, and especially how targeting of some people by the government went almost unnoticed, I present some specific cases around the world. Since the 1960s many national family planning programs emerged in developing countries with a very diverse approach to effectiveness and to coverage depending upon their government, economic support, international alliances, and health plan. The key features for a strong national family planning programs were a “provision of a variety of high-quality family planning, counseling and contraceptive options, as well as broad multisectoral governmental and private sector support” (Kuang & Brodsky, 2016, p. 33). Consequently, forcible and coercive sterilisations of urban and rural women in poor conditions took place on a massive scale in different parts of the world. In Bangladesh, sterilisations were in many cases made as a condition for food assistance, while in India, local administrations set targets for sterilisations for non-health personnel, stopping their salaries for failing to reach these targets, leading to large-scale kidnappings and forcible sterilisations (Wilson, 2015). Equally important, the Chinese government developed a hegemonic narrative of population control and used physical force to restrict the number of births with abortions and forcible use of sterilizations of both women and men. The narrative indicated that people of reproductive age were subjected to coerced practices (Oxford, 2017). Moreover, the “Chinese government was equally interested in the quality of bodies that were to be part

of the new modern nation that needed to compete in the global economy. In this way, the policy was also one of eugenics” (Oxford, 2017, p. 5). Unfortunately, these policies continued until recently. These sterilizations often targeted indigenous groups, people with disabilities, people with HIV, and people in vulnerable conditions (Taylor, 2014), which suggests that stigma and discrimination are at the heart of most of the FS and other violations (Baumgarten, 2009).

According to Amy & Rowlands (2018), the United States was the first country to introduce norms of FS as a criminal punishment rather than as a eugenic measure. In 2013, the Center for Investigative Reporting disclosed that almost 150 female inmates in Californian prisons had been illegally sterilized between 2006 and 2010. In this scenario, we should question how the consent was asked and given. In this case, the procedures were discussed with women during childbirth, or other medical interventions, when they were most vulnerable (2018).

In the 1960s, women of childbearing age in Puerto Rico underwent sterilizations. Studies show that one-third of all women who had children, aged 20–49 years, had been sterilized, and the incidence of these sterilizations was more than ten times that among women living in the USA. The concern of the USA was the overpopulation of the island, which could worsen social and economic conditions, that is why public policies were brought in to control the rapid population growth (Amy & Rowlands, 2018).

Canada also has an important history, and present, on the eugenics movement, where indigenous people and people with mental health issues were targeted, because it was believed that they were not citizens and that their reproduction did not fit with the goals of development and sovereignty of the country. Moreover, one of the main

reasons for these action was, and still is, the aim to gain control over indigenous lands and resources (Amy & Rowlands, 2018; Sifris, 2016).

During 2018, there was a big commotion within Canada because Indigenous women reported that they are still being coerced into sterilizations. New research from Alberta, Saskatchewan, Manitoba, and Ontario territories suggests it is still happening. According to the reports, women are being coerced to accept the TL without proper and informed consent. Plus, they felt pushed into signing consent forms for the procedures while they were in active labour or on operating tables (Kirkup, 2018).

With this information, we can establish that the neoliberal discourses and practices related to gender and development constructed the idea of “Third World women” as a recipients of development. Their bodies and fertility are targeted of the population control policies framed in the goal of economic development (Ewig, 2006). “Population control discourse is marked by its reduction of ‘Third World’ women to their reproductive organs, and specifically their wombs, which are pathologized as ‘excessively reproductive’ and requiring intervention” (Wilson, 2015, p. 813). Most importantly, on a global scale, women’s reproductive health and reproductive rights have been denied, ignored, and violated; and its claims “ranks at the bottom of the international community’s list of priorities” (Wang, 2016, p. 3).

### **Methodology and Reflexivity**

This research is based on a qualitative feminist methodology in order to privilege women’s voices and lived experiences from a gender perspective taking into consideration that there is not just one woman’s experience and that there is a plurality of personal stories that represent different connections of class, gender, sex, and race (Harding & Norberg, 2005; Hesse-Biber, 2014).

In the same way, with this approach it is hoped that the rigid power relations that are normally established in the research process will be destabilized, taking into consideration “the feminist principles of respecting women’s (and other oppressed groups’) unique ways of knowing” (O’Shaughnessy & Krogman, 2012, p. 495), which can challenge the social construction of gender inequalities. All this highlights the possibilities to give space for women’s voices using qualitative research methods that are linked to feminist research, because they allow women to express their main concerns of any issue in a way that their knowledge and subjectivity are valued. In addition, qualitative methods also encourage women to express their emotions, taking into consideration that they play an important role in the development of knowledge (Jaggar, 1989; O’Shaughnessy & Krogman, 2012).

On the other hand, reflexivity is an important part of feminist methodology, because it allowed me to recognize my personal biases and analyze the effects that they may have on the data collection. This was a permanent exercise that I did during all the research process. I was conscious that there was a relationship between the researcher and the researched participants where our biases could interfere; therefore I tried to identify how the power relations were being handled. I always introduced myself as Marieliv (without any titles) and I addressed the participants using “Mrs.” followed by their names as a sign of respect. They called me “*señorita*”, which is a sign of respect and affection, but at the same time it draws a limit between us.

During the fieldwork I was aware of the power differences between my role as a researcher and the participants, and that this could bring a certain amount of social constructed power disparities to the research (Bell, 2014). In order to do that I had to be conscious about my class, education, and urban background; that is why when I introduced myself I also explained where I was born, where I studied and the purpose of

this research. In addition, I follow the ethics requirements for the research, so the participants have the opportunity to address their concerns about the research topic, methodology, and the objectives (Harding & Norberg, 2005; Wolf, 1996).

On the other hand, one of the biggest challenges I had to face was to prevent women from becoming re-traumatized by their participation in the research. For this reason, I highlighted that the participants had the control and could make choices during the data collection, like asking questions, deciding not to answer, or to withdraw from the research at any moment. Essentially, I tried to create a caring environment and took actions so the participant could feel respected and valued (Campbell et al., 2010; Hesse-Biber, 2014).

Lastly, I have attempted to use sources from feminist scholars from Peru and the Global South with the aim to nourish this space from the perspectives of women who are familiar with this context, and also to emphasize that the knowledge about human rights violations is being developed from women's stand point of view. In addition, I find important to support some participant's testimonies about their bodies and conceptions of life with arguments of women who share that knowledge.

### **Method and Analysis**

Before I started with the data collection, I obtained ethics approval from the University of Ottawa. I interviewed ten women who underwent sterilizations between the period of 1995 and 2001. I decided to use interviews as a method of data collection in order to not only talk about their experiences, but also to share feelings, thoughts and beliefs. With this, I tried to exchange information in a horizontal space. In addition, my intention was to humanize the idea of being a "victim" and invite the reader to engage empathetically with the stories of women who were forcibly sterilized (Westlund, 2018).

As part of my research I attended conferences, talks, and activities on the issue of FS. To start with the interviews, I first talked to the people of DEMUS NGO<sup>3</sup> to ask for the possibility to get in touch with women who were forcibly sterilized. They invited me to participate in a performance activity called “*Las empolleradas*”<sup>4</sup> to protest outside the Conference Center of Lima, where different international organizations were gathered to discuss topics related to human rights. We were ten women (not all were victims) shouting “Fujimori never again” or “We’re daughters of the women who you couldn’t sterilize”. Unfortunately, the police came, pepper sprayed us and pushed us approximately 10 metres outside the building. This experience was difficult for everybody, because policemen never talked to us; they just decided to use their force against us. After this experience we gathered and talked about it, then I was introduced to three women who underwent sterilizations, we exchanged our contact information and this is how the snowball sampling began.

Most of the interviews took place in public places where we shared a snack or a meal; in other cases women invited me to their houses, and only in one case a woman that lived far from the city told me that she was really interested in participating, but she preferred to have a telephone interview. I digitally recorded all the interviews with the permission of the interviewees. Only one woman did not want to be recorded because she preferred to be cautious for her security and the security of her children.

For the transcription and analysis of the data I did not use any software. I began the analysis by grouping commentaries together to uncover themes, and then I categorized the information according to the objectives of the research. I realized that even when each story is unique, they also share some similarities regarding how they

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<sup>3</sup> Feminist Peruvian NGO that has been working with victims of FS. I have been in touch with this NGO before I presented my thesis proposal

<sup>4</sup> Women dress in red *polleras* (skirt) to claiming for justice.

were contacted by the HCP, what they were told, and the consequences in their bodies, identities and relationships.

All women who participated in the research had children and a partner at the time they underwent sterilizations. Some of them were in their 20s, others in their early 30s; some were born and raised in Lima, and others were born in different cities, but came to Lima searching for a better future for their families. Two of the ten participants were victims of terrorism; in one case the husband was killed by soldiers, and in another case the family was killed by terrorists. All of them had meetings with the psychologist of the REVIESFO (Registro Único de Víctimas de Esterilizaciones Forzadas - Single Registry of Victims of Forced Sterilizations), and according to their testimonies this helped them in different levels; some of them had two or three meetings, and others did have a therapy process. Moreover, all the participants did have the support to think about and discuss their experiences of FS.

As mentioned before, the total number of participants was ten, which is why the length of this research and its findings will only be related to women that have a similar interpretation process of FS, considering that the participants were a similar group of people who share a certain decision on their own process of healing. In addition, I want to point out that the women who participated in this research have been living in Lima for years, and this investigation is only focused on them. This makes the investigation more significant because, until now, the others researches on this topic have focused on women in remote and rural areas, but not in the capital of Peru. The work done on this subject, by the government or by researchers, has centered on gathering information of women who underwent sterilizations in different cities of Peru, specially in the highland and the jungle. Mariana said:

What I want to emphasize is that the Ministry [of Women] always sent assistants to the provinces, “go search for women [who underwent sterilizations] in the provinces”, sure there are, but they didn't worry about Lima, why don't they go to the hospitals and ask for the records. How many have had a C-section, how many have had a tubal ligation? (Mariana, September 19, 2018).

Moreover, according to women who live in Lima (Peru's coast), this kind of research can count as evidence that can pressure the government and help them to be recognized as victims.

At the beginning of the process of data collection, I had one experience that made me reflect a lot about the role of the gatekeepers as important agents who can allow us to contact and establish relationships with people that might be interested in participating in our research.

A woman that I had interviewed, invited me to a meeting of women who underwent sterilizations so I could present my thesis topic and ask if anyone was interested in participating. It was a very friendly meeting. After a while a woman arrived and asked me if I knew that I should ask for consent if I wanted to record women. I explained to her that I understood all that, and that I did have a consent form. I felt kind of rejected at that moment, but I understood that those were important questions. I was surprised that after some weeks, when I interviewed some women who were in that meeting, they told me that they did not need that woman to say all those things, that they wanted to talk at that moment, but after that, they felt shy to do so. This made me realize that sometimes the gatekeeper may influence the people that they are trying to protect and limit their own agency (Bell, 2014).

On the contrary, one of the things that I can highlight from the interviews, which I honestly never thought possible, is that the participants thanked me at the end for the

time that I gave them to talk: “If anything, thank you for the interview, you made me vent”. (Ana, November 1, 2018).

Definitely, this is another step, to be heard, that we didn't remain anonymous, as it is said, and that at some point there can be justice for all. I definitely want to thank you for this interview, because it is a way of venting and making this known and spread. (Luisa, August 15, 2018).

At the end of the interviews I asked if there were any questions or ideas that I was missing or that they wanted to explain better. In this way, I attempted to share authority with the participants as a way to democratize the space of knowledge that we had created, which will have significance to a larger community (Sheftel & Zembrzycki, 2010). Ana told me the following:

Only that I hope that you are already engaged in this and that you like this topic, and apart from this being your thesis, maybe with everything that you have heard out there, with all that you have been able to grasp in people's experiences, look at them through their eyes, sadness in some, frustration or anger in others; later you can meet with a group of young people like you, who want to talk about the subject not only at a national level, but to cross borders, and something can be done; qualified people like you can be gathered to study and plan; you can form a group that also helps us to strengthen this request with the Government, that's all. I would like there to be people like you, who are interested in this, to expose this case maybe to other young people and to be able to form forces with the youth, and that this won't be repeated at any time with another genocide and with another dictator who might

come in another future, because you are the future and what will happen later will fall on you. (Ana, November 1, 2018).

I was very touched by her request. I am planning to disseminate the findings of my research in academic and social spaces, and more importantly, to share this thesis with the participants in the formats that they need: Power Point presentations, images, videos, etc., so they can use them for their own purposes.

In addition, just as formulating the research methods requires reflection and reflexivity, so does the process of writing, because we are not only presenting facts or stories, we are producing knowledge about a group (Fabian 1983; Harrison 1991; Behar & Gordon 1995). For this reason, the selection of quotes is an important process, considering that it contributes to the reader's perspective about women experiences. Each of the quotes has been chosen for its unique and representative characteristics.

In the same vein, following Tuck & Yang (2014) in refusing studies, I have chosen to not present certain parts of some interviews or women's specific information about their struggles for three reasons. First, in order to protect them; second, because it was very sensitive information about tensions and conflicts that are too tender to be open to the light of scrutiny; and third, because all of these remain women's decisions of what, and especially how to tell certain information. That is why I have also used pseudonyms for the quotations.

While writing, I found it hard to concentrate and connect with the quotes in order to analyze them. I feel insecure at this moment, because I struggle to find a way in which I can embrace their stories giving the correct amount of space so I do not hijack them. At the same time, I realized that I wanted to protect myself in an emotional way, because while I was reading the transcriptions, their voices and faces were becoming

clearer in my mind, and even though I have the privilege of having met these women and talked to them, it also brings back their pain and mine.

### **Chapter 3: Setting the context: Peru's State and Power**

It was my problem, my responsibility. Nobody has to touch my body [...]

In the famous VSC (Voluntary Surgical Contraception), my signature is there. (Carmen, September 30, 2018).

In this chapter, I follow the relations between the State and its power as a way to understand how the implementation of a program was focused on the sterilization of certain women in Peru, and, more especially, how women identify the different kinds of force used against them; all of this is related to the notion of biopower. In order to do that, I divide this chapter in three sections. First, I will present an overview of Peru's context in order to have a general idea of the social relations and economic problems at the beginning of Fujimori's government. Second, I will explain how the implementation of the RHFPP was carried out. In the last section, I will explore the dynamic between the HCP and women, in the context of obtaining consent to perform TL. I will analyze the testimonies of women who participated in this research regarding their relations with the medical staff, consent, and whether they received information.

