THE MEANINGS OF SOBREPARTO: POSTPARTUM ILLNESS AND EMBODIMENT OF EMOTIONS AMONG ANDEAN MIGRANTS IN SANTA CRUZ DE LA SIERRA, BOLIVIA

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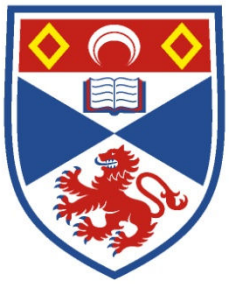
The meanings of *sobreparto*: Postpartum illness and embodiment of emotions among Andean migrants in Santa Cruz de la Sierra, Bolivia

Karolina Kuberska



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ABSTRACT

This thesis concerns a postpartum condition known as *sobreparto* among female Andean migrants in the lowland city of Santa Cruz de la Sierra, Bolivia. While *sobreparto* is a traditionally Andean illness, its occurrence in the lowland city of Santa Cruz opens up new dimensions of analysis. In addition to exposing transformations of the traditional understandings of health, illness, and the body, the study of this phenomenon in an atypical setting sheds new light on issues such as migration, social networks, biomedicalisation, or gender patterns. By means of narratives of lives interrupted by *sobreparto*, it is possible to locate this condition within a wider frame of life trajectories, exposing motifs beyond the temporarily dysfunctional body. I argue that the narratives of *sobreparto* can be used as a springboard for a study of transformations in the understandings of motherhood and womanhood, migration and social networks, as well as emotions. Looking at these processes through the lens of a postpartum illness also reveals the connections between the ill body, the troubled mind, and imperfect social relationships. On the one hand, *sobreparto* can be analysed at the micro-level – in terms of an understanding of the body, individual reproductive histories, or the availability of other people's support. On the other hand, *sobreparto* constitutes a commentary on phenomena occurring at the macro-level, such as large-scale internal migration in Bolivia or the increasing domination of biomedicine as a model of health and illness. The city of Santa Cruz offers a unique setting for scrutinising these changes using a traditionally Andean postpartum illness as a point of departure. Being much more than a postpartum bodily dysfunction, *sobreparto*, therefore, can be used as a lens through which it is possible to see the interplay of social and political macro- and micro-processes in people's lives at the time of reproduction.

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Introduction
The meanings of *sobreparto*

This thesis examines a postpartum condition among female Andean migrants in the lowland city of Santa Cruz de la Sierra in Bolivia. Known as *sobreparto*, it is a dangerous illness that typically occurs in the Andes. It may happen to women who do not observe postpartum rules, such as staying warm, not touching water, avoiding exposure to cold air or winds, or eating appropriate foods. With its symptoms of chills, cold sweats, fever, and general weakness, *sobreparto* can render a woman temporarily unable to take care of her newborn baby. The cure involves drinking hot herbal infusions and massaging the body with fat. Left untreated, *sobreparto* can have permanent consequences in the form of chronic debility or proneness to all kinds of ailments. In the ethnographies of the Andean zone, this condition is usually presented as an illness requiring a very specific, non-biomedical treatment. While it is clear that *sobreparto* can be analysed in categories of health and illness, I argue that it should be considered as a lens for wider, non-medical processes at work in migrant women's lives, such as motherhood and womanhood, emotions and sociality, or the biomedicalisation of pregnancy and childbirth.

The lowland Bolivian city of Santa Cruz de la Sierra may not be the first choice for the study of a phenomenon typical of the Andean zone. However, the last sixty years of population growth in Santa Cruz were significantly fuelled by incomers from Western Bolivia, who have shaped a diverse population of Andean migrants. People's motivations for migration are complex and varied, but for many of them the economic opportunities offered by Santa Cruz constituted a significant incentive. Although many managed to stabilise their economic

situation over the years, poverty frequently correlates with the concentration of migrant population in the suburbs. While it is possible to come across migrants from the Andes everywhere in the city of Santa Cruz, many of them live in marginally located zones, such as Plan 3000, where I conducted my fieldwork. In addition to their own ways of living, Andean migrants also brought new ways of healing. As a result, both traditional Andean healers and illnesses have established their place in the lives of Santa Cruz inhabitants. Some of the largest markets have entire sections dedicated to traditional Andean medicines, and almost every local market has at least a few small stalls with herbs and incenses for everyday ailments. This situation is made even more complex – but also particularly interesting – by the ostensible dominance of biomedicine in Santa Cruz, embodying the city's (and country's) claims to progress and modernity. In this context, what can be made of the fact that Andean migrants in Santa Cruz unanimously say that biomedical doctors do not know how to cure *sobreparto*?

My interest in *sobreparto* stems from a more general concern with medical pluralism and women's health. Medical pluralism in Latin America has a long and fascinating history.[1] Given the deep-rooted character of diverse systems of healing in the Andes, ethnographies of this phenomenon in Bolivia frequently focus on the situation in the highlands.[2] Often neglected by medical anthropologists, Santa Cruz de la Sierra offers an interesting setting for the

[1] There is abundant literature on this topic, which analyses not just the deep-rooted character of medical pluralism in Latin America, but also the historical relationship between medical systems and socio-political structures. See for instance Cueto & Palmer (2015) for a fresh perspective on Latin American public health policies as intertwined with medical and sociomedical research; Campos, Citarella & Zangari, (eds.) (2010) for a collection of papers discussing recent attempts at implementing intercultural health guidelines, particularly in Bolivia but also elsewhere in Latin America; Foster (1994) for the now-classic overview of the hypotheses on the origins of humoral medicine in the New World; and Crandon-Malamud (1991) for a demonstration of important links between medical pluralism and political power through an analysis of how co-existent medical systems may be used by people for purposes other than healing.

[2] See e.g. Loza (2008); Ramírez Hita (2005); Koss-Chioino, Leatherman & Greenway, (eds.) (2003); Fernandez Juárez (1999); Castellón Quiroga (1997); Crandon-Malamud (1991); Pedersen & Baruffati (1989).

dynamics of medical pluralism in lowland Bolivia. It is a city where most women give birth in hospitals[3] and take advantage of the state-funded universal maternal insurance (Galindo Soza 2010).[4] Thus, on the surface, it seems like biomedicine has succeeded in dominating female reproductive lives. Still, it is widely recognised that there are illnesses that lie beyond the scope of biomedicine, such as *susto*, *nervios*, and *sobreparto*. Although it would be easy to classify this situation as a set of contradictions, it may be more productively seen as a set of tensions existing between various understandings of the body, health, and illness. In other words, rather than separating these understandings into mutually exclusive categories, the tensions tie various concepts together, offering them the power of flexible explanatory models. The fact that it is common to hear that biomedical doctors do not know how to cure *sobreparto* suggests that medical pluralism is understood as consisting of complementary (or partially overlapping) – rather than competing – systems of healing (see e.g. Loza 2008).

However, there is more to this postpartum condition than issues of health and illness. *Sobreparto* usually occurs during the puerperium, which is a vulnerable point in a woman's life for reasons going beyond the physical strain of childbirth. It is also a time when a woman might like to rely on her social network, which may be more difficult if one is a migrant in a large city. People who live in the peripheries of urban areas, such as Plan 3000 in Santa Cruz, must often devote a lot of time to remunerated work and commuting, which limits the amount of attention they are able to offer to family or friends. As a result, urban social networks may be extensive with regard to the number of people they link, but they are not necessarily reliable. It is particularly interesting that in most accounts of *sobreparto* I heard, ill women could rarely rely on members of their households, including their closest relatives. Narratives of this postpartum condition revealed material and emotional instabilities underpinning these female migrants' lives.

[3] According to the 2012 census, over 74% of women in Santa Cruz experienced their most recent childbirth at a biomedical hospital or clinic (INE 2012).
[4] See Chapter 2.

Furthermore, speaking about their own experience also enabled the women to try to make sense of the world when looking back at their individual life trajectories.

Central to the understanding of *sobreparto* proposed here is an analysis of this postpartum illness with respect to the social world. In their research on health and illness in Delhi, India, Veena Das and Ranendra K. Das have focused on "the relation between failure in the body to failures in one's social world" (2007: 69), and it is interesting to apply this to the context of reproduction in a lowland Bolivian city. While pregnancy is not explicitly considered to be a medical condition in Santa Cruz,[5] women are encouraged to have antenatal checks as well as to give birth in biomedical hospitals. This, in turn, situates the processes of pregnancy and childbirth nearer the issues of health and illness. One way of theorising such a complex set of relationships is through a mindful social body, one which is inherently related to other people, a body which feels, knows, and speaks (see Chapter 4).