#### **Peru's Context**

I find important to clarify that when we talk about Peru's context at the beginning of 1990s, we must specify three facts: first, the internal armed conflict; second, the election of Fujimori as president; and third, the new neoliberal politics that he implemented. At that period of time, the population of Peru was approximately 24,400,000; 51% of this population lived in the coast and 67% in urban areas (Instituto Nacional de Estadística e Informática, 1997). In addition, all the economic, political, and social power had been centralized in Lima. These facts underline a cultural concept of social value, related to how civilized a person could be according to the place where

he/she lives; that is why the “outsiders”, like the people living in rural areas, have been struggling with unequal access to the nation’s wealth (Hudson, 1992).

**Internal armed conflict in Peru.** Throughout the 1980s and early/mid 1990s, Peru’s security forces battled two insurgent guerrilla movements: the Sendero Luminoso (Shining Path) and the Movimiento Revolucionario Tupac Amaru (Tupac Amaru Revolutionary Movement - MRTA) (Sanchez, 2011). From the beginning, the two groups were labeled as criminals and force was considered the only acceptable response.

Peru’s internal armed conflict was largely ideological. “Both the MRTA and Sendero Luminoso’s ultimate goal was to take control of the country, installing its leaders as rulers. Each group followed a different ideology: the MRTA was Communist/Marxist, while Sendero originally described itself as Maoist” (Sanchez, 2011, p. 518). Moreover, even though the internal armed conflict was not ethnic in nature, we cannot deny that the soldiers and some mid-level leaders were part of ethnic groups from the highlands and remote areas who had a long history of feeling discriminated against by the ruling elite who were generally white or criollo in Lima.

The groups that participated in the internal conflict launched their first revolutionary operations when Peru was establishing its most open democracy in its long and often turbulent political history (Goldstone, 1980; Palmer, 2012). The majority of victims were farmers and local authorities, not members of the political and economic elites of the country (Isla, 2008). Unfortunately, according to the final report of the Truth and Reconciliation National Commission (CVR), there were approximately 70 000 persons killed from 1980 to 2000 by the terrorist groups and the military force of the government (2003). In addition, Peru sustained an estimated \$24 billion in national

infrastructure destruction and lost production, with close to one million Peruvians displaced and an equal number emigrating abroad (CVR, 2003; Palmer, 2012).

When we analyze the armed conflict in Peru, we can say that it was a “direct result of the social, economic, and political exclusion of the majority of Peruvians” (Isla, 2008, p. 42). Resultantly, different sectors planned and executed subversive acts against the established order with the objective of re-establishing and of enshrining rights that had been negated, while others sought to gain control of the State.

It is important to clarify that the internal conflict in Peru was concentrated within Peru’s poorest regions, where people in marginalized conditions, who were considered second class citizens by the State, lived without political and economic representation in the central power. Essentially, this conflict had political and economic consequences for people in marginalized areas, specifically those living in the southern highlands of Peru, making indigenous and rural farmers the target of the violence (Sanchez, 2011).

When the Government realized that the terrorist attacks were increasing and their modus operandi was changing in order to attack the capital of Peru, where the political and economic powers were gathered, they felt that they were losing control over the Peruvian people. Not being able to execute its biopower and losing the management of the potential of its own population, the Government intensified its role and necessity to defend and control the purity and worthiness of the idea of citizenship (Million, 2013).

**Fujimori: the Game Changer.** To start, we must have in mind that from 1980 until the beginning of 1990, Peru was facing different economic and political instabilities. At the end of the 1980s, Peru had lost all access to international credit because we failed to pay foreign debt obligations for more than three years (Iguíñiz,

2000). The hyperinflation was out of control, at a 7,600 % annual rate. Unemployment hovered close to 30 %, with underemployment almost twice that figure and the GDP was in free fall with more than 20 % during the two years before Fujimori was elected (Iguíñiz, 2000).

Under that context, in July 1990, Fujimori was elected as the new president of Peru. He instituted a number of drastic measures during his first months in office. More specifically, he included “an economic shock program that ended government subsidies and indiscriminate currency printing, the reinstatement of regular foreign debt payments, a new tax collection agency, economic liberalization, and one-time financial incentives for members of a bloated government bureaucracy to retire” (Iguíñiz, 2000, p. 30). At the same time, President Fujimori arranged a frenetic schedule of appearances throughout Peru, including places historically least favoured by the central power (Iguíñiz, 2000). By doing so, he wanted to create a sense of connection between *regular Peruvians* and the most important person of the country: the President, who would be their saviour. In that way, everybody could feel that his decisions were not against them, but were designed to create new opportunities for success.

By taking advantage of not having a (good or bad) historical political record, he presented himself as the new path for a better development of the country. He focused on demonstrating that he had a particular understanding of the Peruvian society, especially because of his distance from traditional political parties and his knowledge of regional groups’ culture (Oliart, 2012). I believe, however, that a particularly important subject in order to explore and understand the acceptance and support received by Fujimori is his interaction with different groups within the population. Fujimori’s image was based on the idea that he belonged to the people. He connected quickly with the population through his short public speeches, his plain style of speaking, his gestures,

and even his clothing (he used to wear jeans and sport shirts, while the other candidates used to dress formally), and he danced to the music of the communities he visited (Oliart, 2012).

As noted earlier, the election's results during the 1990 campaign placed Fujimori in a special position in the social sphere: he represented, for the *cholo* middle class, the possibility to gain the power and emancipate their rights. Fujimori was the son of Japanese immigrants; he appeared to be humble and hardworking. He was often compared in the popular consciousness as the *chino*<sup>5</sup> from the grocery store that everybody knew. "His motto was 'Honor, Technology, and Work.' And he promised to be 'A President Like You'" (Oliart, 2012, p 415).

By taking advantage of the internal conflict's violent context, his charisma, and his disdain for parties and democratic procedures, Fujimori staged a self-coup d'état in April 1992. He suspended the constitution, censored the media, and the military force helped him to dissolve the National Congress, until international organizations forced him to restore formal democracy. Nevertheless, national support of the self-coup d'état was over 70% and by that time he had approved a new constitution<sup>6</sup> that made it possible for him to remain in power (Ewig, 2010/ 2012; Getgen, 2009; Iguíñiz, 2000; Vargas, 2006). Looking more closely to these actions, "between 1990 and 2000, Alberto Fujimori's dictatorship created a death squad targeting farmers, students, and professors" (Isla, 2008, p 41) who were supposedly working for Shining Path or MRTA. But it was not until the increased focus on the government, because of the self-coup d'état and the third time that Fujimori tried to prolong his regime in 2000, that the

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<sup>5</sup> This word is used to describe a person from Asia; that includes the stereotype of being an honest and hardworking person.

<sup>6</sup> In Peru we continue to have the same constitution that was first implemented in a dictatorship government.

international community intervened. Naturally, the evidence of his corrupt actions was indisputable and the Fujimori regime collapsed in 2000 (Isla, 2008).

**New neoliberal politics for the health care system.** Fujimori's government represent a period of time where a lot of changes were made, especially in the economic sphere, that had huge social consequences. Moreover, the implementation of a neoliberal perspective during Fujimori's government generated different and severe changes in Peru's health care system. I argue that these decisions were based on economic benefits for the country instead of protecting and improving the Peruvians' quality of life (Rousseau, 2007).

According to Ewig (2010/2012), when a country is facing crisis, it gives politicians a scenario with greater freedom of action where they can make quick decisions without always making sure if they are the best options for the country. In the same vein, this perception of freedom explains how and why foreign ideas prevail in certain cases. When there is no crisis, policymakers are more likely to make an internal evaluation to continue with their process of political learning or to pay attention to the demands of stakeholder policies, rather than to select a more uncertain foreign model (Ewing, 2010/2012).

It is also important to recognize that the historical formation of health policies in Peru was influenced by the discriminatory assumptions of physicians, policymakers, and international agencies about the relationships between gender, racialized status and disease (Ewig, 2010/2012). The new public health care system was not built on the idea that all citizens had the right to health, but was informed by vertical, authoritarian actions that reflected the attitudes of the elites towards the poor, non-whites, and women. The goal was to use those bodies to control the population growth to lead national development, both economic and moral. Importantly, indigenous women and

women in poor conditions “were seen as a group that had to be constrained in the name of the economic and social development of the nation” (Ewig, 2010/2012, p. 74).

Therefore, the State had to control their bodies and regulate their maternal skills and desires so the new and improved Peruvian public health system could work. In short, women were considered, on one hand, as substantial for the society development because they were seen as the producers of the future workforce, but on the other hand, they constituted a threat to economic growth due to their unstoppable fertility.

Moreover, former President Fujimori appropriated rights-based discourse in order to improve his international reputation, especially after his self-coup d'état, while deceptively maintaining the same basic Malthusian demographic policies. He was the only male head of state who spoke at the Fourth World Conference on Women in the United Nations in Beijing, where he supported the reproductive rights of women (Ballón, 2014; Lerner, 2011).

In that context, Fujimori's new policy served to shore up financial support and achieve tacit approval from important bilateral and multilateral agencies. The support for women's reproductive rights seemed to be a democratic gesture to ameliorate the image of the government, rather than offering effective protection (Boesten, 2006).

It is no coincidence that before the Beijing Conference (around September 1995), the Congress that was dominated by Fujimori's party approved the legalization of "voluntary surgical contraception", which was illegal in Peru until that moment (Lizarzaburu, 2015). Despite the opposition, the Government expanded access to contraceptive services provided by the State, including vasectomies and "voluntary" TLs. Taking into consideration this information, it was not a surprise that the Government formally implemented the RHFPP 1996-2000, which was aligned with the Cairo program. This plan considered family planning as a priority for the country

(Subcomision investigadora de personas e instituciones involucradas en las acciones de anticoncepcion quirurgica voluntaria [Subcomision investigadora AQV], 2002).

### **Reproductive Health and Family Planning Program 1996-2000 (RHFPP)**

After Fujimori's speech in the United Nations, the approval of surgical contraception and the implementations of the RHFPP 1996-2000, the Government seemed to be progressive, in favour of individual liberties and the reproductive well-being of women and men. Even the RHFPP's publicity looked feminist as it emphasized the rights of women and couples to decide the number of children they wanted to have (Comite de America Latina y el Caribe para la Defensa de los Derechos de la Mujer [CLADEM], 1999; Ewig 2010 / 2012).

One of the keys to unlocking this idea of a progressive Peru is to understand, from an intersectional approach, how the social policies implemented during that period of time had different effects on diverse groups of women and men, according to their ethnicity, socioeconomic class, gender, and location (CLADEM, 1999; García, 2017).

**The route of family planning in Peru.** Since the 20<sup>th</sup> century, fertility regulations have become an important topic in Latin America, especially with the growing assertion of the relation between family planning programs and economic development, more autonomy for women, and better maternal and child care (Necochea, 2014). However, there was a eugenic desire to classify people based on their phenotypes, which led to the imperative need to increase the "correct type" of population. At that time, the academic medical elite argued that the growth of the indigenous population needed to be controlled in order to be civilized, so they could become a part of the national progress idea (Necochea, 2014).

In this context, in Peru, on July 28th, 1990, a new population program implemented a new policy regarding population growth called National Population

Program 1991-1995. This program established new demographic policy guidelines, as well as new methods to achieve the goals it proposed and, most importantly, to receive all of its support from the Inter-Ministerial Commission for Economic and Financial Affairs of Peru (Subcomision investigadora AQV, 2002). At that time, the Sectoral Technical Committee's demographic diagnosis demonstrated a negative relationship between population growth and economic growth. Based on this assumption, the National Population Program established restrictive, controlling strategies and methods for population control. In addition, the United Nations Population Fund (UNFPA) acted as the Technical Secretariat for the program, in coordination with the National Population Council. As many have already discussed, UNFPA had a record of supporting population control in developing countries (Subcomision investigadora AQV, 2002).

In that context, the National Population Program's activities were focused on the sexual behaviour of people who were classified as high risk because high fertility itself was related to high rates of disease and death, which had to be regulated through the "Reproductive Health Program" (Subcomision investigadora AQV, 2002).

Therefore, in 1991, the president established the "Year of Austerity and Family Planning". The demographic goal for the period 1990 – 1995 was to reduce population growth to an annual rate of no more than 2%, as well as a Global Fertility Rate of 3.3 children per woman. By the middle of 1995, the goals had been met, although apparently the Government was not satisfied with the results (Subcomision investigadora AQV, 2002). Then, in 1992, he declared that the 1990s would be the "Decade of Family Planning" (Rousseau, 2007). This was also the year that the National Program for Family Reproductive Health Care 1992-1995 was implemented with the objective to contribute to the decrease of fertility, in harmony with the free decision of

the population about the size of their families and the interval between each child (Ministerio de Salud, 1992). Thereby, his message to the Nation of July 28th (Peru's Independence Day) 1995 was centred on reproductive rights (Ewig, 2010/2012; Subcomision investigadora AQV, 2002). Finally, in 1996, the RHFPP was implemented.

**International aid.** Since the 1990s, international financial organizations have promoted social policies as a central component of development strategies under the slogan of human capital. The health reform strategies advocated by the World Bank, the Inter-America Development Bank, and the World Health Organization in the 1990s were guided by basic neoliberal premises. Their decisions were based on cost-benefit analyses to determine health priorities, cost control, incentives for greater participation of the private sector, and more efficient public management. This meant, that the way in which the population was growing in the Global South did not contribute to having a free market, in theory because the countries were focusing on creating national policies to help their citizens. At the same time, it was believed that if the growth did not stop, the raw materials for food were not going to be enough for all the people (Wilson, 2015).

Furthermore, since the 1960s, many national family planning programs emerged in developing countries with very diverse approaches to effectiveness and to coverage, depending upon their government, economic support, international alliances, and health plans (Kuang & Brodsky, 2016). In addition, at the international level, the discourse of population control for reasons of national security and economic development included the position to prioritize the reproductive rights of women and gender equity (Ballón, 2014). In the political context of 1995, in theory, Fujimori, on one hand, led a democratic regime, which was a requirement for international aid and, on the other

hand, he had the control of the legislature. All of this resulted in audacious reforms that did not actually require approval because he already had enough power to execute his plans, such as the ones implemented in the field of family planning (Rousseau, 2007).

**Where did the money come from?** After the Cairo conference in 1994, population control loans increased; the World Bank reported that it had lent almost \$1 billion USD in support of population and reproductive health objectives (Mosher, 2008). The antinatalist programs spread rapidly, especially because of the group work of international organizations, like USAID and UNFPA, the United States, and the increasing number of developed countries that wanted to participate in order to achieve their economic goals (Mosher, 2008). According to Liagin, USAID's internal documents revealed that in 1993, the USA was in charge of the Peruvian National Health System, as part of the bilateral agreement between Peru and the USA (from 1993 until 2000). With this, we can say that USAID was in charge of the health care system before and during the implementation of RHFPP, where the FS were executed, and that the USA through USAID was responsible for the funding of the program, its progress, the training of the health care staff, the target-settings and the monitoring plan (Subcomision investigadora AQV, 2002). Importantly, since the beginning of family planning activities in Peru, UNFPA has participated jointly with USAID in practically all financial activities. Their participation as technical advisers matched the aims and objectives established in the Kissinger report that analyzed the economic, population, food and environmental growths and needs of the developed and developing countries, and which concluded that the population growth should be stopped (Subcomision investigadora AQV, 2002). In order to do that, developed countries, like the USA, were likely to commit to a set of policies that would lead the international community, especially developing countries, to the achievement of more "responsible" reproductive

decisions (United States National Security Council, 1974). Nevertheless, it is important to clarify that when the complaints regarding FS arrived in the US Congress, USAID removed their economic contribution for a period of time. At that moment, President Fujimori looked for other sources of funding, like the Nippon Foundation; therefore, the Ministry of Health organized an specific project to carry out sterilization actions in native communities in the rainforest of Peru, under the auspices of Integral Health services, with the aim to decrease the fertility rates. Resultantly, they extinguished more than ten indigenous groups of the Amazonia (Subcomision investigadora AQV, 2002).

The RHFPP was the largest demographic control program in the Americas that was established as a public health state policy from 1996 until the year 2000, although the program was carried out even until 2001. Also, it should be noted that most of the complaints made by those affected by FS around those years came from indigenous women, plus women with limited economic resources and from remote rural areas (Henriquez, Ballón, & Arnillas, n.d.).

### **Consent: Did women “agree” to the TL?**

Now, that we have a general view of Peru’s context and how the RHFPP was implemented, in this section, I want to introduce how the notion of consent was or was not included in the process of TL. Moreover, I will explain that women did not give their consent to the HCP. To understand this, we should consider what ideas, thoughts, and feelings intervened in their decisions, having in mind that the HCP are representatives of the State.

According to the testimonies, I can argue that the medical staff used different techniques to contact them and give them insufficient information so the women could accept (not make) a decision, this will be explained in the next chapter. There are different scenarios and different stories, but the way the medical staff treated them was

very similar. It looks like they did not want women to understand what a TL was, they did not want women to have the complete information. Thus, the power imbalance between the traditionally male doctor and the female patient also carries information on class, ethnicity, and ideas of development that influence the power dynamic between them (Sifris, 2016).

At this point, it is important to highlight that there was like an “encouragement chain” between the government, the HCP, and women. There is evidence that, in some cases, the HCP were given incentives to perform TL, like: food, trips or special recognition. In addition, they were also threatened with firing if they did not accomplish monthly quotas of TL (Subcomision investigadora AQV, 2002). On the other hand, the HCP sometimes offered food to women or their partners in exchange for the TL, in other cases, HCP scared women telling them that they would not be able to pay for the food and education of their children (Subcomision investigadora AQV, 2002).

**Trust the authority.** Even though women did not have all the information or felt pressured to accept the TL, the idea of respect was very powerful within this power dynamic. They identified the medical staff as professionals who represented the State and had a better understanding of health, which is why women did not consider the possibility that the doctors and nurses were “bad people” who wanted to hurt them. Thus, while the “Hippocratic Oath may demand that doctors ‘do not harm’, in practice, the possession of knowledge and power may lead to abuse of such knowledge and power” (Sifris, 2016, p. 48).

We were confident, we were confident that they were telling us the truth; we didn't doubt that because they were also people, since we know almost everyone in the village; they were friendly people, people we couldn't distrust, who worked in the health post. Because in the end, I think that they also had to do

their job, I imagine that they were also questioned to convince people to make that decision no matter what, because at that time there was no job security, I imagine that it was something like if you didn't do that, you could lose your job. (Fiorella, November 1, 2018).

**Coerced decisions.** Asking for consent should always include cultural and demographic factors in order to obtain a truly informed answer of women. In the case of Peru and the RHFPP, they should have prepared different types of consent and different ways of explaining all the process of TL before asking for it, according to social and cultural contexts (Paz & Blair, 2006).

Once they knew where my house was, they kept coming, the nurses kept coming, and I finally said: but these doctors, these nurses will come here constantly. Well, what can I do, I'll go and maybe, in the future, I will have more children and I won't be able to send them to school, maybe I won't be able to support them, and that's how I decided to get it. (Rosa, September 22, 2018).

Some women do not know how their signature ended up in the consent form for the TL, because they did not do it. Others, who did sign felt guilty and ashamed, even when they were coerced to consent. They felt, at that moment, that it was their responsibility to understand what the consequences of the TL were, that they would not be able to have more children, and that they would experience pain.

But I told her [the nurse]: "I have not given my consent" and she tells me: "but everything is fine, you feel good." And I remember, what I do remember and I will never forget, that I was very dizzy, I felt dizzy, I was just waking up. So, they did tell me, you have to sign this piece of paper, that you're fine, because you're fine. What's your name, do you feel ok, does anything hurt? No, no, no, no. So, to be honest, let's say that until then I was very, I was very ignorant in

many things, and one of those was that. So, I signed a paper, I don't know what paper I signed, I never read it, I never knew, it was only the doctor's voice, because at that moment it was already the doctor who was next to me, it was a doctor and he made me sign a paper. (Ana, November 1, 2018)

In this testimony, Ana describes how she was coerced to sign after the TL procedure. She did not know what the paper was about, she just follow the doctor's instructions, just after she was waking up from the anesthesia.

When we analyze this from a racialized, gendered, and classed biopolitical power, we can understand that asking women for their consent was not part of the plan, because women were identified as objects with the option of giving birth, but that they could not make good decisions about their bodies. So, the HCP –as representatives of the State– were in charge of making decisions for them (Ballón, 2014; Whatcott, 2018). In the case of FS, some women had the “opportunity” to say no to the TL, but the doctors did not take their decisions into consideration.

Besides feeling like I was suffocating in the C-section, when he put me on the bed, I laid down. I saw him like a man, I don't know, like I felt something and I warned him: “Doctor, don't do the tubal ligation.” I grabbed his hand, because I was laying down, and he let go of my hand, like saying don't touch me, let go of me. I said: how strange, but inside of me I was saying I'm already warning him. He won't touch me. (Mariana, September 19, 2018)

In all the scenarios, it is clear that women did not have a chance to refuse the TL (CLADEM, 1999). At the same time, it is important to notice that when health professionals do not explain to the patient all the procedure risks, it is categorized as negligence (Curran, n.d.). With all this, the Peruvian State failed to warranty the right to information and free will of women, and to protect women from violence and

discrimination based on gender, race, ethnicity, and language. “(...) the doctors did a malpractice regarding us, because they received a bonus for each sterilized woman, so they already saw the commercial side, overstepping all human rights”. (Carmen, September 30, 2018).

Well, they [the medical staff] may have been influenced by the Government. The Government said: “There is a lot of population and it is necessary that all couples, families are made up of one, two children; three was too much,” they said. All the nurses and the doctors had this thought in their heads, and since they received something for it, they agreed as well. (Andrea, September 25, 2018)

As part of the RHFPP, the Government established TL goals that HCP had to accomplish. The use of goals in population programs makes possible that the rights of individuals come into conflict with the Government interests and policies (CLADEM 1999). Resulting in a dualistic dynamic: power State versus reproductive rights of individuals. In addition, the lack of sensitivity to intersectional approach, especially on the relations between intercultural framework and gender perspective has led to negative impacts on the female population (CLADEM 1999).

#### **Chapter 4: The process of FS and women's bodies**

I realize that the damage, the damage is both physical and psychological, because it's something irreversible, it's something that you won't be able to recover again. (Fiorella, November 1, 2018)

We live in a male chauvinist country. For a man, a [sterilized] woman was useless, she wasn't worth it; she was dead. (Carmen, September 30, 2018)

This chapter is divided in three parts. First, I will analyze how women were contacted by the HCP, and under what scenarios they did or did not received information about TL. Second, I will present how women were treated during the procedure of TL, where it was performed, how they reacted to the anesthesia, and the use of physical and psychological force against them. Finally, I will explore how women are dealing with the consequences of FS on their bodies, identities, and relationships. It is important that the reader remembers that this analysis only focuses on the experiences of women who participated in this research, and also to have in mind that each woman had very particular ways of reacting to the pain according to their personal and cultural stories.

##### **The HCP's approach to women**

From this section I will present the stories of women who participated in this research. Before analyzing how women were contacted by the medical staff, I want to briefly outline that even when the ten stories are unique, they also overlap, especially in their relationship with the State's representatives as the health care staff.

As an overview, there were three scenarios where HCPs interacted with women: right after giving birth, when they went to the hospital to ask for information about contraceptives or other health issues (not necessarily related to reproductive health), and as part of social and health campaigns. We can say that the contexts where they were

introduced to TL did not have the best conditions for an informed and free decision making about their reproductive health (CLADEM, 1999).

I also want to give to the reader a clear sense of how women remember receiving (or not) information about TL for the first time, which means starting at the beginning of their stories of FS, especially their first interactions with the health care providers.

**Never got the information.** Some of the women that I interviewed told me that the medical staff never explained to them what a TL was, so they did not know what happened to their bodies until after they realized that they were forced sterilized. Indeed, most of them had never heard about TL or about its potential consequences for their own health and lifestyles.

Of course, and they didn't even tell me: "Ma'am, we are going to do a tubal ligation, with this you will feel this way, you will later feel sick, it will affect your hormones, you will have future consequences, it is not revertible", nothing like that. So there wasn't a before, a during, and an after [of receiving the information]. (Luisa, August 15, 2018).

In addition, according to Tamayo, before having this kind of procedure it is mandatory to have a health evaluation in order to know if the patient is in good health and to prevent complications (CLADEM, 1999). However, none of the women who participated in this research were requested to undergo a health examination, and more importantly, the medical staff did not know anything about their reproductive health.

On the other hand, there is a particular story that connects reproductive rights and customs that I would like to present. A woman who underwent sterilization in Rioja, the rainforest of Peru, told me that the next day after giving birth in her house,

she went to the clinic<sup>7</sup> to ask for a medical examination. Unfortunately, when she arrived, the HCP immediately told her to take a shower, which according to her customs was something that could make her sick, because her body was just recovering from an extreme loss of force (Córdova, September 20, 2018). In the area where she used to live, normally women just clean themselves instead of taking a shower. She did not understand why she had to take a shower, but she did it anyway.

And they say if you shower, you get *sobrepardo*<sup>8</sup> (postpartum illness), right? So I was scared and cold, it was cold at that moment and they told me to shower, and I was telling myself, I'm clean, I don't smell, why are they telling me to shower? And just like that, without removing anything, I put the gown on, shivering, and they tell me "sit down here", and there were many, many [women] sitting. (Sara, August 17, 2018).

At this point it is important to note that a cultural perspective was not included in the RHFPP. From an intersectionality framework, we can say that women had different backgrounds relating to their own conceptions of well-being that answer to very specific cultures and customs (Miranda & Yamin, 2005). Unfortunately, when women became patients, they were more downgraded in the power relations with the health professionals, so their voices and desires were not taken into consideration.

**Misinformation.** There were some women who did have more interactions with the HCP, however they did not receive information about the procedure itself, the medical staff only focused on general ideas, such as: it was a contraceptive method and it did not demand changes on their bodies or lifestyles.

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<sup>7</sup> It is like a small hospital that functions in small towns in Peru, but they do not have the same category of hospitals: it does not have all the services or medicine required.

<sup>8</sup> This word refers to the possibility of getting sick after labor.

Fiorella was looking for contraceptive methods after her second child died at the moment of birth, but the information that she received in the clinic was that contraceptives were no longer available, there was only one: the TL.

All that was like psychologically, like a big concern, now I'm going to get pregnant again and what will I do, how is it going to do. So, they said that there was going to be a [contraceptive] method, just one way of being careful. In the health post I was told that there are two ways: the one that is forever and the other that is temporary, at any time you could have children again and that it wasn't dangerous, nothing. It was a small cut and it healed quickly afterwards, and they were telling that to the other women. (Fiorella, November 1, 2018).

I want to highlight how the economy and the place where women lived were important aspects in the decision as to what contraceptive methods they could access or wanted to use. Fiorella, in 1995, used to live far from the city; she had to walk seven to eight hours to find a car to the city. She told me that in case she wanted to buy any of the contraceptives methods she would had to travel to the city; however, she did not have enough money or time for the transportation and to buy the contraceptives. This is a clear example of how the structural division of power can be reflected in reproductive health decisions of individuals. Women who lived outside urban areas and in poor conditions did not have the opportunity to choose freely and according to their desires (Ewig, 2010 / 2012).

When thinking about the moment when the medical staff gave partial information about the TL, Fiorella reflects on their responsibilities:

They didn't tell us "this is like this" or "think it through". Supposedly, they had information, they were supposed to prevent first, to say "think, think, because afterwards there won't be this, there won't be that", they would have realized the

conditions. They knew that, they had the information, they knew that contraceptives were always going to be there, because there were always some afterwards. That is, the contraceptives of the health posts were always there, it was always there. (Fiorella, November 1, 2018).

I recall her frustration at this moment of the conversation, analyzing why only some people had access to this kind of information and decided to keep it from women who needed it under the false assumption that women would not be able to understand, that they could not make their own decisions, and that they did not know what was best for them. Thereby, doctors may not fully inform patients of their options and simply proceed on the basis that ‘doctor knows best’, which clearly shows a paternalist point of view from the health care providers as representative of the nation state leaders (Ballón, 2014; Ewig, 2006).

**Manipulation and threats.** The moment of giving birth was one of the most common contexts where the medical staff decided to sterilize women. Luisa believed that the medical staff used her baby to force her into signing the TL consent form. After the baby was born, the nurse told her that her baby had disappeared. They implied that if she agreed to the TL, they would return her son:

I told her [my stepmother] crying, because I was crying, worried that my son was nowhere to be found. She left the room screaming: “Where is my grandson, my grandson had better be found!” And he was found. He was all cyanotic, crying so badly, because he had cried a lot. They say that he was found in the back of a room that didn’t belong to babies, maybe someone wanted to take him, or what could it be, or maybe it was a way of pressuring me to accept, because I didn’t want to sign. With that condition that I had to sign and then they would give me my baby. (Luisa, August 15, 2018).

This is a clear example of the power dynamics between patients and the medical staff, taking into consideration the vulnerable situation of women right after giving birth. The power imbalance between a doctor and a patient may manifest itself in a number of ways as an abuse of power, whose consequences are clearly not in the patient's best interest. Plus, this power differential "is magnified when gender is factored into the equation. Involuntary sterilization procedures may be viewed as one example of the ways in which the medical profession has abused its power over women" (Sifris, 2016, p. 46).