Many ethnographic studies from Latin America point to an interesting link between embodied distress and life's hardships among women. It has been argued that social, economic, and political processes significantly impact female well-being, which is related to "women's culturally determined responsibility to maintain household health and a care for children and families and thus their vulnerability to social changes that complicate the provision of such caregiving" (Yarris 2011: 228; see also Browner 1989, 2001; Inhorn 2006). An example of this may be found among Nicaraguan women who commonly complain of *dolor de cerebro*, brainache (Yarris 2011). While *dolor de cerebro* is a particular kind of bodily distress that is located in a specific area of the head (the brain stem at the back of the head), women explain this experience of pain as a result of "thinking too much" or worrying about all kinds of social hardships, such as abandonment, outmigration, or illness in the family (ibid.). A similar link between bodily distress

[5] However, pregnant women are described in Quechua as *mana sanuchu* (not healthy) or *unqusqa* (ill). The root of that latter word, *unqu*, points to a bodily disequilibrium (Platt 2002: 132). See Chapter 5.

and social suffering was studied among the rural Nahua of eastern Mexico (Smith-Oka 2014). Nahua women complain of *isihuayo*, classified as fallen/displaced uterus by local ethnomedicine,[6] and interpret this condition as a symptom of lack of stability in their lives, such as physical weakness or insufficient support from their family members (ibid.: 106). The case of *isihuyao* resembles *sobreparto* in many ways: although both are related to reproduction, neither is synonymous with their biomedical categorisations (uterine prolapse and sepsis/infection respectively). Furthermore, both implicate networks of meanings on personal, interpersonal, and national health policy levels.

While the postpartum condition of *sobreparto* manifests itself through a set of undeniably physical symptoms, such as fever or cold sweats, it would be reductive to limit the understanding of this phenomenon to the physiology of an individual body. In some areas of the Andes, bodies are considered to be porous: emotions are perceived as being able to pass between people, affecting them even to the point of making them ill (Tapias 2015: 45-50).[7] Similar understandings emerged from the data I collected among Andean migrants in Santa Cruz. Thus, in order to appreciate the multidimensionality of the phenomenon of *sobreparto*, it is necessary to consider the relationship between the body, emotions, and medical conditions.

I would like to present Julia's[8] story[9] to better illustrate the way that *sobreparto* is interwoven with wider patterns of people's lives, such as household economy, tensions in intimate relationships, or individual reflection on one's life.

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[6] *Isihuayo* resembles the biomedical category of uterine prolapse, but differs in aetiology and treatment, as argued convincingly by Vania Smith-Oka (2014: 106-108, 117-118).

[7] See Tapias (2015: 9-11, 2006). The relationship between emotions and illness has been described in other parts of Latin America; see e.g. Rebuhn (1993, 1994) for northeast Brazil or Cartwright (2007) for Oaxaca, Mexico.

[8] Research participants' names have been anonymised.

[9] This story is based on numerous conversations as well as a couple of recorded interviews carried out during my fieldwork in 2012-13. Although I learned about different aspects of Julia's

In 1999 Julia was pregnant with her second child. She and her husband, Rodrigo, had had some relationship problems: he was having an affair and Julia demanded that he make a choice between herself and Rodrigo's lover. As a result, Rodrigo left Julia when she was eight months pregnant. Julia said that it seemed to her as if her world had stopped (*Me parecía como si hubiera parado mi mundo*). It appeared that even her pregnancy had come to a halt, as she failed to go into labour after her due date had passed. She then went to a private clinic[10] to consult a doctor, who warned her: "If *you* keep going like this, the baby will become too big for normal delivery and *you*'ll need a C-section" (my emphasis).[11] Julia did not have the money to pay for the surgery and explained to me that she thought she gave birth out of fear (*Creo que de miedo parí, nomás*). It finally happened well into the tenth month. She recounted only starting to feel the contractions a couple of days after the doctor's admonition. After childbirth, as she had nobody to help her with household duties and her two small daughters (the newborn Silvia and the three-year-old Nohelia), she cooked and did the laundry herself. She fell ill two days after coming home; she had chills, cold sweats, fever, and felt very weak. A female neighbour who came for a visit told her that it was *sobreparto*. She continued to visit Julia daily, offering traditional Andean treatment for *sobreparto*, consisting in giving Julia hot herbal infusions to drink and rubbing her body with chicken fat.[12] Julia recovered after a week. She spoke to me about her experience in 2012 and 2013, many years after Silvia was born. She compared that pregnancy to her other pregnancies, those after which she had not fallen ill with *sobreparto*. When asked why she thought she became ill

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experience of *sobreparto* at different stages of my fieldwork, I present the story chronologically here. The non-chronological character of narratives and memories is discussed in Chapter 3.

[10] Julia had a bad experience giving birth to her first daughter, Nohelia, at a state-run hospital. Consequently, when she became pregnant again, she decided to save up money for a private clinic. This aspect of her story is analysed in more detail in Chapter 2.

[11] *Si* Usted *continua así, el bebé se volverá demasiado grande y* Usted *va a necesitar una cesárea.* It is interesting to note the phrasing used by the doctor, which emphasises Julia's role (or even responsibility) in the birth giving experience.

[12] Massages with fat are commonly used in Andean medical systems as fat, next to blood, is considered to be one of the two vital bodily fluids (see e.g. Bastien 2003). See Chapter 4.

after Silvia's birth, Julia explained: *Es que entonces estaba solita*, I was alone back then, pointing to the difference in available social support when her second daughter was born.

Julia's experience of *sobreparto* gives voice to multiple aspects of everyday life, in addition to the lack of physical strength caused by the illness. There is the emotional pain of being abandoned by her husband, the economic hardship of a single mother with two little children, and the unreliability of her social network manifested in Julia's feelings of loneliness. But there is also resistance, perseverance, hope, and understanding. I argue that their confluence in a bout of postpartum illness is not coincidental. On the contrary, this particular postpartum event allows them to be meaningfully articulated in the mindful social bodies of migrant Andean women in Santa Cruz de la Sierra.

The central themes of this thesis revolve around reproduction and loneliness. Specifically, this study is concerned with understanding how reproduction and loneliness intersect in the shape of a postpartum illness known as *sobreparto*, which befalls migrant Andean women in the lowland Bolivian city of Santa Cruz de la Sierra. This postpartum condition embodies the hardships of women's fates but also implicitly symbolises perseverance and the importance of other people in one's life. While narrating their individual experiences of *sobreparto*, female migrants in Santa Cruz pointed to aspects of women's lives beyond the episodes of illness, revealing the complex landscapes of their everyday existence. On the one hand, it is possible to look at *sobreparto* at the micro-level – in terms of an understanding of the body, individual reproductive histories, or the availability of other people's support. On the other hand, *sobreparto* also constitutes a commentary on phenomena occurring at the macro-level, such as large-scale internal migration in Bolivia or the increasing domination of biomedicine as a model of health and illness (cf. Tapias 2015). However, by pointing to what is important in these women's lives (Kleinman 1992, 2006), migrant women's

narratives of this illness demonstrate how these micro- and macro-level processes become connected to each other through episodes of *sobreparto*.

The body that feels

In order to better understand how emotions are socially and culturally constructed, it is necessary to look at the relationship between the body, emotions, and society. "[E]motions," assert Gillian Bendelow and Simon Williams, "lie at the juncture of a number of fundamental dualisms in Western thought such as mind/body, nature/culture, public/private" (2005 [1998]: xiii). They suggest that "the reality of emotions lies in the *interaction* of the biophysical, personal and social, and the complex affective compounds that are thereby formed in the process" (original emphasis, Williams & Bendelow 2002 [1998]: 136; see also Lyon 2005 [1998]; Hochschild 2005 [1998]). Thus, emotions are experienced in the body, reflecting and affecting social relations, also expressing relations of power (see Abu-Lughod & Lutz 1990: 12-13). Looking at emotions in this way allows us to see their multidimensionality in terms of social, corporeal, and communicative potential. It also makes it more complicated to label them with unambiguous terms.

In addition to their multifaceted expressiveness, emotions are characterised by a certain ambivalence or tension. They are considered to stand in opposition to rational thought;[13] yet, neurological-psychological research demonstrates that emotions are essential to decisions-making.[14] It would be all too comfortable to assume that terms that appear to be intuitively translatable are exactly equivalent

[13] See e.g. Lutz (1988: 53ff.).