Andrea explained to me that:

[In 1996] sterilizations were popular, but it was not called a sterilization, they were revertible tubal ligations. So, I was convinced because I was told that it was my third C-section, that they were three children and that it was really risky to have more than three. But later in time [I realized] that it was not true, because there are people that have five, six, seven C-sections. (Andrea, September 25, 2018).

In her case, she was afraid that she could die if she had another baby, but it is also important to clarify that she was not planning to have more children. She got scared because of what the nurses and doctors had told her, plus they also assured her that the TL were not permanent. We must have in mind how the power relations work in the context of HCP and women in vulnerable conditions in order to understand how the lack of information or the general statements about the TL were not perceived as opinions or suggestions, but as demands. The hierarchy of power reinforced the message that women must follow the indications of the health care providers.

Another way to threaten women was related to the notion of motherhood. The women constantly received messages from the medical staff explaining that they would not be able to be good mothers, because the economy of the country was not improving.

“When years pass, life will become more difficult, you will not be able to educate your children; when they get sick you won’t have enough money, you will not have enough clothes, shoes”, everything they [medical staff] added. So many things, that everything was a lie because, I say, how can you not be able to buy when you work, ma’am, although my children don’t dress elegantly, at least they wore clean clothes, a shoe, not broken, but something good, in good state. But they simply put things in your head to encourage you, to confuse you, so you would think that it’s that way; but now realizing, I think about everything, everything that they have told me. Everything was a lie, everything has been wormed out of us clearer. (Juana, August 17, 2018)

The doctor who operated on me told me that he had done me a favour, but I told him: “What do you care? Did I ask something from you, or did someone tell you that my children were abandoned? I haven’t bothered anyone.” (Valentina, December 21 2018)

When we analyze these testimonies, we can see that the medical staff explained a very particular scenario to women: that if they did not accept the TL –even when they did not have all the pertinent information– they will definitely have more children, they would die if they had another Caesarean, and they would not be able to raise their children. Therefore, they should be grateful to them because the TL was a favour, so they could have a “better life”. This, again, is a clear sign of paternalism. In addition, they never asked women if they were planning on having more children, the medical staff assumed that this would happen and decided to act on it (CLADEM, 1999).

**Harassment.** In addition, in some cases, the HCP visited women in their own houses as part of social campaigns; however, in this scenario, they did not give them information about TL, instead they harassed them for several days, repeating that they would not be good mothers, and that they would not have enough money to support their families.

The nurse came over to convince us more than three, four times. The doctor and the nurses that came to my house told me that I had to get a TL, a surgery, that I had to go, they told me. “How many children?” “I have three”. “You can’t have more, no more kids. Why do you have so many? You are having more ma’am, your husband isn’t even a professional, he’s only a farmer and you can’t have more children, you can’t have more anymore. I’ll come back at 4 pm, to check if you accept, and I’ll be back” and so she came back the next day at 4 pm and told me again: “Have you decided already, ma’am? Ma’am, you have to get surgery, get it while you can, then when you have many children you won’t be able to support them, the prices will go up, the schools will change, the hospitals will be privatized, do you think that you will [be able to] afford all of this? And the school for the children? You have many kids that have to go to school; the economy will get worse for you to take them to the hospital. Ma’am, you have to get it [the tubal ligation] now, you have to, I will come back tomorrow, and the day after tomorrow, and so on” which she did. (Rosa, September 22, 2018).

It is completely understandable that women surrendered to this pressure and to the information related to the economy and better options for their children. Plus, at that moment, it seemed that this was the only way to recover their personal space and keep focusing on their daily activities.

Until this point, it is clear that HCP did not follow a procedure to correctly inform women about the TL, moreover they did not care about the desires, fears, and health of women. Therefore, women did not get a proper space to accept or decline the TL, because at the end it was not an option, it was an obligation. On the other hand, there are some women who expressed that they did want to have more children, and that they would have probably agree to the TL if the HCP had given them all the information in a respectful and correct manner. In the interviews, only one women told me that she felt relieved when she knew she could not have more children.

When I was told that I wouldn't have more kids, I was kind of happy, but they should've told me, right? And I would've known the consequences, which I wasn't told. [...] I was free to decide, whether to have it done or not. (Sara, August 17, 2018)

### **Women's first steps into the FS**

To start this analysis we can focus on the connections of biopower and identity characteristics –sexuality, traditions, culture, racialized status– that, according to Foucault—develop repression, force, discipline, and technologies that the State can use to structure the society in order to increase its power with the goal to highlight whose lives should be optimized and nurtured and those who should not (Ludwig, 2016). In the case of Peru, and as we can notice in this research, women in poor conditions were the target of FS, because the Government decided that their bodies did not fit the modern structure of society, that is why what happened to them did not matter, they were labeled as invisible by the State (Ballón, 2014; Ewig, 2012).

**Health campaigns.** Following the instruction of the Government, one of the methods to engage women in TL was the health campaigns organized by the nearest clinic. In the case of Fiorella, the HCP of the clinic where she lived told her that they

had all the logistic prepared to travel to a bigger hospital that supposedly had all the instruments and medical staff necessary to perform the TL.

They told us that there was going to be a campaign for sterilization, there's going to be a campaign and we have to go for that date [...]. In order to go to the health post of the province we had two transportation methods: by river and by road, it takes seven or eight hours by road, and by river it was almost a day. So, we went by road; we were like 14 - 15 people, all the women. [...] We went to the health post, they had an ambulance, we all traveled in it. We were cramped like animals and all closed. We were well filled and it was hot, everything; it was us, the obstetrician and the doctor, because the doctor was driving. [...]

When we got to [the health center] Puerto Inca, it was on a hill, so you had to go up. The plain is right above, but to climb it you have to walk through the plants, in the rainforest, but you also climb a type of stairs. It was high because the river bank went up with the stairs until it reached the plain. When we got there we realized that there were a lot of women there. Sure, because they came from all the districts. Like that, the way we arrived. So, there were a lot of people, there were a lot of women, they were all there with the robes that they had and when they took us there, they put us in a little room. "You have to wait for your turn, and when your turn comes we will let you know what you have to do." So, we looked and the place was crowded with women, and since I am a curious person I started walking around to know the place, and I saw that the women were taken on stretchers and they were put in the hallway, there were a lot of women sitting on the floor. With anesthesia, some of them fell asleep; when they sort of reacted, because they came out intubated, some came out with a tube in their mouths. After a while, when the anesthesia wore off, they were taken, and they

had mattresses and blankets for the people who didn't reacted quite well, and we watched what they were doing there, the door was almost open. (Fiorella, November 1, 2018)

According to this testimony, the hospital did not have all the surgical equipment to perform the operation, especially taking into consideration safety precautions for patients that are required for those under effects of anaesthesia (Vargas & Granados, 2016).

But imagine doing this operation in a free environment. Half open, when it is supposed to be an aseptic place, where no insects can get in, something that can go inside you and give you an infection. How can the door be open? (Fiorella, November 1, 2018)

When she told me this part of her story, she was frustrated to acknowledge the conditions of the place where they were "cut" and the idea that any insect could get inside her.

In addition, during all the procedure and since she arrived in the hospital, the HCP were insensitive and took advantage of their own knowledge about the medical procedure. They did not explain anything; they just told them what to do.

We were told to go shower, "then you will come here because they will shave you, they will clean you." Then, one by one, they entered the room to shower us and clean us, they shaved us themselves. And there in the room there were many, I don't know if they were assistants, but there were a lot of them; they checked everything, they looked at our parts, just like when you get a pap smear. I mean, what did it have to do, what did it have to do to have our uterus removed, that they check us there, it didn't make any sense?! Or for me it didn't make any sense to have our parts checked or to have that thing inside in order to

look at our uterus, if the cut was up here; but they all went through it. At that time we didn't say anything we were told we're going to do the cleaning, I don't know what they would check, but that was the process. [...] The men were the ones who examined us; the women were the ones who shaved us. (Fiorella, November 1, 2018).

In this testimony, Fiorella had to struggle with the emotional impact of being surrounded by a lot of women. "There must have been 150, it was a lot of people, as they were finishing they were taken." (Fiorella, November 1, 2018). Some of them were in pain and under the effect of anaesthesia. She was worried about those women, she was also stressed because she was in a place that was not familiar to her, and she was touched and examined without being asked. Fiorella has a very good memory of that day, even though this happened in 1995, she also remembers feeling confused at that moment because she did not know what was really happening to her and to all the women there.

The campaigns were a very well thought plan to make women feel included and valuable, because the HCP promoted the TL as something good that the State was giving to women without any cost (CLADEM, 1999). However, in reality, women were placed in a more vulnerable situation, they were cataloged as objects with the ability of reproduction that had to be conquer and stop by the Peruvian State (Escribens, 2012).

**Giving birth.** Another way to be coerced into the TL was during the process of being pregnant and giving birth. We must consider the issue of health from a cultural perspective as a theme of democracy, citizenship, and rights. In this context, there is a key issue between comprehensive health and human rights. Understanding health from a well-being point of view implies the opportunity and ability to fully exercise human

rights by all Peruvians, taking into consideration their culture, beliefs, aspirations, and desires (Escribens, 2012).

With my third child I went to the hospital [for the first time] and I had my checkups, but it was never, never, about sterilization or contraceptive issues; I was pregnant and it was only to see if my son was okay, how my belly was, what I was feeling, and all that. (Ana, November 1, 2018)

Rosa underwent sterilization right after giving birth; she was never asked for her consent or had the opportunity to refuse the TL:

From one moment to another, I fell asleep and when I woke up after one hour, well I saw myself normal, but I felt pain. And a person next to me told me: “We did a tubal ligation,” and I told her: “But why? I have not given my authorization, I am alone.” Then she says: “No, but everything went well.” (Ana, November 1, 2018).

According to the National Women’s Health Report (1999), a woman should always have a clear idea of exactly what to expect from a medical intervention. That is why a woman needs to be informed enough about the surgery to tell the HCP her doubts, thoughts, desires, and ask for more information or refuse to continue with the procedure. More importantly, the doctors should always specify the possible complications, such as infection, bleeding, or reactions to anaesthesia.

**Other medical reason.** Juana went to the hospital because she was not feeling well. She had several exams, but the HCP did not find anything in particular. While she was staying at the hospital, she underwent sterilization. She was very afraid because she was alone; she did not understand what the doctors were doing with her body and why. It is clear that there were not any kind of informed decision, which is a requirement of any correct medical procedure (National Women’s Health Report, 1999).

The next day a nurse showed up when I was hospitalized, in my bed, to tell me: “Ma’am, how many children do you have? How old are you? And how long have you been living here?” I told her everything, without thinking that she was plotting against me. “I have six children, ma’am,” “and how many years?” “I’ve been living here for two years, just two years, recently; but I don’t get used to it, I want to go back to my village, everything is going wrong for me.” [...], I told the doctor: “Doctor, I need to urinate, my belly is hurting, I feel it’s sort of swollen.” “Wait for me, you’ll urinate in a second, in a second,” he told me. So he put a bin under the bed with some catheters. They made me urinate through the catheters, ma’am. I heard how it fell, like a river. So, I finished urinating and the nurse came, there were two nurses, two doctors, I saw all that and he came with a liquid this big, a bottle, they began to clean my whole stomach, I saw a brown thing. I looked up like this, “what are they doing to me? Oh my God,” I say, looking like this. [...] “No, Miss, I’m not well, I said, I feel pain in my belly.” “Then, they will give you an injection to calm you down.” And there I was, crying, “what have they done to me?” At that time, ma’am, I didn’t know what it was, why, where they cut me; I felt such a sting in my belly. I began to cry at that moment, that even until now I think about everything that has happened to me. (Juana, August 17, 2018).

I have presented three scenarios where women were forced into TL. First, as part of a health campaign; second, in the process of giving birth; and third, if they went to the hospital for another health issue. As we can see, in any of these cases their rights and desires were respected; on the contrary, the HCP abused of the power they had in order to accomplish their goals of numbers of women sterilized. We can also analyze this under the biopower and reproductive rights perspective, implying that under the

power structures women's bodies belonged to the men in their lives, and if we consider that the State functions and develops centering its notion of power in male perspectives, it is logical that the forced sterilizations targeted women instead of men (Sifris, 2016). Being their condition of giving birth the main characteristic that the State wanted to control.

### **The use of anaesthesia as a tactic of violence**

Before having a surgical procedure, the anaesthesiologist and the doctor who will operate have to discuss the surgical procedure and anaesthesia-related issues with the patient, prior to the scheduled surgery. In this meeting, patients should express any fears or concerns that they might have (National Women's Health Report, 1999). In these cases, women did not have this space or even any kind of medical exam prior to the intervention, potentially endangering their lives. Some women shared Valentina's experience who said: "It was the first time that I had anaesthesia". (Valentina, December 21, 2018). The medical procedure that they had is still unclear for them, especially with the different news surrounding it (Ballón, 2014).

In addition, another malpractice in the procedure was related to the role of the HCP in the postoperative care. According to the testimonies, they did not receive any kind of help, even while waking up from the anaesthesia. It is important to recognize that there is a medical protocol to follow for these contexts, like being aware of how the patient is going to be moved, because they cannot do it by themselves, even if they are awake (Vargas & Granados, 2016).

We started helping the women, since there wasn't a lot of staff, so there were women who were about to suffocate, because once they got out, they were left alone to react on their own. So, my sister-in-law and I looked after the women to

help them when they reacted, because they got scared with the tube that they had. (Fiorella, November 1, 2018)

The role of the anaesthesia was not only to sedate women, it was also a method of subjection. Women were not familiarized with all the steps of modern medicine or with the effects of analgesics, which is why in some testimonies they narrate these experiences as being dead, not feeling their bodies, not remembering anything or being asleep (CLADEM, 1999).

Yes, you are conscious but you don't feel anything, your body doesn't feel a thing. I saw my baby and after that I feel asleep. It was while I was asleep that the tubal ligation was performed. (Andrea, September 25, 2018).

I was told: "*hijita*<sup>9</sup>, stretch your arm," and they put me an IV, and I was like: "What? What is this for?" "Count to five," they told me, and I began one, two, three, and at three I started to be like that [dozed off]... but I felt how they were cutting me, while I was half asleep I felt it, I was saying ouch, ouch, in my sleep. And then I woke up, but I think that they were not done with the stitches, so I started to scream, it hurt, it hurt. "You have to cooperate, you have to help us, you need to be strong," they told me. (Sara, August 17, 2018).