[14] To be precise, decision-making is dependent on well-functioning frontal lobes, which are responsible for emotional responses, among other functions. Studies have demonstrated that people whose frontal lobes became permanently injured are largely unable to make simple decisions, such as choosing one of two identical items; cf. e.g. Lutz (1986: 287-288); Bechara, Damasio & Damasio (2000); Williams & Bendelow (2002: 132); Damasio (1994).

across cultures, especially given the ubiquity of emotions.[15] There are ways of conceptualising emotions as bodily states par excellence, ways that have not disappeared from Western common-knowledge understanding. They are often still present in language, highlighting the divergence between common and scientific understandings: in English people get their hearts broken or feel butterflies in the stomach; in Polish, worries lie on one's liver. These different conceptualisations of the capacities of the body leave evidence in seemingly metaphorical language, although various studies demonstrate that expressions associating various body parts with emotions were quite literal in the past in Europe.[16]

There are numerous examples in anthropological literature that discuss understandings of emotions as bodily sensations found all over the world. For instance, Robert Levy describes the relationship between the mind and experiences in Tahiti, where feelings, referred to by a term resembling the semantic field of "energy", are thought to originate in the intestines (although as a result of the influence of Christian missionaries, the heart has also come to be recognised as possessing such a function). The strong bodily aspect of emotions such as anger, fear, or desire, can be seen in the language with which the Tahitians describe their physical states. Levy notices that Tahitians who have lost a close relative complain of "illness" rather than sorrow, which was anticipated by the ethnographer (1973: 272). The "disordered bodily function, an illness" (ibid.) is the focus of a person experiencing strong emotions, and the danger of this situation consists in the ability of such emotions to render individuals out of control. A way of keeping these emotions in check is to dramatise one's feelings wilfully rather than allowing them to express themselves through an illness (ibid.:

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[15] The idea that emotions are universal has been criticised by e.g. Kitayama & Markus (1994) and Lutz & White (1986). The issue of translatability of words used to express emotions has been addressed by, among others, Beatty (2005); Escandell & Tapias (2010); Tapias & Escandell (2011); Rebuhn (1999); Lutz (1988, 1986); Rosaldo (1980).

[16] See e.g. Bound Alberti (2012 [2010]) for an in-depth analysis of the understanding of the function of the heart in European medicine. See also Chapter 4.

272-3). But the apparent paradox comes from the anthropologist, not the Tahitians; for them, it is the body that can become out of control, and ill, which is why it should be deliberately controlled.[17]

Andean migrant women in Santa Cruz often spoke about emotions by means of references to their bodies. The day before I left my field-site, I visited Julia one last time. We did not speak much, but at some point she said: "You know, when I got *sobreparto*, *tenía partido el corazón, no tanto el cuerpo*", I had a broken heart, rather than a [broken] body. Julia's choice of metaphors and meanings is quite striking even though it may seem almost intuitive. Her bout of *sobreparto* is the point of departure – this is what she means by the "broken body". However, she parallels this broken body with a broken heart – a well-known metaphor for failure of love. Julia points to the failure of love as the cause of her illness, the reason for a "broken body." At the same time, she explicitly describes the state of her body, a broken heart. Speaking about emotions and illnesses or bodily states as parallel experiences reveals a way of thinking about them as inseparable.[18] Chapter 4 argues that if emotions can be spoken of in terms of bodily states, then bodily states – such as illnesses – can also be understood as expressions of emotions.

The body that speaks

The non-linguistic character of emotional experiences often makes it difficult to talk about them. Although articulating emotions is possible, the precision of their expression varies between individuals as well as across different societies.[19] Even though many language-oriented studies suggest the universal nature of emotions

[17] In Chapter 5, I will argue that *sobreparto* can also be interpreted within the framework of emotions understood as bodily events.

[18] Maria Tapias discusses this relationship for Punata in the Bolivian Andes (2015, 2006). There are ethnographic studies discussing this relationship in the Andes in general. There is an abundance of studies on the topic: for an analysis of *pena*, sorrow, in Ecuadorian Sierra see Tousignant (1984); for *tirisia*, pining in Bolivia see Alba (1989) and Tapias (2006); for *nervios*, nerves, among children in the Ecuadorian Andes see Pribilsky (2001).

[19] See. e.g. Heelas (2007); Milton (2007); Wulff (2007); Beatty (2005); Kleinman & Good, (eds.) (1985).

and the significance of their linguistic expression (see Boellstorff & Lindquist 2004: 437), it is still worth paying close attention to the social construction of emotions and to their local meanings. At the same time, an anthropologist's (or anyone's, for that matter) insight into the feelings of others is largely based on what people say about what they feel. Still, it is clear that discourse on emotions should not be automatically taken at face value, since simple words such as "fear," "love," or *solita*, lonely/alone (see Chapter 5), represent networks of meanings, contexts and implications, which reach further than an understanding of emotions as a neurological activity might allow.

There is consistent research demonstrating that psychological distress can be manifested through somatic conditions (Watson & Pennebaker 1991: 72; see also Kleinman & Kleinman 2007 [1985]). Importantly, numerous ethnographies document this finding: from the intricate ethnography of *nervos* in Alto do Cruzerio in Brazil by Nancy Scheper-Hughes (1992), to living in constant fear in Guatemala, which causes people to suffer from chronic illnesses (see e.g. Green 1999, 1998, 1994), to conditions caused by the traumatic memories of recent history, such as the communist regime in Soviet Latvia (Skultans 1998) or surviving the Holocaust in Poland (e.g. Hoffman 2008). The level of verbalisation of psychological distress depends not only on the abilities of the individual experiencing such distress, but also on the political climate as well as the social group to which this individual belongs. Some societies encourage the repression of certain emotions,[20] thus, no matter how sensitive and verbal a person is, it may be rare for this emotion to be admitted (not to mention openly expressed), either to oneself or to somebody else. Nonetheless, if speaking of one's emotions is a conscious, intentional act of will, the occurrence – or embodiment – of feelings is irrespective of one realising their occurrence and possibly even labelling them.

In fact, there is a growing body of literature critiquing the excessive weight attributed to thought over bodily experience in the context of emotions.[21]

[20] Stoller (1984).

[21] For an overview, see Williams (2001) and Strathern (2010 [1996]).

Laurence Kirmayer emphasises the meaningfulness of the somatic which, he argues, is obscured by scientific hyperrationalism, "a radical abstractionism and relativism that negate the meaning of the individual lending themselves to totalitarian modes of thinking in which the suffering body is subordinated to philosophical or political ideals" (1992: 324). He suggests a way of conceptualising the body "as not only an object of thought but as itself a vehicle for thinking, feeling, and acting" (ibid.: 325). In this, Kirmayer points to knowledge and experiences which are beyond either thought or language, although without the implication that they cannot be thought of or articulated (ibid.: 330). However, the primacy offered to the processes of thinking and speaking often means that the bodily experience is only validated through conscious cognitive processes, which are then transformed into language.

These "linguistic confirmations of […] understandings" are treated like a basis for knowledge of a phenomenon, while this knowledge or understanding may have already been obtained non-linguistically, through living and co-operating with people on a daily basis (Bloch 1991: 194). Bloch contends that non-linguistic knowledge becomes transformed as it gains a linguistic form. He claims that this non-linguistic knowledge possesses a holistic character and is thus impossible to fully articulate by means of language (ibid.: 193-194). Within this understanding, speaking about emotions reduces them to semantics. Bloch also argues convincingly that transmission of non-linguistic knowledge can successfully occur beyond language, and that in fact a large amount of everyday knowledge is acquired or transmitted without words (ibid.: 186), although, ironically, he himself is condemned to convey his ideas through language.

The body communicates then, although it is not always easy to tune into. The reliability (or "truth") of gut feelings, so often considered a metaphor, is very difficult to explain in common terms, beyond neurological non-linguistic cognitive processes (cf. Durham 2011: 137). An awareness of such a limitation can be productive, however. On the one hand, it forces us to think beyond what is being said towards what remains unsaid. On the other hand, it poignantly

demonstrates that effective communication can occur independently of linguistic cues. To Andean migrants in Santa Cruz, ill bodies could express *tristeza*, sadness, *tirisia*, pining, or *estar solita*, being lonely.[22]

Feeling ill: Emotions and illnesses

An examination of the meanings ascribed to bodily states and processes, such as illnesses, together with an exploration of the social implications of these states and processes could open up avenues for new understandings of what the body is able to express socially. These "somatic modes of attention" (Csordas 1993: 137) constitute ways of being in the world, which are elaborated culturally, and which consist of using the body to be in one's surroundings (including being with and around other people) as well as paying attention to one's body. Emotions, in addition to being embodied, are also an intermediary between the social world and the body (Lyon & Barbalet 1994). The inextricable connection between bodily experience, including emotions and illnesses, as well as cultural meanings[23] is demonstrated in the process of acquiring knowledge of the social world through the senses. Additionally, moral values, the way in which certain events or behaviours are perceived (such as the distinction between what is polite, aesthetic, or correct – and what is not), are encoded in the body.[24] Thus, the body is the primary tool of investigation, in addition to being the object of it (see Freund 1990).

Numerous researchers suggest that phenomenological aspects of human existence are perceivable in the body; thus, it can be presumed that the body reflects social conditions (cf. Rublack 2002: 11-12; Scheper-Hughes 1992: 185-187). Illness is a state which undeniably foregrounds the bodily experience: a situation in which the body, so effortlessly taken for granted, fails (Kirmayer

[22] See Chapters 4 and 5.

[23] See Low (1994); Jenkins & Valiente (1994). See also Chapter 3.

[24] See e.g. Tapias (2006: 403); Laderman (1994: 192); Csordas (1994: 17); Abu-Lughod & Lutz (1990).

1992: 324; see also Frank 2005 [1995]). As an analytical tool, embodiment has been used to examine the issue of social suffering, which often assumes the form of chronic illness, especially in contexts where openly discussing the hardships of one's life is not safe.[25] Theoretical foregrounding of the bodily experience employs the notion of embodiment understood as "sensations, perceptions and experiences bounded by the interior, frame, and flesh of an individual" (Greenway 1998b: 148). However, in societies where the boundaries between the self and others are understood to be more permeable, such as Andean societies, it is also possible to extend the notion of embodiment beyond an individual body (ibid., see also Tapias 2006).

There is a proliferation of literature concerning the embodiment of war experiences (see. e.g. Quesada 1998; Olujic 1998; Nordstron & Robben [eds.] 1995).[26] Linda Green analysed illnesses as somatised "violence of social reality" (1998: 5) and living in fear as a chronic medical condition in Guatemala (1999, 1994).[27] A focus on the influence of emotions and social relations on illnesses may be found in the analyses by e.g. Tapias (2006), Rebhun (1999, 1994), Finkler (1994), or Frankel (1986). Stephen Frankel, for example, describes how the Huli of Papua New Guinea discuss the causes of their illnesses through accounts of how they became injured: by giving details of fights or arguments they had with other members of their family or community (1986: 131). In another ethnographic example, Maria Tapias (2006) demonstrates how Bolivian female market vendors and working class women consider their children's health to be the result of the mother's incorrect reaction to distress, passed through their bodies during the time of pregnancy and breastfeeding.

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[25] Linda Green describes such a situation in rural Guatemala, where criticising life's hardships equalled criticising the military political regime and made people prone to persecution (1994, 1998, 1999).

[26] See also Hatzfeld (2006, 2008, and 2009) for ethnographies with a journalistic overtone of post-genocide Rwanda.

[27] The impact of similar phenomena on health was studied by Fassin (2007); Farmer (2004, 1996); Kleinman, Das & Lock, (eds.) (1997); Scheper-Hughes & Sargent, (eds.) (1998); and Scheper-Hughes (1992).

Basing her observations on fieldwork conducted in Punata, a small town an hour away from Cochabamba, Maria Tapias treats emotions as dimensions of sociality and social relations rather than simply biological states. Punata's inhabitants often face economic hardships, which translate into unstable income, lack of certainty about the future, malnutrition, and everyday social and familial tensions. People of Punata believe that negative emotions, when unexpressed or "held in," may cause harm to the body. Such behaviour is even more pernicious in the case of pregnant or breastfeeding women, as they can pass them on to the foetus or baby, either through the placenta and umbilical cord or through breast milk, which may cause sickness. Foetuses afflicted with maternal distress are born *débil*, weak, which makes them more prone to falling ill. Infants breastfed by mothers who are withholding some negative emotions may develop *arrebato* (Sp. ecstasy, rapture, [rage-like] fit), which presents with blue or purple mouth, nails, and feet as well as severe diarrhoea (2006: 404-6). Local people say that when the mother's emotional balance is regained, her breast milk becomes normal again, and the infant gets better (ibid.: 406). In the case of other Punata inhabitants, negative emotions are potentially dangerous to those who repress them (ibid.: 405). On the other hand, the expression of emotions, in a socially acceptable context, constitutes healing.[28] It would be easy to dismiss the case of Punata with some kind of hydraulic theory of emotions,[29] but I argue that this situation demonstrates how people are able to work through or process their emotions upon expressing them – rather than simply releasing them uncontrollably. Socially acceptable ways of expressing emotions leave people changed, in addition to transforming the emotions themselves.[30]

There is a body of anthropological literature on the relationship between emotions and illnesses in Latin America. For instance, Michel Tousignant studied

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[28] An American psychologist, James W. Pennebaker researches the issue of the relationship between trauma and disease and edited a volume on the effect of disclosure and sharing of emotions on health across cultures (1995).

[29] Cf. Bastien (1985).

[30] See Chapter 3.

the impact of *pena* on health among Quechua-speaking people in the Ecuadorian sierra (1984). There, *pena* is both a state of mind characterised by sadness and anxiety as well as an experience making one prone to attacks resembling epileptic seizures. Strongly linked with the social world, *pena* represents the state of being worried about one's family well-being, the crops, the future. An accumulation of worry, without the possibility of resolution, may lead to illness. The difficulties associated with fulfilling one's social roles may cause *pena*, which manifests itself through the body, especially the heart (the centre of emotions), the blood, and the head (ibid.: 385-6). Tousignant asserts that the ill body directs the attention to the social element of *pena*, emphasising the interdependency between the individual, the family, the community, as well as the environment.[31] These multiple mutual relationships highlight the deep embeddedness of well-being in social networks in the Ecuadorian sierra, which echoes among Andean migrants to Santa Cruz.

Within the framework of ailments whose aetiology is found in distress and hardships, illnesses may signal people's difficulties in life, possible conflicts or critical economic situations. In her ethnography of people in the Alto do Cruzeiro, Brazil, Nancy Scheper-Hughes writes about *nervos*,[32] primarily understood as a general weakness of the body caused by chronic hunger, but also as "an all-purpose complaint" serving as a commentary on people's everyday frustrations (1992: 177). People who fall ill with *nervos* do so despite their desire to remain healthy. Scheper-Hughes demonstrates how a conceptual transformation of the state of hunger into an illness removes the blame from society, thanks to the neutral social status of sickness (ibid.: 174). By complaining about their medical condition, people assign blame to no one and yet, they are able to express what bothers them (ibid.). If personal and social distress is expressed physically rather than psychologically, and if people are members of a

[31] *Nervios* (nerves), *susto* (fright), and envy are the three emotional areas with the largest theoretical contribution; see e.g. Scheper-Hughes (1992); Davis & Low (1989); Taussig (1987).
[32] Portuguese for "nerves".

social class and culture where the body is privileged, it is likely that they will closely observe their own bodies, for both sensations and symptoms (ibid.: 184-185). In the Alto do Cruzeiro, then, *nervos* serves as an idiom to articulate people's anger and dissatisfaction, both through the body and through language (ibid.: 195). At the same time, the commonness of *nervos*, understood as a social illness by the anthropologist, is an embodied commentary on the precariousness of life among inhabitants of the Alto do Cruzeiro (ibid.: 195).[33]

The phenomenon of somatisation has been described as "the expression of personal and social distress in an idiom of bodily complaints and medical help seeking" (Kleinman & Kleinman 2007: 469). In other words, somatisation is a situation in which these emotions are expressed through the body, but not necessarily processed into linguistic categories (ibid.: 469-470). Understood in this way, somatisation was more socially acceptable than verbal articulation of feelings, which made it a more effective way of dealing with emotions in the context of Kleinman and Kleinman's study in China (2007). A similar observation was made in a study of reproductive health problems, which often serve as an idiom for expressing emotions in contexts where it is inappropriate to complain about emotional states, such as sadness, grieving, or stress (Basu 2006: 113-114). However, it is possible to look at this phenomenon in such a way where a medical perspective is one of many. In other words, somatisation could be thought of as a process of articulating emotions and experiences by means of the mindful social body, which comments on people's social circumstances in an eloquent manner.