### **The use of physical force and psychological manipulation**

The HCP had a discriminatory, intimidating, and humiliating treatment towards women. They did not review women's medical history, they did not follow up the postoperative care, they did not warn them about the possible complications, and even indicate as normal signs that deserved medical attention (CLADEM, 1999). All of this is a clear demonstration of rights violation.

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<sup>9</sup> This word can be translated to "my child"

Violence can be used in different ways, it can be physical, but it can also be used for intimidation and coercive acts:

They have been subtle in using us, but forced as people say, “but it hasn’t been forced, or have they put a knife, a weapon?” For people, forced means to violate you, but not the fact that you walked in yourself, but we are going to see under what conditions you have done it. So people don’t see it from that point of view. So, if you went there yourselves, you have done it to yourselves. (Fiorella, November 1, 2018)

While talking to Fiorella, who is also a victim of terrorism, she proposed a very interesting analysis, comparing the coercion by the HCP as a subtle way of terrorism because both of them took away her freedom to decide and the option to protect herself.

Imagine that they tell you now that the contraceptive costs a thousand Soles, how am I going to get that money together if I am earning my minimum salary of 800/900 Soles. How am I going to get that? Where am I going to get my contraceptive if I barely have enough to eat? Like that, I just saw that what they were doing was violence, it was like a disguised terrorism, because in one way or another they were inducing me to take that alternative, I was going to take it no matter what, at that moment I didn’t want to get pregnant, I was scared of pregnancies, but it wasn’t that I didn’t want to have children. (Fiorella, November 1, 2018)

We must highlight that any forced surgery is a violent act and should be punished, however, forced surgery in a setting where women hold less power than doctors—within a society where women’s capacity for pregnancy has been historically used to sanction their exclusion from full citizenship—is more than a simple fact. It is a form of gender-based violence under the domain of biopower that does not hesitate to

use physical force to maintain the nation state's power in the government, being the people in charge the settlers of women's bodies. (Diaz-Tello, 2016).

We were told to shower, I was taken to the operating room and at that moment I started to cry, because I didn't want to, I didn't want the doctors to touch me, I didn't want to, I was nervous. And well they, they grabbed my arm, my feet, they tied me down, and then they cut me. It was like they were cutting a pig, an animal, because that's how we were treated, it wasn't just me, no, I am talking about all the women that went through this. At that time I was not alone, we were over 60 women. (Rosa, September 22, 2018).

I was like "ouch, ouch", but my hand was tied, I couldn't grab anything, and so they gave me a painkiller; I ended up a little bit disoriented, but I was already conscious. After a while, still on the stretcher like we were animals, the lady said "it's done" and they took us to the ambulance; 10, 5, 6 people to take us home. They didn't leave us at the hospital for one hour or two, they sent us home with our pain, just like that. (Sara, August 17, 2018).

On the other hand, the surgical intervention for the TL breaks the "inside world" and makes the person feel that she is no longer complete (Henriquez, Ballón, & Arnillas, n.d.). The way in which HCP intervened, without adequate preparation, stripping them of their clothes, lying, not listening to them, is interpreted as a violent fact. Moreover, an intervention to the body (the cut of the belly) in conditions of total precariousness, without information or any explanation of the procedure, caused panic on women, exacerbated by witnessing the loss of blood, pain, and disorientation; breaking the composition of balance for a good comprehensive health (Henriquez et al., n.d.).

## **Women dealing with the physical consequences of FS**

In the second section of this chapter I will present how women are dealing with the different consequences of FS.

In Peru, we can affirm that health care is still deficient, considering that the public policies do not recognize the diverse and complex situations of getting sick that affects people's bodies. This means that our health care system does not really incorporate intersectionality and intercultural perspectives that can develop a holistic knowledge of our bodies. Undoubtedly, the varied and unique ways of conceiving the body and health of different people are not yet taken into account and, rather, these conceptions are either unknown or excluded for various reasons, including ignorance and prejudice (Ansi3n & Villacorta, 2014).

When talking about surgery and informed consent, it is important to know what to expect beforehand; especially the consequences related to pain, taking into consideration that pain is an inevitable part of surgery. "Pain is the body's way of sending a warning to the brain that it has been damaged and needs attention" (National Women's Health Report, 1999, p. 7). One of the most highlighted consequences that women pointed out was the physical pain they have until now. "Imagine, if when you cut yourself a little bit it hurts, imagine the cut that goes that deep". (Juana, August 17, 2018). I found particularly interesting that when women described their pain, they struggled to find the words and used some terms that are not normally associated with the body. This is a reflection of how we conceive our bodies, plus I believe it is difficult to explain how pain feels, especially within an area of the reproductive system. At the same time, women have embraced their pain as part of their bodies, as something that they carry all the time, but it is not a complete burden because it is part of who they are now.

In reference to the pain, I feel it too, how can I tell you, I don't know how to define it. At first, pain because you feel that something stretches, that there is something stretching, but I think you get used to living with that pain, it becomes a part of you. I couldn't explain it. I wouldn't. Do you understand me? And I couldn't call it pain because it's already part of me, it's mine. (Ana, November 1, 2018)

I can confirm that it feels like two balls. You walk and the pain comes. Look, not to lie, but until today I cough and I feel the tubal ligation and the C-section; it's like a line, the C-section, a line on this side, it seems that the stitches didn't close well and it always drains. (Mariana, September 19, 2018)

Because of the pain they have, they had to learn how to do their activities and struggle with the pain at the same time. This has forced them to connect with their bodies in a way that they did not expect or want.

When I'm walking or I'm making an improper movement, I feel inside like something is being pulled, so I have to stop and move like this, like that, rubbing me, and then it's over. If I'm lying down, I have to turn to the other side, there I feel it gets stuck, so I have to press it, to move it, to move it, and then I can turn around. (Fiorella, November 1, 2018).

Now, I turn our attention to the general background of the women who participated in this research. Even when they underwent sterilizations in urban areas, that does not mean that they are not connected to their own traditions about giving birth, being pregnant, being a mother, and having a family. These cultural traditions do not always follow biomedical perspectives of health. Normally, after a medical procedure, especially after giving birth, women tend to have a period of time to rest and recover their energy (Córdova, personal communication, September 20, 2018). This recovering

space might have different meanings and associations for women, where colours, lights, food and temperature play an important role, even at subconscious level (Ansión & Villacorta, 2014; Córdova, personal communication, September 20, 2018).

Women experience headache and eye pain, which they believe is connected to the effects of anaesthesia, because they started after they underwent sterilization. “I have intense pain and my sight bothers me, which is presumably due to the anaesthesia, the overdose received. And many of my friends have sight problems, for our age” (Luisa, August 15, 2018).

Other consequences related to their bodies is the pain they have in their bones, as if they had lost their strength. Women connect this discomfort to the fact of not feeling young.

Pain is one of the most important things, like there was a decalcification because everything has its period, the body is very wise.[...]. I still have many things to do and when they did this to me, they practically accelerated my old age and not only to me, other women, my friends. Because they cut the hormones, they cut everything. (Mariana, September 19, 2018)

They also described feeling tired and lacking energy to do their normal activities, which was kind of frustrating because most of them had to work a lot to take care of their family, due to the fact that they were single mothers after the separation from their husbands.

[...] not with the same strength and energy that I initially had, because as far as can be expected, I was still young but I felt really tired and I had to push myself due to work, because I had the function of a mother and a worker. (Luisa, August 15, 2018).

When we analyze their testimonies related to the pain, they might seem as individual and disconnected facts; however, the body can react in different ways to a same action. Moreover, there are not many research studies that associate the TL and the physical pain, or reactions in general, under a context of FS. It is possible that adverse effects of TL include uterine bleeding and/or menorrhagia, and physical problems that may lead to reduced ovarian function. In addition, the resultant of hormonal changes can be a risk factor for developing osteoporosis (Wyshak, 2005). As we can see, there is not a clear or unique list of the consequences of FS, which opens a space to question if we need to have an official occidental catalogue of what to expect from this situation in order to believe women.

Women feel frustrated because they do not have a clear sense of what is happening to their bodies and especially, since the HCP do not give them the necessary support to understand how the TL can or cannot impact their bodies.

No, everyone denies it, everyone denies it [the doctors deny that there is a relation with the sterilization]. They say that it has nothing to do with it, that it is only a tension thing. But how can it be tension if it's definitely the hormones of the organism itself that are reacting to it, right? (Luisa, August 15, 2018).

The question remains then: What are the direct consequences of the TL on their health? Specially, from an holistic perspective, where we can connect the effects of the TL on a physical, emotional, social and spiritual level. Unfortunately, when talking about reproductive health in our context, the voice of women expressing pain is not enough to be considered as something real that demands special and immediate care (Gianella, 2014). This makes women doubt their own emotional and physical experiences. This intensifies when we think of women in vulnerable conditions that are the last concern of the Government within the health care system.

Look, uhmm, how to know, how to know, I have so much pain nowadays, in my breasts, my head, that when you go to the doctor and he asks you, right? when you go to the gynecologist he asks you: “was it a normal delivery, an abortion?” And you say it was a tubal ligation. “At what age did you have the tubal ligation?” And you say at 23, “wow, at 23?!” There are different versions, I don’t know if they all have the same thing, but well, due to the tubal ligation at age 23 there will be hormonal changes. Maybe that’s the reason for the headaches that we get, or the bad mood, breast pain. So, I wouldn’t know if that’s why. (Ana, November 1, 2018).

There is a definitive sense that, following the loss of their reproductive capabilities, women identify their bodies as objects, resulting in changes in their psychosocial behaviours. These changes, however, cannot be recognized immediately after the surgery has taken place, they can develop according to women’s experiences in their daily lives and health (Warehime, 2007).

In the workplace as well, many times the feeling of being unable to work, not having a field of work also bothers you, you feel bad, you are like a caged wolf, like a lion locked in a cage that doesn’t know what to do, you just scream and scream and you feel helpless for not being able to get out, for not having freedom. (Luisa, August 15, 2018).

Finally, another consequence is related to the physical changes that they experience because of the TL, the pain and the other health issues. Women mentioned their scars as something notorious in their bodies that did change the way they looked, and they are a clear remainder of the pain.

Look, physically, yes, because you still have a scar that is like another navel, and over the years you start developing the body of an adult woman, so that becomes

a deeper navel. And you have two navels, you don't have one; and at that time I was young, I was 23 years old, I was thin, but for the same reason that I was young I wanted to show my navel sometimes, it was fashion. I couldn't anymore, no, because I was told you have two navels and it was shameful, and my children too, especially the oldest: "Mom, why do you have two navels?" People always bothered me: the two-navel girl. That's on the physical side. (Ana, November 1, 2018)

By tapping into physical consequences now we can question if the RHFPP took into consideration how women could react to the TL and why the Government did not care about the postoperative period. In addition, under reproductive rights perspectives, the involvement of both men and women is considered a key element to the success of family planning programs; however, women were the most obvious target in Peru (Capurchande et al., 2017; CLADEM, 1999). Moreover, these connections mainly reflect how the structure of the execution of the program answered to a male and patriarchal perspective, where the Government tried to silence and make the lives and capabilities of women disappear before, during and after the FS.

### **Women dealing with FS consequences in their identities**

One of the main ideas that women mentioned was the notion of maternity that they find directly linked to the identity of women. Since the option of being a mother was taken away from them, women who underwent sterilization felt different and isolated from other women, like they could not share the connection of womanhood. "You are no longer the same" (Valentina, December 21, 2018).

In addition, as a background culture, women in their reproductive capacities are considered an expression of earth because of their role of harmonization of production. Therefore, there is a devalued conception of a woman who cannot have children, even if

she has had them before (Henriquez et al., n.d.). “My life as a woman is over and I felt lonely, and loneliness is really ugly, especially for me” (Luisa, August 15, 2018).

Likewise, it is important to connect the relation between the notion of motherhood as something that exists as an innate instinct of women that answers to a social and cultural experience, or as a result of a personal choice. Even when we did not discuss this specific subject, they did express their pride and emotion to have raised their children within a context where they had to face the consequences of the FS (Badinter, 1991).

[...] because our function as women of bearing children into the world and maintaining a home is not easy, and our case of having been tied and being sick is much worse, and we are not faking it and the Government has to understand, and the whole world as well, that this was something serious, something that impacted everyone and that we definitely didn't leave, we haven't left, because we have enough of it for a long time (Luisa, August 15, 2018).

The other important struggle that they identify is the notion of family related to how their lives had to change after the FS, not only due to the pain and the separation from their husbands, but to the new structure of their families. Women feel that the State took away from them the option to fulfill a family dream, some of them wanted to have more children, others did not, but they strongly rectify that it was their own decision to make. In Peru, it was normal to expect to have many children, this answers to the logic of risk diversification, to ensure work force for the family, security, opportunities, and resources (Mujica, personal communication, September 10, 2018).

Moreover, until this point we can argue that the role of women in the society is linked to what their bodies can do, and to what the State is going to allow them to do. That is why women's bodies often serve as an hostile and violent location to struggles

over national identity (Sifris, 2016). Therefore, it is normal that in many patriarchal societies, when men supposedly try to protect women's reproductive rights, they are actually controlling it as male property rights.

I want to highlight that when women noticed that their bodies changed in different ways, like the scar, pain, weight gain, etc., it also carried an important meaning for them that made them feel ashamed and afraid of doing their usual activities. More importantly, the dynamic of consequences "among women who have undergone a tubal ligation may go beyond their biologic capacity to conceive" (Warehime, 2007, p. 271).

Something bad? The obesity, because due to this I lost my self-esteem, I haven't felt the same, I've restrained myself from many things, I didn't go to parties or anything. For me, it was like being sick, I wasn't presentable, I didn't feel like that, I was a woman that didn't... I hit rock bottom. (Andrea, September 25, 2018)

On the other hand, a matter of special interest is how women have been dealing with the changes in their bodies and identities at an emotional level to understand their unique stories and value their struggles. They express feelings like depression and anxiety. "And because of this I felt terrible, I was depressed, I wasn't the same person that I used to be". (Andrea, September 25, 2018).

Under this scenario, according to the National Women's Health Report, we should consider the important role that hormones play in a context of reproductive surgery, because of the connection to emotional and physical impacts on women (1999). For example, some women may become depressed, fearful, or angry at their bodies. In addition, the anticipation of being hospitalized and separated from family members increased the tension. There are good reasons why people are anxious and afraid, unfortunately most HCP do not usually understand the emotional suffering that their

patients are going through, which of course increases under forced treatments (National Women's Health Report, 1999).

I have days where I don't have strength for anything, where there's nothing that I want besides sleeping; but then I say no, I have to get up, I have to do things, I have responsibilities, obligations, I have to see my patients and I get up and go, from being lying there to putting it on my back and show something else. (Luisa, August 15, 2018).