Within such an understanding of the body, an illness is not just a potentially dangerous bodily state. Rather, it is an articulation of the complex situation of an individual in their social world. Thus, *sobreparto*, as a traditionally Andean postpartum illness found among Andean migrants in Santa Cruz, should be

[33] Similarly, Williams and Bendelow call for rethinking of understanding ways of being and knowing, and in particular, how the lived experience becomes embodied in response to "macro-structural issues of power, domination, and control" (2002: 132).

considered something more than a severe bodily disequilibrium. The *sobreparto* of Julia described in the beginning of this Introduction speaks of hard life experiences and loneliness, coexisting medical systems, womanhood and motherhood, migration, the porous body,[34] relationships and social networks, among other themes. However, *sobreparto* is not a shorthand for these aspects; it is an idiom of few words.

Organisation of chapters

Sobreparto is embedded in a complex web of interrelated processes. I will seek to illuminate this postpartum illness by discussing the dynamics of particular phenomena, such as migration, medical systems, illness narratives, and motherhood. At the same time, it is clear that these processes influence each other, irrespective of whether they lead to postpartum conditions. In the concluding section, I will show how *sobreparto* can be seen as their interplay.

The first chapter sets the discussion within the unique ethnic landscape and context of the city of Santa Cruz. It begins with an outline of the history of migration from the Andes over the past 65 years. Furthermore, it addresses contemporary transformations in the understanding of the category of "indigenous," especially in the case of Andean migrants. I then briefly sketch an outline of the situation of Andean zone migrants in this lowland city with a particular focus on Plan 3000, where I conducted my fieldwork.

The second chapter analyses the landscape of medical services in Santa Cruz. While official statistics suggest that biomedicine has successfully reached most of the city's inhabitants, medical pluralism remains widespread. Within this context, the phenomenon of pregnancy offers an interesting case. I argue that even though women's reproductive lives have been largely biomedicalised, they still actively negotiate their options within those limitations. I also show how people

[34] See Chapter 4.

distinguish between conditions within and outside the realm of biomedicine and navigate through available options in search of effective solutions.

The following chapter focuses on illness narratives as ethnographic data. It discusses the methodological issues of my research, including retrieving packed-away memories and speaking about the previously unspoken. In addition to articulating what matters the most to people (Kleinman 2006, 1992), illness narratives of *sobreparto* are also analysed as opportunities for self-reflection, for making sense of women's own lives.

The fourth chapter considers an understanding of emotions as bodily and social processes and the productivity of such an understanding for an interpretation of *sobreparto*, a postpartum illness traditionally found in the Andes. Ethnographic data I collected among Andean migrants in Santa Cruz de la Sierra suggest that there is a link between experiencing negative emotions and the occurrence of postpartum illness, although each of these conditions is quite different. I argue that if it is possible to look at emotions as being expressed through the body, then it is also possible to look at bodily states – including illnesses, such as *sobreparto* – as expressions of emotions. This requires a special understanding of the body – a mindful, social body.

The fifth chapter explores the possibility of analysing the remembered emotional trajectories of pregnancy followed by *sobreparto* from the point of view of the mindful social body. I argue that even though *sobreparto* is often defined as an illness, it is also possible to see it as an event of social significance, rather than a solely medical one. The second half of this chapter analyses two cases of *sobreparto* and highlights their common themes, such as lack of support, porous body, and uncertainty about the future, among others. Women who fell ill with *sobreparto* had made risky decisions, which were motivated by a feeling of abandonment by their social networks. Drawing on the argument from the previous chapter, I suggest that bodily states can be seen as expressions of emotions. In the context of *sobreparto*, being alone and feeling lonely stood out as

a common thread in the narratives of most Andean migrant women who shared their experiences with me.

The last chapter looks at the challenges of motherhood among migrant Andean women in Santa Cruz. Women are expected to be the main caretakers of their offspring, which can significantly limit their employment opportunities. The frequent unreliability of male partners forces women into the double role of mothering and breadwinning. The chapter also briefly discusses relatively absent fathers as well as the dynamic between male and female parents. Finally, I show the links between motherhood, loneliness, and social network in the lives of Andean migrants in Santa Cruz de la Sierra.

The concluding discussion of the thesis shows how these aspects feed into each other and how their interplay may be seen in an illness occurring at a vulnerable moment of women's lives.

Chapter 1
Welcome to Santa Cruz: Everybody is a migrant

The magnetism of scorching sun: A brief history of Santa Cruz de la Sierra

Bolivia seems to have everything a landlocked country may dream about: fertile valleys in the centre, the imposing mountain ranges of the Andes in the west, as well as the thicket of Amazonian forest and sun-scorched plains to the east. Despite the fact that natural resources abound, it is one of the poorest countries of South America, in terms of economic development indicators. Ethnically, a considerable part of the population self-identifies as indigenous – although the category has acquired noticeable political overtones in recent years. Politically, it is a country of continuous turmoil, which has taken on new colour since the election of Evo Morales, the first head of state in Bolivia to emphasise his indigenous ethnicity. However, many of those issues fade into the background when the focus shifts towards Santa Cruz de la Sierra, Bolivia's largest and richest department, whose heart beats in its namesake capital, the city of Santa Cruz de la Sierra.

The beginnings of the city were not without their obstacles. The capital of the department was established in 1561 near the present-day San José de Chiquitos in the region known today as the Chiquitanía, which later became an arena for Jesuit missionary activity. Some thirty years later, as the area was plagued by slave hunters, Santa Cruz de la Sierra was relocated to another site, near the town of Cotoca, relatively close to its current location. Another five years passed and Santa Cruz was moved again: this time to a location near the Piraí river, where

the city was finally able to grow stronger roots and where it finds itself today (see e.g. Casanovas et al. 1989: 1; Peña Hasbún et al. 2009: 21).

For many decades following settlement to the present-day location, Santa Cruz remained a relatively small town, especially in comparison to urban centres found in the Andes. Santa Cruz continued as a rather small settlement until the mid-20th century. In 1900 the town had approximately 16,000 inhabitants,[1] a population which increased almost threefold during the following half century (Blanes 2007: 26). Between 1950 and 1976, the number of inhabitants grew from 43,000 to 254,000 (ibid.). Although the first waves of internal migration, prompted by employment opportunities in sugarcane and cotton harvesting, occurred as early as in the 1930s, it was the agrarian reform of 1952 that opened the valve to the rarely interrupted population flow from the Andean zone to the Bolivian lowlands (Peña Claros & Jordán Bazán 2006: 49). This change was made possible due to the completion of a motorway between Cochabamba and Santa Cruz in 1954 (Peña Claros & Boschetti 2008: 31), which shortened travel time between the cities from two weeks (see e.g. Crist 1946: 300-301) to less than a day. On the one hand, the existence of the new motorway translated into significantly intensified trade between the highlands and the lowlands; on the other hand, it meant that migration became easier than ever (Sanabria Fernández 1986: 61). Additionally, in the face of a crisis in the mining industry in the Andean part of Bolivia and the idea of activating the agricultural potential of the lowlands, the government began offering incentives for those who chose to move to the east of the country, such as land or loans (Bazzaco 2008: 72-73; Manzoni 2005: 141; Peña Hasbún et al. 2003: 94-95). Migration paths varied; for some, the countryside or a small town constituted the first stop before moving to the city (see e.g. Vilar & Saramiego 1981; MacLean Stearman 1985, 2011 [1976]) while others headed directly for the capital of the department. Nonetheless,

[1] The population of Bolivia in 1872 was estimated at approximately 1.55 million inhabitants. The following censuses was carried out only in 1900 and 1950; in the latter the population was calculated at 2.7 million (*Opinión* 18/11/2012).

within just half a century, the population of the city of Santa Cruz grew from approximately 50,000 inhabitants in 1960 to the currently estimated 1.45 million (INE 2012).

Year	Population of the city of Santa Cruz	Source
1900	18,335	Peña Hasbún (2003: 57)
1950	42,746	Blanes (2007: 26)
1976	254,000	Blanes (2007: 26)
1992	709,584	INE (1992)
2001	1,135,526	INE (2001)
2012	1,442,396	INE (2012)

Table 1. Population growth in the city of Santa Cruz de la Sierra.