That's right, *señorita*. Our joy faded, maybe I would've had 10 children, but I would've been happy, I would've been content. [...] I didn't have to walk around crying, I don't know, things would have been different. (Sara, August 17, 2018)

In some cases, women had a difficult time accepting or embracing their self-concept and self-identity after the FS, considering the pain and all the changes in their bodies. We must understand that, for them, experiencing all of this was like having a new body. Therefore, it is reasonable to consider that in some cases women have the tendency to report a kind of mutilated body image (Warehime, 2007). In two cases they mentioned that in the past they thought about suicide.

It's terrible, I wouldn't wish it to anyone, anyone, anyone, anyone; the things that a man, how far they can go when a woman is useless for them, like leaving with another woman, men are such animals that they prefer sex, sex and not a woman, it's like they were our owners, they want to do and undo. I've been through many things, I've cried because of that, sometimes I even wanted to kill myself due to the things that I've been through, ma'am. Things, things. Only for not being able to read, to satisfy his needs. (Sara, August 17, 2018).

There are hormonal changes, ma'am, that I have lived. Fatal hormonal changes, they came, sometimes I have locked myself in my room to cry, to say my God what has happened to me, why am I like this, why do I feel this way. Sometimes I said: "dear God if you have to pick me up, take me already because I'm suffering a lot," that's what I said, ma'am, sometimes I felt that way, that my life was collapsing. (Juana, August 17, 2018).

Culturally, when the reproductive capacity of women is abruptly broken, this articulated a sense of everything being broken, so the link between woman, earth, nature and identity does not longer exist. And it has very strong social sanctions, like women being called "*machorra*" (being like a man) or "*mule*" (being like a sterile animal), meanings that allude to the loss of the female condition of women (Henriquez et al., n.d.). "You are even afraid to rebuild your life, because you know you can't." (Ana, November 1, 2018)

### **Women dealing with the changes in their relationships with their husbands**

In order to talk about the wellbeing of women under the scenario of FS, we should also include the impact of domestic violence against women. According to Boughima & Benyaich, violence within marriage affects women's autonomy and undermines their potential as individuals and as members of society (2012). We should also understand that after a medical procedure as the TL, their bodies have experienced consequences that are unique to women. In addition to that, rape within marriage, that also carries physical and psychological violence, has consequences such as stretching, bleeding and tearing of the vaginal and anal walls, cystitis, sexually transmitted infections, etc. (Boughima & Benyaich, 2012; Ruch, 1992).

When you have already had a tubal ligation, you don't love yourself, you are not attracted to having proper intercourse with your husband. I had a tubal ligation, I

didn't want anything anymore and my husband told me that maybe I had another partner. He made up everything, he invented things that weren't true, that hurt me deeply. "If I'm living with you, we've had six children, how can you think that I'm going to have another partner, outside of you, don't be mean," I told him. He had me like one, like a trash can, that dumped me, and he didn't pick me up anymore. I felt, if I lived crying; but ma'am, I now stay strong, I stay strong, I don't want to cry anymore, I've cried already, I've been living and crying for a long time. He told me things: "go away, I'm going to kick you out of my house, I'm going to kick you out. I am going to leave for another woman." "Go," I told him, "go away, please leave me alone with my children, go away. Don't make me suffer, why are you doing this to me?" I said. "If you don't want to have intercourse with me!" "So you know why I don't want to, I don't have periods." Sometimes I did have intercourse with him by force. (Juana, August 17, 2018)

It's been many years that I have lived with my husband as a raped and mistreated woman. *Señorita*, my bed was like a box ring, that's what my husband used to say, I was afraid that the night would come because I didn't want him to touch me. God, I wanted to grab him and throw him against the wall, I didn't want to do it, I didn't, I refused and he demanded saying "you are my woman, you have to do it, you have to..." (Sara, August 17, 2018).

When talking about their relationships with their husbands, we also mentioned if their sexual desire changed or not, and how their husbands reacted to that. They said they had a difficult time, because after the TL they did not want to have sex anymore. "When I was going to have sex it was something so painful that you can't stand it". (Mariana, September 19, 2018). That caused a circle of violence and trust issues from

their partners, who believed that women asked for the TL because they had sex with other men and did not want to get pregnant. This results in physical and psychological violence.

I have suffered all that, first, if he was already jealous, when I told him [that I had a tubal ligation] he became more obsessive, he followed me everywhere, he reproached me, I couldn't have girlfriends, I couldn't have male friends, it was a very ugly time [...] so we arrived to the point where we hit each other once. It was ugly; the biggest psychological abuse that I received in my life was this, to be told that I had the tubal ligation to do things, supposedly. (Ana, November 1, 2018).

You don't have sexual desire anymore, that's what I was forgetting. "You no longer have that desire of having intercourse, that's because you have another man out there." Those things have traumatized us a lot, he even hit me. Until I separated from him, because it reached a point where I could no longer tolerate it. I remember he even destroyed my underwear. (Valentina, December 21, 2018).

With all this information, it is reasonable to argue that the TL disrupts the sexual desire in women, and has short and long term emotional effects in their sexual satisfaction. Taking into consideration the effects that it has on the dynamic of their relationships, like rape, physical, and psychological violence (Warehime, 2007). We should not forget that women were forced to suffer these consequences under the direction of the Government that violated their rights and used their bodies as tools to prove that the economy of the country was being handled.

### **Women dealing with the changes in the relationship with their communities**

Our bodies are not just physical substance, they develop in communities and societies that build a projection of what they are socially, politically and culturally. It would be optimal that this construction of who we are becoming happens in a space of freedom, respect, and affections. Unfortunately, these images of us come loaded with sexism, racism, and classism according to the position that we have in the structure of power relations and what we represent for the rest of the people (Paredes, 2014).

In the popular consciousness, the sexuality of women and her relationships are very close related to their capabilities of reproduction, which responds to a form of social control as part of the imposition of the body, naturalizing the “body-reproduction connection”, in the construction of the female subjectivity (Carril, 2002). In the case of women who underwent sterilization, they were a target of gossip insinuating that they were easy and promiscuous women.

Besides there were rumors of the men who talked [...], saying that the women who have these things done is because they are going to betray their husbands, because they want to prostitute themselves, they won't find out this way. So, that's what you heard from other people's mouths. (Fiorella, November 1, 2018).

My mother-in-law, may she rest in peace, and my sisters-in-law, they all started saying “she's got a tubal ligation because she'll surely be with another man.”

They only talked that way, vulgarly: “street women, working girls, they are the only ones who do these things because they want to be with different men, she surely wants to be that way now,” so they were already pointing a finger. (Sara, August 17, 2018).

Some women were afraid of telling someone in their neighborhood about the FS, they were anxious and fearful to be discriminated against by their friends and people

that used to live near them (CLADEM, 1999). They thought people would not believe them, and that the respect that they had in the community would be lost.

I was quiet, I kept quiet about everything so people wouldn't look at me, *señorita*, you know that the people out there are ... they could say the woman is ... so I wouldn't be pointed at more clearly, because they might be talking out there, you know that people think the wrong way about things, in order to avoid that I didn't tell anyone. (Juana, August 17, 2018).

### **How did women realize they underwent sterilizations?**

If women did not have spaces or someone to talk about what had happened to their bodies, it is possible that they did not know their civil rights or how to proceed under the circumstances of violence. Most of them did not know exactly what had happened and they were not sure who the HCP that performed the surgery was (Ballón, 2014).

But since at that time you live far [from the city], you don't get more informed about what happened. But later, when the time passed, all this happened, you sort of start thinking, meditating, and I noticed then that it was something irreversible, right? (Fiorella, November 1, 2018)

Therefore, it is not surprising that women did not realize the implications of the TL for their lives until the subject was mentioned at the end of Fujimori's government in 2000, where he was charged of different crimes. Until that moment they had hoped that the TL could be reversible.

When they released everything, that's when we just realized. Until then we had the hope that this could be reversible, that is, one surgery and another one and I can get pregnant again, but we realized that it wasn't like that, when more information came out. (Fiorella, November 1, 2018).

Another way women realized what have happened to them was a violation of their rights, was when the former President Ollanta created a program in 2016 with the objective to identify how many women underwent sterilizations. Women identified this as an opportunity to tell their stories and ask the Government to take responsibility. Taking into consideration that the body needs and wants to be nurtured, healthy, and loved, this space gave the opportunity for women to understand what had happened to them, with the hope of justice (Paredes, 2014). “After five years I found out that my tubes had been cut. I got engaged to someone, I gave myself the opportunity. But then I was told that I couldn’t have children, never again.”(Carmen, September 30, 2018).

Not at that time, it wasn't like we heard about the sterilizations. No, no, it wasn't around. So when I went to the Ministry of Justice because I had a case, last year, I found the signs there, and a girl who assisted me asked me if I ever had a tubal ligation or sterilization and I said yes. (Mariana, September 19, 2018).

And finally, there was also a group of women who did know that they underwent sterilizations just after giving birth because the HCP told them. However, this does not mean that women understood what this was for and what the consequences were, especially because they did not have time to process what had happened.

It was in the C-section. Well, I found out about that when I was hospitalized, a doctor who visited me asked me: “ma’am, do you have your document?” I told him no. When he went to the next bed I thought about what the doctor wanted my document for. So I called him and I told him: “Doctor, excuse me,” “just a second, yes, *hijita*,” he tells me, “Doctor, what do you need my document for, so when my relatives arrive I can tell them to bring it,” then he said: “You know that you had a tubal ligation and you didn’t sign.” And that’s how I found out. “But why, if I didn’t say that I could have a tubal ligation.” “Well, sweetie, what

can you do?" At that moment I was kind of traumatized, because nobody ever told me that they were going to do that to me. Because we didn't bother anyone, that we had several children, anyone. I didn't bother anyone, we worked in our businesses, our children had food to eat, we preferred to make them eat well, that's why none of the children have been sick. That's how I found out that they performed a tubal ligation. (Valentina, December 21, 2018).

After 11 years I met my second partner who was also young, more or less, he was 31 and I was 31 as well; and that's when I found out, since he wanted to have children, that my tubal ligation was not reversible, [...], and I found out that there was no going back, as people say. (Luisa, August 15, 2018)

## **Chapter 5: Resilience: Women's voices asking for justice**

“They have used our bodies. What a thirst for justice. The number of homes that were destroyed.” (Carmen, September 30, 2018).

After presenting how women were targeted for FS and their daily struggle with their physical and emotional consequences, I now turn to the requests and actions of women demanding the accountability of the State.

In order to do that, I will analyze the demands of women who underwent sterilizations, which were related to justice, health and economy. Then, I will present their thoughts about social movements and NGOs working on the subject of FS. Finally, I will describe how they feel and what they think about the government and the health care system in Peru. With this analysis, I will try to connect the implications of the mechanisms for the control and regulation of their bodies and the idea that they are active women claiming for justice, despite their physical and emotional pain. Taking this into consideration, within Foucault's biopower framework, we can reflect on the strategies employed by women to resist encroachments on their bodies and lives (Deveaux, 1994). Especially, from a resilience perspective that “encompasses notions of competence, perseverance, hope, optimism, and flexibility” in women's responses to gender related oppressive experiences (Szymanski & Feltman, 2014).

Before we proceed, it is important to reflect on the associations between an individual experience and an embodied social experience. In other words, we need to consider how our bodies carry emotions, thoughts, and facts that can have effects on the social and cultural structures to which we belong (Escribens, Portla, Ruiz, & Velázquez, 2008), and more interestingly, in the collective memory that helps us relate to a shared past (Glăveanu, 2017). Including the different ways in which our culture context can

help build the notion of resilience as something to “posit that despite negative live events, health and well-being are possible” (Fava & Bay-Cheng, 2013).

And this Government definitely has to give us an answer, because we can't stay like this. We can't stay like this forever; and the day when a favourable response comes out for us, it is going to be a gratifying satisfaction for us, physically and spiritually; not for the money, but because we will say that we have done justice, justice has been done in the name of all the victims, even those who are dead.

(Luisa, August 15, 2018)

### **Women demanding justice**

When I asked women about the idea of justice that they have regarding the FS, their answers focused on the notion of responsibility, not only in the legal repercussions or the concepts of blame and liability (Young, 2006). They want the State to accept the role they played in the FS in order to apologize to women. From this perspective, responsibility is understood as a sense of moral right that encourages the government to respect agents as individuals and expects them to behave in respectful ways towards others (Young, 2006).

I believe, I think the Government should apologize. The Government of Fujimori, they too, right? in their conscience they must say, you know what, we have done wrong, we recognize that we have acted in an incorrect way, perhaps justify that the idea of the State was good, but no, but we haven't done it in a proper way; and apologize to people, to consider us as victims and find a way of how we can be compensated. I think that is the way to be able to reconcile.

(Fiorella, November 1, 2018)

Women are not asking for formal apologies, they want the State to really examine and understand that what they did was wrong. It is a matter of dignity; they

want to be treated as equals, because in all of the process of FS they were perceived as inferiors, as people without rights, desires, and voices (Córdova, personal communication, September 20, 2018). Women consider that if this happens, it would be acknowledging not only their accountability, but also accepting that all their suffering and claims were always true, that they did not invent any of that. With all this, the path for forgiveness can be initiated by the State (Córdova, personal communication, September 20, 2018).

Imagine, who wouldn't, when you apologize to someone and you do it sincerely, who wouldn't forgive you? For example, I don't want jail, the thing is that that person recognizes, recognizes his fault and says: "You know what? I will see how we can improve this so it never happens again." And in Peru there are many people who are hurt, not because of the way we have been treated, we have been treated in an inhuman way, they have done all this at that time, because it wasn't something that you are and you die, what do I care, I'll do it; and then there were incentives that each doctor earned for each sterilized woman, they received some sort of bonus, in order to earn something extra, so they had to find the way of persuading people. That's what they said later, that they were earning, and now, for example, if that had been a good plan, if it was good, why don't they continue to do the same thing? (Fiorella, November 1, 2018)

At least, it needs to be acknowledged, they need to apologize. Just like it happened with the [internal] conflict, they need to apologize. Everyone needs to know that an abuse was committed; it needs to be done in writing, apologizing for the case, just like it was done with the victims of terrorism. (Andrea, September 25, 2018)

If we question why it is so important for women that the government accepts its fault, it is because since the moment they underwent sterilizations, the Government and its representatives have been trying to silence their stories and eliminate any kind of evidence, including the consequences on their bodies (Henriquez et al., n.d.). That is why the case of FS has been filed a couple of times; moreover, it is not possible to know exactly how many women who underwent sterilizations acknowledge that this happened to them. An apology from the government is meant to recognize women and grant them the category of subjects with rights. This means that they will share the same value, and the State should not be able to violate their human rights (Escribens et al., 2008).