At the moment the city of Santa Cruz de la Sierra is one of the most populous urban areas in the country – it is second to the combined population of La Paz and El Alto, estimated at just over 1.6 million (Candela 2013; INE 2012). Even a brief overview of demographic changes strongly suggests that migration must have been the fundamental source of new inhabitants, in addition to population growth as a result of high birth rates as well as the formal incorporation of new, previously inhabited areas into the city borders of Santa Cruz. Migrants came from both rural and urban areas, although the proportion of rural to urban migrants to Santa Cruz has shifted in favour of people coming from towns and cities. These changes are largely fuelled by economic motivations. However, the significant increase in the number of urban dwellers also stems from the transformation of formerly rural areas into urbanised ones, as the sole criterion consists in the number of inhabitants surpassing 2,000.[2] A classificatory change of this kind impacts the distribution of statistical data concerning rural and urban migrants, as opposed to actual individual migratory trajectories within the country. There is also a considerable group of Santa Cruz inhabitants who are classified as "second generation migrants", which implies their allegedly alien

[2] In comparison, in Britain an urbanised area must have at least 10,000 inhabitants (Department for Environment, Food & Rural Affairs 2014), but the definitions as well as criteria vary across countries (United Nations 2003: 101-104).

status in the city. Neither originating from a city or a village nor being a first or so-called second generation migrant indicates a specific ethnicity, in fact, a significant part of the city's population comes from the eastern crescent of Bolivia,[3] or the lowlands (INE 2012; see also Appendix I). It is curious, therefore, that in Santa Cruz de la Sierra migrants tend to be imagined as people from the Andes.

It is perhaps even more curious to analyse the discourse about migration in all its manifoldness. On the one hand, migrants' role in building Santa Cruz is widely recognised. Simultaneously, they are blamed for certain features of any city whose population grew faster than the road, canalisation, and electricity grids. Then again, there are probably only very few people in the city who have never had repeated contact with migrants, either as service providers, co-workers, or – just as importantly – friends and relatives. Markers of ethnicity, such as Quechua, Aymara, *cruzeño* (from Santa Cruz de la Sierra, either the city or department), *valluno* (from the town of Vallegrande), Chiquitano, *andino* (generally from the Andean zone), Ayoreo, Cochabambino (from the city of Cochabamba), *beniano* (from Beni department), among many labels either self-appointed or assigned to others, are as frequently highlighted and accentuated as they are criticised in a constant process of building individual and shared identities.[4]

Migration of this degree in a country with a heterogeneous ethnic composition was bound to raise certain issues. Despite the fact that neither the department nor the city of Santa Cruz itself have ever been ethnically homogenous, the discrepancies between the locals and the new settlers from the Andean zone stimulated the transition of the general ethnic labels of *camba* (for native inhabitants of the department of Santa Cruz) and *colla* (*kolla*, *quolla*) (for the

[3] Eastern crescent is a collective name for the lowland departments of Pando, Beni, Santa Cruz, and Tarija (cf. e.g. Robillard 2010).

[4] It is beyond the scope of this thesis to discuss the meanings and transformations of the category of "indigenous" in Bolivia. This topic has been analysed in depth by Andrew Canessa (2012, 2009, 2008, 2007, 2006, 2005); see also Combès (2006); Weber (2013).

indigenous migrants from the Andean zone) into two opposed categories.[5] Years have passed and the categories have significantly transformed, nonetheless, they never ceased to exist.[6] People in Santa Cruz use them for self-identification, description, or even insults on an everyday basis.[7] I sometimes heard Doña Paula, my landlady from Cochabamba, admonish her daughter for being lazy: *¡No seas* camba*!*, Don't be like a *camba*!

When seen from above, the city's road network resembles a spider web. The very first time I saw Santa Cruz was from a plane. It was a flight from Sao Paulo with a stopover in Campo Grande, whose name seemed hilariously uninspired. It was well past midnight. The pilot announced that we were approaching the destination and I looked out of the plane window to see what awaited me. A delicate luminous cobweb of orange streetlights stood aglow amidst the darkness of the lowland plains. There was one almost pitch-black dark strip, stretching almost to the very centre. I later learnt that it was *El Trompillo*, an older, smaller airport that had never been moved away, biting into the core of Santa Cruz through its unflinchingly convenient location. I made a list of things visible from the plane at night. It was short: moving cars, streetlights, darkness. On that very

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[5] The categories of *camba* and *colla* started as denotations of ethnic opposition during the colonial era. The term *camba*, originating from the Guarani word for "friend," was employed for the peasant class and referred to a peon working in a *finca*, a large agricultural establishment. Over time, the meaning of *camba* expanded to include the lowland society – both aristocratic and peasant. Furthermore, with the intensification of contact between lowland and highland people, the term *camba* was used to emphasise distance, cultural as well as geographical, from highlanders who were often referred to as *collas*, after *Kollasuyo*, the Bolivian sector of the Inca Empire (MacLean Stearman 1985: 20-21, 208-210; Peña Claros & Boschetti 2008: 137-168).

[6] Some recent anthropological publications allude to these identifications in different Bolivian contexts, e.g. Waldmann (2009) for the city of Santa Cruz or Lopez Pila (2014) for Bolivian Amazonia.

[7] Claudia Peña Claros and Alejandra Boschetti analysed these stereotypes using each group's perceptions of self and others. Most of these perceptions are based on straightforward oppositions. The *cambas* consider themselves friendly, sociable, sincere, but also lazy. The *collas* consider *cambas* to be loud, courageous, imposing, and also lazy. The *collas* consider themselves humble, patient, and hard working. The *camba* consider *collas* to be serious, reserved, family-oriented and also hard-working (2008: 205-208; see also Bergholdt 1999).

first night the regularity of the road system, a logic to be understood, spelled promise, possibilities, and excitement to me. I would arrive in Santa Cruz at night time and time again. On each occasion, I would be able to read the luminous cobweb in a more nuanced way and recognise the daylight differences in the meaningful glow of the city at night.

Figure 1. Santa Cruz at night. Source: ANF, http://www.noticiasfides.com/img/news/i_candidata-del-mas-propone-crear-region-metropolitana-de-santa-cruz_31139.jpg

I lived in Santa Cruz de la Sierra twice. The first time, I stayed for nine months in 2009, when I was carrying out research on the topic of migration from the Andean zone to the city. I left a couple of weeks after Evo Morales was re-elected as the president of the Bolivian republic. The second time I arrived in Bolivia in March 2012 and stayed for fourteen months. During that time I focused my research on the topic of postpartum illness and emotions, but the aspect of migration never really left the picture, underpinning and reverberating in the life stories of women that I worked with. For almost every single one of them the decision to leave what they knew elsewhere and head for the big city was ultimately life-changing. The consequences of those individual choices echo

in the way they live, understand, and transform their lives. Perhaps it was possible for me to see it so clearly as a result of my previous research. Perhaps it was because I, just like them, was a migrant to Santa Cruz.

Santa Cruz de la Sierra enjoys the reputation of being an open, welcoming, even cosmopolitan, city in Bolivia. A superficial look at the people in the streets of the historic centre reveals a mosaic of individuals: different facial features, different clothing, different ways of moving. A more discerning eye may notice divisions of, roughly speaking, a socio-economic nature. People who have little stands in the streets and peddle freshly squeezed orange juice or deliciously sweet sugar-coated *maní*, peanuts, tend to be darker-skinned than people behind the wheels of 4WD cars, with music blasting through the open windows. The former tend to be women, the latter – men. The former often wear traditional items of clothing, the latter sport colourful fake-brand t-shirts with frequently deliciously misspelt logos. It would be a gross oversimplification to suggest that this divide runs across gender and ethnic status, although there are many instances in which it would be an accurate description. But there is something in Santa Cruz de la Sierra that often made me think that it is a city made of cities, where certain people follow only certain paths which overlap or intertwine from time to time.

Figure 2. Currency peddler, *Plaza 24 de Septiembre*, 2009.

Among the knots of multiethnic contact there were, most notably, markets, hospitals, the bus and train stations, as well as various schools and universities. The main city square, Plaza 24 de Septiembre, named after the first attempt at freedom in Santa Cruz in 1810 (see e.g. Peña Claros & Boschetti 2008: 24), is quite open to everyone, but not without its patterns. The northwest corner is the nest of foreign exchange dealers. They circle the area close to the hole-in-the-wall eatery serving empanadas and *salteñas*.[8] Each of them clutches a folded wad of bills, absorbing the hand sweat of its business-minded owner. When they spot someone who could be taken for a tourist, they try to establish eye contact and hiss *dólares, euros, pesos, reales*… at them, as if trying to cast a spell. The northeast corner is often dominated by chess players. The municipality had installed a number of stone tables and painted black and white chessboards on them. These tables are accompanied by short stone benches on opposite sides. Locals, almost exclusively males, bring their sets of carved chess pieces and play endless matches, usually with friends, but sometimes a stranger is challenged. An occasional tourist gets invited to the game, which event gathers a larger-than-usual number of spectators.

Figure 3. Chess players, *Plaza 24 de Septiembre*, 2009.