In this context, social memory has a significant meaning for women because it can help to validate their collective narratives of their suffering. Therefore, they can fight the silence enforced by the State and the social amnesia which constantly threatens to consume the memory and underestimates their struggle (Henry, 2012). “What I really hope is that they listen.” (Ana, November 1, 2018)

The Government had spread that the sterilizations were a lie, for people to believe it, that it was a lie, that everyone had signed consents and that it was no longer valid, it's a lie. They say that it is something that people want to do against Fujimori. (Andrea, September 25, 2018).

One of the things that women mentioned a lot, and that can be considered as something simple, is their desire to be listened by the Government and the society. They believe that if there is a space where they can tell their stories, other people will help them to find justice, or at least people can know and understand that the FS were real. (Andrea, September 25, 2018).

However, they know –because of their own experiences– that their testimonies and bodies will not be enough proof, so they told me that they have been thinking that the State should implement a medical process to examine women and verify that they were indeed forced.

Look, let's clarify this, if they were really [sterilized], the Minister of Health, all women have to go through an evaluation, the health posts need to make this big, the health posts need to see the complaints, if anyone has felt affected, if they have had a tubal ligation without their consent. So, it starts to spread, everyone knows each other and it spreads, but no, it's like there's something that won't allow it. Now I say, well, some say that it's because of that Government, but I say, why didn't the other Governments. (Mariana, September 19, 2018).

As we can see, women are thinking about different ways they can prove that what happened to them is real, that they are not lying, and that they just want justice “We ask for justice, nothing else, justice for all the damaged people that is us”. (Sara, August 17, 2018). However, the resistance to the case of FS in Peru is the result of the interaction of a sum of actors - sometimes fragmented among themselves, which makes more difficult for women to be believed (Tamayo, 2014). Especially if we analyze this under an intersectionality lens, where gender, along with race and class, marks identities and values them in specific ways, which have repercussions on their participation in the construction of the social memory. In addition, gender is an important dimension of power relations related to the decisions of what a culture remembers and what it chooses to forget (Henry, 2012).

On the other hand, women want that not only Peruvians acknowledge what happened to them, they also consider important that other countries and abroad institutions should have this information. They believe that this can be a strategy to

pressure our Government to take actions. I find this very interesting, because they want to spread the word of the consequences of FS to ask for justice and to communicate their stories in order to change their future embracing their past (Glăveanu, 2017).

This is not only being seen here in Peru, that many times they don't pay attention to us, but they hear us abroad and that is a voice, a strong echo for Peru to realize that if they don't pay attention to us, the whole world supports us and will support us, so they give us an answer to what is fair and necessary to those of us who have been victims, whose rights as women, as mothers and as persons have been violated. (Luisa, August 15, 2018)

When I was about to finish her interview, Mariana told me that she hoped that this investigation could at least inform people in the faculty about the problem and reality of Peru.

Well, I would tell you that your thesis serves so that at least those of your faculty take into account that there truly are cases, and emphasize that they didn't always occur until 2000, until 2001. And that many women still don't know, because it hasn't been spread [the announcement of REVIESFO]. But above all, that your faculty becomes aware that there were forced sterilizations. (Mariana, September 19, 2018)

### **Women demanding a better health treatment**

The other claim women mentioned to me was the improvement of the health care system, especially to treat the pain and problems that they have because of the FS. They are conscious that this will not solve what happened to them, but at least this could improve their quality of lives.

We are asking them [the Government] to help us, at least to be able to heal the pain we have because of the tubal ligation, that's what we are asking. When they

compensate us, ma'am, we are going to be thankful. Although we are damaged of all this and we are not going to heal, but at least to be able to live, they need to give us for our medicine at least, to have insurance, in order to be healed.

President Fujimori needs to become aware of our case, that's what we are asking for, that he takes responsibility for all the people that are damaged, at this moment we are not going to heal anymore, we are going to die like this. (Juana, August 17, 2018)

Moreover, they claim for a special attention in the hospital, considering that the health system in Peru is deficient and sometime a medical appointment can take months. They feel that, currently they continue to be treated as non-important people, because they are still suffering all the pain, without any real help from the Government. "Yes, yes, the medical attention needs to be at least specialized, that we can get there and be assisted, instead of waiting for a thousand hours or a thousand days, because it really hurts that we are mistreated like that". (Ana, November 1, 2018).

They are also worried that getting old will mean to have more pain and more health issues, plus the fact that they do not have a lot of strength to work because of the pain, they consider that the Government should help them with three things. "We need the Government to respond to three things: health, housing and compensation. Like a pension for our old age, it's three points that will interest the people, why something else; that's what the human being needs". (Fiorella, November 1, 2018).

When the power relations are so unequal, people who are in vulnerable situations are more likely to assimilate the stigmatized notion of themselves that is promoted by those in power (Escribens et al., 2008). However, the women that I talked to, even when they are still dealing with the feeling of guilt for what happened to them,

really understand that the FSs were a violation of their rights and they are confident that justice is a fair thing to ask.

### **Women demanding economic improvements**

Money is one of the things they would want to receive as part of the reparation, which makes completely sense taking into consideration that they are not able to work as they used to, because of the pain that also caused marital separations, being women the only responsible parties for the financial income and the family care.

It could be an economic compensation; the congressmen need to set that, just like they did with the victims of terrorism. Set an amount, right? Even if it's not much, but they need to set it (Andrea, September 25, 2018).

They know that money will not actually help them to overcome all what they have been through, but it would help them to pay their treatments or with their financial security.

Women were very clear that they were not just asking for money, but they find it important because they connect that their current financial status is not what they would have wanted, but they could not work as much as they wanted after the FS. "If money is the problem to accept this, why don't they give us lands, work? There are women who died with that hope". (Carmen, September 30, 2018).

We are asking for a compensation, *señorita*, but not even the money will erase these marks, these scars that we have in our souls, the pain that we carry in our souls for what we've been through, for every single thing that we've lived.

(Sara, August 17, 2018).

### **Women's thoughts about public activities and NGOs**

Women's will to fight for their rights is ultimately a demonstration of citizenship, that they are executing in different ways (Richards, 2003)—talking about the FS, gathering with other women to talk or to get organized to ask for justice. There is,

however, a difference between what women are willing to tell and share with the society after an event of rights violation and what the public is willing to hear and accept as true, which is a dichotomy that will persist in the activism (Million, 2013).

Activism is one of the methods that women in Latin America have developed to achieve representation of women's rights, and demand action from their government and interest from the public (Richards, 2003). During the last decade, there has been a close relationship between activists and women who underwent sterilizations, especially through art and memory (Henriquez et al., n.d.). Moreover, activism can be triggered by different kinds of emotions, from indignation for the experience of injustice to compassion by identification with a problem (Hodgson & Brooks, 2007).

Some women told me that they consider it important to participate in different actions of organization's activism, because they can connect with other women and ask for justice and help from the NGOs; however, other women do not find activism as something that can help them. For this group of women, activism focus on public demonstration (march), and they rather focus their time and energy on developing better alliances with other victims in order to establish a formal group of victims of FS.

I see, for example, that everything is set like a mafia, do you think that even if there is one march after another, do you think that this will have good results for us? It won't proceed. I mean, I'm going to spend my energy, a lot of things, and this is not going to happen because everyone is in collusion there (Fiorella, November 1, 2018)

I do agree with the marches, I agree with the fact that they protest, that they demand, that justice is done for all the people who have been affected or who have been victims, but the way they are doing it doesn't seem right to me, it doesn't; they are forming groups in different places and they are simply asking

for help for that group, they are not asking, they are not analyzing the whole group. (Ana, November 1, 2018).

Moreover, when they mentioned the work of some NGOs that focus on victims of FS, they do not understand where the results are. They told me that after all this time women need actions, not just conversations and promises. Even when they know that NGOs have no responsibility on political decisions, there is a feeling of frustration and tiredness of the promises. “So, where is the help from the NGOs and, we’ve had interviews, the few NGOs that there are, it’s only to talk”. (Andrea, September 25, 2018).

I have also noticed that in the NGOs there are many people [participating], but I don’t know to what extent their life may have changed, I would have to ask how it has benefited them, if something has changed in their life and if they feel strengthened or healthy, cured, if they feel safe. (Fiorella, November 1, 2018).

In addition, they have identified that in some cases victims are not members of the NGOs, this makes them question how do they know what is better or what are the needs of the women who underwent sterilizations. They do not feel that in this case the NGOs really care about them. I believe these statements are important so the NGOs can improve the way they communicate with women, taking into consideration that women have elaborated a discourse and strategies related to their rights and justice (Henriquez et al., n.d.).

I don’t know, I don’t know to what extent all this, all these institutions that do that, because there are institutions that are not even victims and sometimes I start thinking, how can you get into this and this if you have never been a victim. (Fiorella, November 1, 2018).

## **Women speaking up**

Women have an urge to tell their truth, so their stories are not erased and people can understand what really happened to them. Moreover, it is important to reflect on the struggle that women have experienced facing the facts that they underwent sterilizations and the consequences. There are various factors that interweave to prevent breaking the silence of any kind of violence, the fear, the stigma, and the honour put in doubt; the institutionalized suspicion, the stigma of being a victim of violence, denial, among others. As we can analyze from their testimonies, women have experienced all of these; however, they have also decided to speak up and claim for justice, even though this means to deal with situations that are probably going to make the experience even more painful due to lack of judges with sensitivity, lack of professional support and a hostile system that is prepared to protect men at all costs (Escribens et al., 2008). “We can no longer keep quiet, we already need to go live and tell everything we’ve been through”. (Rosa, September 22, 2018)

At this point, I have mentioned social memory as a tool that helps develop collective narratives of their own struggles (Henry, 2012). Now, I would like to introduce the concept of collective memory as a phenomenon that facilitates a shared understanding of a particular emotional event that elicits different levels of empathy in the group members who experienced the event from different emotional views. Moreover, the overlapping memories develop specific information for their cultural, political or group identities, thereby facilitating communication and social bonding (Maswood, Rasmussen, & Rajaram, 2019).

A while ago, I opened up about my issue, I never talked to anyone, I just kept everything that I went through to myself. And that’s how, in God’s hands, I ended up opening up. Nowadays, I am no longer afraid of opening up, I am no

longer afraid of telling everything, no. Let people know, the women as well, that the things that happen to us are not kept behind. (Rosa, September 22, 2018).

According to Glăveanu, the collective memory helps us to design our relations as individuals and communities, connected to the collective past. “This past includes events or circumstances that shape entire communities or societies. So, in this sense, what is ‘collective’ here is the past, rather than the actor doing the ‘remembering’” (Glăveanu, 2017, p. 256). This means that in the case of the FS, the collective memory is not based on the individual stories of women and their bodies, it is based on the actions of the nation state to eliminate vulnerable, poor, and rural women’s capabilities of reproduction. Therefore, collective memory is useful in the understanding of the critical relationship among the individual, social, political, and cultural dynamics (Henry, 2012).

**Remembering the FS to prevent them from happening again.** The problem of remembering will become important as cultural structure replaces communicative memory; in this case, the question of how a tragedy should be remembered (Niven, 2004). Plus, we should take into consideration the construction of our emotional and moral engagement with the past, our roles in the conflict, and the violation of human rights; thereby, reflecting how the past can become a matter of interest of the present (Irwin-Zarecka, 2009).

Women mentioned that they wanted to talk about this in order for people to know what happened, but also to prevent other women from suffering the same consequences they went through, just because they were in vulnerable situations. They believe that telling the truth is a great way to sensitize people, so they can be aware of future reproductive programs.

So, to raise some awareness, organize talks, to talk about how to act, probably many fell into the trap and said yes, others like me, that despite saying no they still did it, at that moment I couldn't run, it was not possible to scream, I couldn't do anything, but what to do, right? How to help the town so they won't fall into this, and to train and train, because I think it would have been a good government plan if it had been with the people who were trained, and the person would have said yes, I want to, and others no. (Ana, November 1, 2018).

In addition, we have to keep in mind that memory validates the experiences and identities of victims, and it does not mean to focus only on the past, it flourishes to connect the past with the present in order to identify what facts keep repeating (Henry, 2012; Escribens et al., 2008). In addition, I believe that remembering and rethinking history is also a way of regaining identity, and it can be an enriching process. Even though it can be painful because of the resistances of the population and the male state that constantly develop an opposed memory (Escribens et al., 2008). That is why the active memory of civil society plays a very important role in the awareness and transmission of knowledge about the methodologies in which contemporary eugenics operate, not only co-opting for a feminist discourse, but also for the discourse of human rights and development. (Ballón, 2014)

### **Alberto Fujimori: Responsibility and pardon**

On Christmas Eve 2017, former President Pedro Pablo Kuczynski granted a pardon on health grounds to lift the 25-year sentence that Fujimori had been serving for corruption and authorizing death squad killings related to terrorism (Collyns, 2017). There was a big commotion between Peruvians and organizations that refused to accept the presidential pardon as a legitimate decision from the government. However, nine months later, the country's Supreme Court determined that Fujimori must complete his

25-year jail sentence for authorizing death squads, overseeing rampant corruption, and vote-rigging. (Collyns, 2018).

I remember that this news came out the day after I had an interview with a participant. It was a surprise for us, especially because we were talking about how unfair it was that Fujimori had not been charged for the FS and we thought that he would not go back to jail. This decision was very well received by the social organizations and groups of people fighting to stop corruption.

In the interviews I asked women what were their thoughts and feelings about the pardon that Fujimori received. This moment was unique, because I had the opportunity to listen and understand what their reactions were, considering that they are not identified as victims of FS by any entity of the government in Peru. The feeling that they all shared after the presidential pardon was hopelessness, because it showed that the current Government was not interested in helping women or any person who was suffering the consequences of Fujimori's government.

Luisa told me they feel:

With lack of hope, because we ask ourselves: Will they give us an answer? Will they do justice? Will they see our case? Will we ever be compensated? And even if we are compensated, it won't be much compared to the psychological damage, our body, our future with our children and everything. (Luisa, August 15, 2018).

Some of them highlighted that this kind of decision and the FS were just symptoms of a structure of power, money and politics that proved that Fujimori's priorities were related to make more money at all cost, without thinking in the consequences for women.

Unfortunately, it was a bad experience for me, for example with the government of PPK [Pedro Pablo Kuczynski], he sold out so he could remain in the power,

as a President, to have accepted the extortion from the Fujimoristas so they would let Fujimori out and leave our whole case in stand-by. We had already moved forward, we are more than 2000 that had already registered, and we are more now. (Luisa, August 15, 2018).