[8] *Salteñas* are delicious baked sweet dough pies with savoury filling.

The southern side of the square is dominated by *La Catedral*, a Catholic cathedral first built in 1770, and then, in 1838, replaced with a red-brick building in a style which could be described as eclectic. Apart from its obvious but rather inconspicuous religious function, the cathedral's entrance steps, generously covered in dark grey polished marble, face the city's main square and serve as a meeting point all year round. In the evenings, Cruceños often sit on the sun-warmed steps for hours on end, chatting to each other, watching people, sipping sweet *café con leche* peddled by men in white jackets with gold buttons, who drag carts with coffee-filled thermos flasks around the square. Many a time I spent long hours sitting on the church front steps, trying to take in the kaleidoscope of the city embodied by the constant motion of people in the *plaza*.

Figure 4. *Plaza 24 de Septiembre*, 2012.

What was before me required engaging all the senses: looking alone was not enough, despite the fact that the constant transformation of what I was seeing would initially privilege this particular aspect of perception. Colours: the crisp white short-sleeved shirts decorated with traditional emerald green embroideries

of elderly *camba* gentlemen, elegantly strolling in their pale yellow *saó* palm hats,[9] or, alternatively, with the hats in their hand doubling as fans. Women pass by, sometimes quickly, their long shiny hair bouncing off their backs. Sometimes they saunter leisurely, hair braided in impressively thick and long plaits, tied together with a beaded tassel, adding shine and volume to the ends of the braids. There seems to be a lot of everything: flip-flops and impractically high heels, trainers and dress shoes, boots and canvass moccasins. Tank tops and white shirts, two-piece suits beach shorts, irreverent miniskirts, and chiffon long dresses. All this mingles in the hot air of the Santa Cruz late afternoon, humidity making people's foreheads glisten with sweat, every breath of the intermittent breeze is welcomed with relief. The plaza is permeated by a richness of sounds: calls, conversations and laughter competing with the honking horns, chirping birds, and music from the nearby bars. The air usually smelt of heat, snacks, and car fumes. People passing by would leave a waft of too eagerly applied body spray behind them. In spring, there would be a delicate scent of the tree blossom. During the rainy season, the air was fragrant with moisture, steam, and wet palm leaves.

Thanks to a multitude of palm trees the square is quite shaded and before the municipality ran electricity lines above the tree crowns, entire families of sloths used to hang from the branches almost motionless. When the streetlamps were installed in the square, the sloths were moved to the Santa Cruz zoological garden. People say it was a mistake. I suppose the sloths agree since every now and then one or two make it back to the square from the zoo, which is nearly two

[9] Saó palm (*Trithrinax schizophylla*) belongs to the Trithinax genus and is quite spiny and slow growing. This particular species is only found in the southeast of Bolivia. Its flat, long leaf fibres are dried and used to make hats as they come in long thin stiff strips, which are relatively easy to braid together. The hats were virtually unknown to a wider public until quite recently but with the emergence of the discourse on indigeneity, they were adopted as one of the symbols of *la cruceñidad*, the cruceño quality, together with white shirts with emerald green embroidery, which have even become official uniforms of the local municipality employees but are also sold widely in souvenir shops around the city centre – from my observations they sell better among the *cambas* than the tourists.

kilometres away. These animals have now been replaced with voracious swarms of pigeons, which are very eagerly fed by boys and girls, who spend their one-peso coins to buy bags of crushed corn grain from the street vendors, conveniently wandering nearby. At times the pigeons suddenly sense the danger approaching and abruptly fly away, to the accompaniment of children's screams of simultaneous fear and excitement, just to be replaced with another group of insatiable birds. The kids resume the feeding, as if nothing happened.

Figure 5. *La Catedral*, 2009.

The main square, *Plaza 24 de Septiembre*, is the official face of Santa Cruz. This means that, while very enticing, it possesses characteristics which are quite absent from many other areas where different kinds of people meet in their activities. The *Plaza* embodies the aspirations and displays a vision of the city rather than constituting an accurate reflection of it. Other squares, markets, universities, and hospitals, tend to lack the flair and wishful grandeur of the main square. In these public spaces, functionality is privileged over the general appearance. And the further one moves from the centre the more different the urban landscape becomes. Plan 3000, a very large neighbourhood where I carried out the majority

of my fieldwork, was a perfect example of how a certain amount of discomfort and inconvenience feature in the daily lives of its inhabitants.

When the city was relocated for the last time, its centre was positioned approximately three kilometres from the Piraí River, a wide but rather shallow watercourse, which – in the vicinity of the city – flows from southwest to northeast. The neighbourhood near the river, appropriately named *Zona Piraí*, Piraí Zone, was far enough from the city centre to be cheap and close enough to alternative water sources (to the city water system) to be popular among the migrants. The city itself is located on particularly flat terrain, as a result of which, when the Piraí River flooded in 1983, virtually the entire Zone Piraí was destroyed. To mitigate the effects of the natural disaster, the municipal government decided to urbanise an area to the southeast of the city centre with a goal of relocating the three thousand families who had lost the roof over their heads to safer grounds. The new neighbourhood received the then-appropriate name of *Plan 3000* (Chirino et al. 2010: 15).

Figure 6. The main market in *Plan 3000*, 2009.

The heart of Plan 3000 beats in its market, *Mercado Plan 3000*, situated around the only roundabout with a greenish area in the middle in the entire neighbourhood – a clear sign of urban planning. Minibuses continually flow through five main arteries, only to turn back at the roundabout. Despite a general appearance of confusion, the market has quite well established sections. There is the equivalent of a food court, a section with longer lasting foods, such as rice, beans, oil, and noodles, a fruit and vegetable section, which abuts multiple butcher stands. On the other side of the roundabout there are a number of pharmacies, stationery shops, and clothes stands. In one of the corners little wooden and corrugated iron sheds are replaced by brick buildings: a hospital, a bank, and a Marie Stopes International, an NGO-run clinic for women. I always find it extremely difficult to describe both the market and the neighbourhood succinctly. Much as I try to avoid being judgemental, the adjectives that came to my mind when I first saw Plan 3000 are: overcrowded, filthy, and provisional. There is, however, a way of looking at this three-word-long description as accurate rather than dismissive. Let me explain.

Figure 7. *La Rotonda* in 2009. Note the Bolivian flag (top) and the *whipala*, representing indigenous people of the Andes.

In 1983, when Plan 3000 was opened for settlers from the inundated zone, only a small portion of what is today used was destined for use. That area roughly corresponded to the anticipated number of people and was prepared for the newcomers in a very general way. Main streets ran along the main water pipes, and access to electricity was created by installing power pylons near the main routes. Families would receive plots of land for a relatively small fee, but were then responsible for connecting water and electricity sources to their own households. There was no asphalt on either the main arteries or the smaller streets on account of the fact that the municipality had plans to build sewage canals before covering the streets with asphalt. The intended provisionalness also allowed for flexibility in the urban design from the point of view of the municipality. By offering a certain degree of access to basic services, the local government also expected that the new inhabitants would display a sense of initiative and take the matter of the future of their new *barrio* in their own hands. And so they did.

Figure 8. *La Rotonda* in 2013. The obelisk is painted in the colours of the flag of the Department of Santa Cruz.

An almost complete lack of regulation (and a rather absent enthusiasm about enforcing existing regulation) of the parameters of the buildings in the area meant that the shapes and colours of houses were only limited by the imagination and economic resources of their owners. Some buildings had four or even five floors and were covered with marble panels. Others – not infrequently adjacent ones – were just windowless sheds. Many houses had flat roofs with vertical iron rods protruding from them – a sure sign that the owners were hoping to add another floor in the future. I saw multiple households where each building was constructed with a different type of material: red brick, its cheaper cousin: hollow tile, wooden boards, plywood, burlap, thick plastic sheets. Those households told the story of the economic situations of the owners quite eloquently. On the other side of the spectrum there were houses which looked prim and proper – or out of place. They were often hidden behind three-metre tall brick walls, with strong steel gates, topped with some barbed wire and pieces of glass. People would often say that they belonged to drug dealers.

Figure 9. Calle Flores, one block away from *La Rotonda*, 2013.

In 2009, when I first arrived at Plan 3000, streets one block away from the roundabout were still just dirt roads, with ruts so deep that walking was a precarious activity, especially in the rainy season. At the end of my first period of fieldwork the municipality finally began digging canals, which were then abandoned in the form of largely uncovered, approximately one-metre-deep ditches, roughly inlaid with concrete panels. Additional concrete panels were used to cover the areas in front of the gates of households, but large portions of the canals were left uncovered to allow the rainwater in more easily during the rainy season. However, the open fragments would quickly fill up with rubbish carried by the wind in addition to the inhabitants' using them as convenient dumping sites. As a result, when I arrived in 2012, the canals were in place but their function was quite different from what was intended.