Other women focused on the setback this meant for their own resistance and fight for justice. Since Fujimori's resignation, his party and ministers have maintained that surgical contraception as an 'informed choice', and that surgical procedures were never carried out against women's wills. During an interview on national television to a congressman, Rafael Rey, he clarified "Women were *not* sterilized against their will," he said emphatically. 'They may have been sterilized *without their consent* but *not against their will.*'" (Olivera, 2016, p. 32). This poor choice of words is just an example of the rationalizing by the people that sympathize with the party of Fujimori, and how little knowledge some people have about women in poor and vulnerable conditions. "Sorrow, crying. How they blocked everything so the case of forced sterilizations didn't come out. There is a lot of money in the way, there are interests in the elections". (Carmen, September 30, 2018).

As we can notice, the action of giving the presidential pardon to Fujimori under a suspicious context revived the feelings of unfairness, insecurity, and shame for women. Moreover, according to the "Forced Sterilization Final Report", there is evidence that proves the damage to the physical and psychological integrity, to the individual freedom of the people, and the selective reduction of births in a specific social group (Subcomision investigadora AQV, 2002). All of this makes women feel like objects with no value or power in their decision-making.

The Government of that time put us into an economic chaos. Them, who call themselves saviours of terrorism, but deep down what they've done is to have us

as slaves, all subordinates, and we were like that, we couldn't progress; we got stuck, until we had another President.

The Government of that time saw us as people that only procreated. In fact, President Fujimori thought that the problem of Peru was the hyperinflation [overpopulation] and that was not the case, wasn't it? Because there are many countries with a lot of population that have a different quality of life, the number of children has nothing to do with it. When there are good jobs, all the economic needs are met; that was a lie. (Andrea, September 25, 2018).

### **Women's perception of the Health Care System**

Until this point we have reflected on the Government's and Fujimori's responsibility. Now, I want to turn our attention to the role of HCP in the problem of FS. Women mentioned that the nurses, doctors and other health professionals should be held responsible for their own actions.

Until this day, the Government has denied the existence of monthly quotas and incentives for HCP, and the creation of clandestine health facilities to operate. Fujimori's daughter, Keiko Fujimori, who almost won Peru's presidential election in June 2016, has chosen to put the blame on 'irresponsible doctors'. However, outraged by her remarks, Peru's Medical Association released an unequivocal public statement pointing out that during Fujimori's regime there was an imposed TL program with monthly quotas, incentives, and sanctions against the will of thousands of women who were poor. These TL were performed in inadequate conditions and they were part of Fujimori's anti-poverty and health-reform policies (Olivera, 2016).

Today we already know why this whole macabre government plan was made, that they simply let themselves be led by the money, to earn a little more, because we know that there were incentives for each doctor to attract more

people, so they are awful people who are not worth it, they are people who should ... if I knew who the doctor was I would fight to send him to jail, those people don't deserve to be free. Well, if at some point there is divine justice, which I hope there is, because they really deserve it, because they harm families, they harm the person, they take advantage of people's ignorance. (Ana, November 1, 2018).

With all of this, it looks like it was almost impossible not to have the TL if you were a woman of poor conditions; it was almost like all the system was against them. With this idea, we can reflect on how public policies can be coercive and located in the field of rights violations, like in the case of FS that happened in a context of structural violence against specific groups of women (Henriquez et al., n.d.; Tamayo, 2014). This is important because it allows us to consider that the implementation of TL was indeed very well connected to national and international interests, with the aim to silence specific women's bodies.

According to the "Forced Sterilization Final Report", the FS can be categorized as an "international crime" and crime against humanity, taking into consideration that the process of TL denied reproductive rights to a specific human group, which constitutes the most serious violation of human rights (Subcomision investigadora AQV, 2002). In addition, this case lies on one of the classes of genocide, consisting of actions that prevent the reproduction of a group (either through castration, sterilization, forced use of contraceptives, forced abortions, separation of sexes or prohibitions of marriage).

Genocide, for me it's genocidal, because poverty is not reduced by killing people. Poverty is reduced with more work, with people working, by paying them more and having their children free, but not by reducing or mutilating

bodies. And that one is genocide, but neither the Government nor the other Governments have taken care of denouncing it, because nowadays we see that the prosecutors are practically bought. So, when will the lawsuit come out, we hope that justice will come one day, because poverty can't be reduced like that. (Mariana, September 19, 2018).

On the other hand, one of the most interesting things that came out from the conversations was the idea of how we acknowledge our bodies in a context of what it means to be healthy and happy from women in vulnerable conditions and the HCP. Under this scenario, as we analyzed in the previous chapter, women had to relearn how to love and respect their “new” body. It was something the HCP forced them to do, because they never gave the space for women to express their desires and consents. Women connected all this with the idea of justice and care for their bodies (Escribens et al., 2008). “There must be justice; we have to raise awareness that the body of each of us is sacred, as they say”. (Mariana, September 19, 2018).

### **Women's opinions about REVIESFO**

The REVIESFO's (Registro Único de Víctimas de Esterilizaciones Forzadas - Single Registry of Victims of Forced Sterilizations) purpose is to identify the number of people who underwent forced sterilizations during the period 1995 – 2001. This program created in 2015 included legal advice and sponsorship for victims, a complete health care treatment through the Integral System of Health, psychological care and social assistance (Henriquez et al., n.d.). All the women who participated in this research had a different kind of contact with this program, that even when it looks complete, taking into consideration the legal and health aid that it promoted, women had very important and valid points to consider for a better implementation of the communication and process of the registration.

**Women registered by chance.**

I registered when I found out. I found out purely by chance, my husband and I were passing by the San Martin square, and there was a sign that said REVIESFO. So, the one who noticed was my husband, he said: "look". My husband checked it out, a registry of victims, and he told me: "Look, they are registering those who were sterilized," and that's when it got my attention, and I said: "Let's find out what it's about," and the psychologist and the lawyer told me: "Well, you have been a victim," "Yes," I told them, "Can I register?" "Of course," she told me. So, I signed up and I saw a medical examiner; obviously, the medical examiner saw me, I laid down, he saw the scar and, well, I gave the exact data as well, the dates and everything. That's where I found out. (Ana, November 1, 2018).

The majority of participants of this research told me that they did not know that REVIESFO existed; they registered their cases by chance. Some of them were in public spaces or in State's offices for different reasons, when the staff in charge of the registration approached them to ask if they had had a TL and how it happened. The first thing they did was to get us examined by a doctor that had to confirm whether they underwent sterilizations.

In 2016 I went to the MINJUS [Ministry of Justice] accompanying someone and because I wanted to ask some things. Two ladies who work for the MIMP approached me, they gave me a brochure; they were recruiting victims of forced sterilizations. I asked: "What's this about? I don't understand, in the time of Alberto Fujimori, were there women who were sterilized without their consent?" I felt that someone was finally listening to me; I didn't know how to defend myself. I was tricked, I had rights. (Carmen, September 30, 2018).

At this point, it is important to recognize that REVIESFO symbolizes the first step of the Government to accept the FS, and for women it is the first space where they are believed and it is recognized that their rights were violated. However, according to the testimonies, it appears that the registration was just a formality without real desires of changing something or helping women. Moreover, this kind of process that requires victims to tell their stories may have psychological consequences; on one hand it can lead to emotional closure and it can also provide a way for victims to publicly reestablish their threatened personhood and to rebuild respect; on the other hand, if there is not a proper guide to help with the process, women may be dealing with revictimization treatments (Westlund, 2018).

There is, however, also an important feeling of community that emerged amongst the persons that went to some workshops organized by REVIESFO. Being able to talk about what happened to them and share their testimonies with women that are facing the same things brings a sense of security, with the option to regain their social acceptance and stop blaming themselves. This is significant because the feeling of stigma and the loss of self-esteem are sensations that can be sustained over the years and the only way to recover is through reparation and justice (Escribens et al., 2008).

I didn't know before, I didn't think that I would find friends with these people who have taught me to move on. I was locked up in a house, as I always say, it was closed with a lock and when they came they have opened the door of my heart and my thought, everything was gone, ma'am. Right now, I'm moving on, I know my friends, several friends, I know the doctors, the young ladies who helped us, thanks to them, they have helped us a lot, I am very grateful to everyone, first to God and then to them. (Juana, August 17, 2018)

After some time that women attended the workshop offered as part of the REVIESFO, they felt that it did not make sense to keep attending if at the end there is not justice. Until now, they have not received any effective responses about their legal cases. Plus, the program only lasted one year; then, when Pedro Pablo Kuczynski was elected president, there was no budget assigned for REVIESFO, so now the program can only register people.

And one day I told them that this looked like an entertainment<sup>10</sup> centre, because in reality, if you don't see an improvement, if you don't go to the Ministry to be checked and if you don't see justice, what is left, entertainment! We were only given one year in 2016, until 2017, that's why I feel it as entertainment. This year, nothing more. (Mariana, September 19, 2018)

In addition, some women told me that they noticed that the people who were in charge of the workshops looked like they really wanted to help women; however, after a while, they realized that at the end these workers were part of the State, so they had to obey certain decisions. Thereby, their expectations did not get higher.

The managers wanted to do a lot, but they were limited. They divided us by sectors. [...] REVIESFO is from the State, and the State will never go against the State. So far, there is no complaint. There is no public prosecutor who dares. (Carmen, September 30, 2018).

Unfortunately, some women that I interviewed had bad experiences in REVIESFO, especially when talking with people in charge about their consent forms and the legal process. The case of Carmen proves that the working staff was not well prepared to deal and give the proper orientation to women who underwent sterilization.

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<sup>10</sup> Mariana used the word *entertainment* to explain that the government designed the REVIESFO as a distraction for victims, to made them believe that they were trying to solve their problems.

She had to deal with government representatives and their biases, and due to a paternalist context, she finally decided not to go back.

The lawyer said to me: “Well ma’am, the truth is that this is no supporting evidence. If you have signed for voluntary surgical contraception, it is better that you disappear from REVIESFO, you could be sued by the State.” I shed tears. I was there for two years and she tells me that it wasn’t evidence, I’m out of this. (Carmen, September 30, 2018).

As we can noticed, after almost 20 years after the FS, the Peruvian justice and health system keeps failing women in their path of recovery; however, instead of giving up, women who underwent sterilizations and participated in this research have developed an incredible power of resilience to overcome their struggles.

Moreover, the understanding of justice by these women has a broader definition that does not focus only on who is responsible for carrying out the RHFPP. They understand justice as a way in which they can get a sincere apology and recognition by the government in order to prevent these events from happening again. Plus, they believe that if they speak up they can help to protect other women.

## **Chapter 6: Conclusions: Women's stories and experiences**

Throughout this dissertation I have presented the stories and experiences of women who underwent sterilizations, they have expressed their feelings, thoughts, pains; and how they have overcome their different physical and emotional struggles. Moreover, the aim of this research was to develop another space, in academia, to value, respect, and trust their voices, in order to contribute to the knowledge about this topic and to the collective memory of Peruvians.

The objective of this research was to understand how the RHFPP was developed and implemented, targeting women in poor and vulnerable conditions. Especially, since the moment they were contacted by the HCP, until the different struggles they are facing as consequences of the FS. This means to describe how women were introduced to the medical procedure of TL, to identify the main consequences—cultural, economic and personal—that women experienced after the TL, and to explore how women have been developing their resilience.

In order to address these issues, I have focused my analysis on feminist notions of biopolitics, intersectionality, and reproductive health. I have also used a qualitative feminist methodology based on interviews. With this method I have tried to cocreate a safe space where women who underwent sterilizations express their ideas and feelings.

The implementation of the RHFPP that turned out in FSs answered to two variables: the political and economic instability of the country, and, the international movement that promoted a basic Malthusian demographic policies. Hence, under the heteropatriarchy and the settler colonial perspective, women – especially women in poor and vulnerable conditions – did not fit under its standards of development, citizenship, beauty, and the idea of being a mother who would guide her children towards the path of a settler colonial society. That is why, their bodies were sexualized

and perceived as dirty and impure (Million, 2013). The government, therefore, established TL goals that HCP had to accomplish, resulting in coercive campaigns from the government to the HCP, and from the HCP to women. Moreover, the HCP developed different kinds of strategies to enforce women to “accept” the TL.

Under the presumption of a heteropaternalist society, women were not supposed to have enough intelligence and power to make their decisions, or be conscious of their bodies (Arvin, Tuck & Morrill, 2013). Under this scenario, women were perceived as naïve, confused, and as objects with uterus that could be controlled by the State, especially on topics related to their sexuality. That is why, the RHFPP did not pay attention to the process of asking consent to women before the medical procedure. Moreover, the health care system functioned for the government interests instead of women’s health, bodies, desires and culture.

The FS caused different kind of consequences on women’s health, identity and relations, that at the same time generated severe traumas and more rights violations, especially from their partners. All of this has changed their own perceptions of themselves, therefore they had a long process to build and to recognize their *new identities*, considering that some characteristics of their womanhood have changed. Furthermore, their experiences are considered as an alternative truth as there is no formal space that has recognized the FS as a program conducted by the government (Ballón, 2014).

After all these years, women have learned to live with trauma as part of the contemporary settler colonial society, where they have articulated the pain and violence of the FS that are reinforced in the context of a biopower state (Arvin, Tuck & Morrill, 2013). Moreover, even with all the bad medical conditions of the TL, women are still refusing to *disappear*, they have been struggling to speak up about the violence that

they experienced, fighting to be the storyteller of their own history and self-determination, so they can overcome the trauma and leave aside the stigma of victims (Million, 2013).

Finally, future research on the relation between women and biopolitics, in the context of Peru and social programs, implemented in recent years, might be necessary to acknowledge if there is a connecting thread between women in vulnerable positions with policies that aim to control them. Moreover, the understanding of how politics related to health issues have or not have included the perspective of women or culture, can give us a general view of the priorities of the governments.

Another course of research might follow how the reproductive health is being managed in Peru, and its relations with indigenous women, and women in poor conditions. Taking into consideration other variables like culture, traditions, geography, and gender, we can improve our understanding on how much a body is valuable depending of its characteristics.

In addition, it is necessary to do more research related to how many women and men have or have not realized that they underwent sterilizations between 1995 and 2001, in order to recognize all the population that had been targeted by the Government. Plus, it is also important to do research focus on the HCP, to fill in some of the gaps of our understanding of how and why they perform the FS, and their own struggles with it.

Likewise, it might be important to do more research on the emotional and physical consequences of the TL and FS, including variables like culture, traditions, gender and social dynamics. In order to have a better understanding of how this medical interventions can have effects on women's daily lives.

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