The general lack of well functioning sewage canals serves as a slightly distorted mirror to Plan 3000's short history. The more people settled down, the more dire the problem would become. Shallow canals were dug out in front of people's households as a remedy, but that only meant that all household wastewater ended up right in front of the gate, creating permanent putrid puddles. With more people resorting to this seemingly provisional solution, the less chance there was of the water actually being absorbed by the sandy soil, irrespective of the other issues, such as the health hazards of living near the cesspool. Even when more professional canals were dug out and set up for use, it soon turned out that their edges were often higher than the street level, resulting in sewage water continuing to accumulate in the street.

Plan 3000's anticipated population in the 1980s, in a very generous estimate, oscillated around 30,000 people – reflecting three thousand multigenerational families. Nowadays, the population of this *barrio* is calculated at 150,000 and despite the fact that the inhabited area is much larger than the original one, the centre remained the same – it only became much more intensely used. The market stands are tightly packed next to each other, the minibuses, filled to the brim, graze each others' sides while inching their way round the roundabout

towards one of the main arteries, trying to squeeze through the crowds moving about in the streets. Taxis wedge themselves between cars, often in a way that could be described as daredevilish, intentionally causing snarl-ups in their desperate attempts to overtake minibuses which seem to stop to take passengers on board every five metres. All this is enveloped in an incessant irregular rhythm of angrily blaring car horns.

Figure 10. Traffic in *Plan 3000*, 2012.

This enormous neighbourhood is chaotic only on the surface, I understand it now. This is how Plan 3000 seemed to me for quite a few months at the beginning of my research in 2009. But then patterns began to emerge and there were more and more occasions where I found myself explaining to someone how to find something – a doctor, a service, or a product. The recognition of an internal logic also translated into a better understanding of why people continue to live there, despite numerous inconveniences, which they recognise and comment on quite overtly. People I talked to frequently mentioned one particular factor quite commonly: the sultry lowland weather. On the one hand, it was not easy to get used to: high temperatures would make sleeping restless and required

a different approach to personal hygiene. On the other hand, however, its relative predictability throughout the year and the practical impossibility of truly cold weather eased daily existence in ways unthinkable in the mountains. To be exact, the winter months in Santa Cruz can be quite chilly. The lowest temperature registered for the city of Santa Cruz in the last decade was -3º Celsius, but the average low temperature during the coldest months of June and July is as high as 16º C.[10] When coupled with a considerably high level of humidity and constant rain, it may feel unusually cold – which makes the weather the main topic of conversation for a while. Nonetheless, in general, the temperatures are favourable, which makes it easier to construct a liveable house or find a job that requires being outdoors for long periods of time. Good weather, despite the dangers related to excessive heat,[11] made a better life possible for many migrants. Additionally, the variety of options offered by Santa Cruz, being a large city, increased their chances of success and prosperity even further. The sun may burn, but for many, it is worth trying to bask in its warm glow.

There is one more feature of Plan 3000 that results from the fact that it is a reasonably new neighbourhood. Most inhabitants were not born there. Almost every person I spoke to would point out that their parents were from somewhere else or that they themselves had moved to Plan 3000. Naturally, the fact that Plan 3000 has only existed since 1983 is a very significant factor in this situation. However, there is more to it, as the neighbourhood became a city within a city, a nearly self-sufficient auto-creation, with porous boundaries, ready to absorb or expel people at any time of day or night.

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[10] See Wikipedia contributors, *Santa Cruz de la Sierra* (2015).

[11] See Chapter 4 and 5 for more details about understandings of heat and cold among Andean zone migrants to Santa Cruz.

Who is not a migrant in Santa Cruz:
The ambiguity of migratory entanglement

Migrants to Santa Cruz frequently feature in popular discourse; nonetheless, the question of who is or who is not a migrant in Santa Cruz de la Sierra is a rather complicated one. Perhaps there is no good way of resolving it at all, however, I will attempt to show certain regularities in the way in which multiple ethnic or regional identities are emphasised or displayed, or – conversely – criticised or discarded. People's identities in Santa Cruz are diverse: both relatively permanent (such as identity related to one's place of origin or gender) and more transitory (concerning profession, current neighbourhood or membership of an association). As far as migrants are concerned, as mentioned above, the main line of division runs along the *camba* and *colla* distinction, where the former indicates "the locals" while the latter "the others". The simplicity of these categories is alluring, and yet the way in which they are used reflects their multifaceted implications.

For instance, both can be – and are – used as positive terms as well as pejorative categories, or even insults. It is possible to notice some regularities – for instance, migrants from the Andean zone, falling into the category of *colla* somewhat automatically, would never use the word *camba* to flatter themselves. On the other hand, they would use this term to classify and criticise certain kinds of behaviours – too frequent fiestas, too skimpy clothing, etc. *Colla de mierda*, shitty *colla*, was often an insult thrown at drivers attempting an unusual manoeuvre; curiously, very often the car windows would be tinted and it was impossible to precisely establish the driver's ethnicity. Additionally, the fact that someone is categorised as *camba* does not mean he or she is not a migrant – he or she may in fact be from a different part of the department. Similarly, *colla* is used as a description of phenotype, associated with darker skin, high cheekbones, a certain nose shape, as a result of which both daughters of my landlady from Cochabamba, who were born in the city of Santa Cruz, would earn such descriptors from others. Thus, in the end, it seemed like these categories have a

dynamic polysemic potential, one that becomes filled with different meanings in particular contexts.

It should not be surprising that such an oversimplified division remains inadequate for the complexity of the city of Santa Cruz. The inherent intricacy of the matter can be seen in the data on ethnic labels gathered in the last two national surveys from 2001 and 2012. The 2012 census asked an open-ended question about belonging to an ethnic group,[12] phrased as "any indigenous original peasant or Afro-Bolivian nation or people" [my translation] (INE 2012). In comparison, the 2001 census asked "Do you consider yourself as belonging to one of the following original or indigenous peoples?" The following options would be suggested by the surveyor: Quechua, Aymara, Guaraní, Chiquitano, Mojeño, other native, none.[13] In the 2001 survey, 62% of people declared that they belonged to one of the indigenous groups (INE 2001; Molina & Albó 2006: 33). Eleven years later, this number dropped by almost a third, to a mere 42% (INE 2012; cf. Stefanoni 2013). Taken at its face value, this could possibly be the result of some demographic catastrophe targeting the indigenous population (or an extreme baby boom among the non-indigenous). However, Bolivia had experienced neither. Let us therefore look more closely at the results of survey

[12] In fact, the 2012 census asked the following question: *Como boliviana o boliviano ¿pertenece a alguna nación o pueblo indígena originario campesino o afroboliviano?* which translates – and forgive the awkwardly crowded adjectives – into: "As a Bolivian woman or man, do you belong to any indigenous original peasant or Afro-Bolivian nation or people?" There are a number of dimensions here: first of all, the question privileged national Bolivian identity over others (and was a difficult one to answer for foreigners living in Bolivia, such as me). Secondly, it acknowledged the newly emergent identities of groups that had moved from Brazil but settled in Bolivia (Afro-Bolivians), however, they were not classified in the "indigenous original peasant" category. Thirdly, it reflected the political changes in the way indigeneity became defined as a result of recent transformations in Bolivian governance.

[13] It is very interesting to note that the census questions are considerably different, despite the fact that they pertain to the same issue of ethnicity. It is not an accident, I believe, as a comparison of questions in these subsequent censuses (from 2001 and 2012) follows the same pattern – and makes it virtually impossible to reliably compare data from the national surveys, which in turn hinders drawing dependable conclusions, or, for instance, designing development/change strategies.

question about ethnicity in the census of 2012 for the city of Santa Cruz de la Sierra.

The two most recent censuses produced data that is not comparable for a number of reasons (cf. Albó 2013). This is true both for particular regions in Bolivia and the country as a whole. First of all – and on the most obvious level – differently phrased questions rendered different results. Ramiro Molina Barrios and Xavier Albó (May 2014, personal communication)[14] criticised the yes/no formulation of the census question, which they argued prompted respondents to answer in the negative as they knew that a positive answer would lead to more questions to follow. Secondly, the political climate surrounding indigeneity had changed considerably – and sometime during the expansion of the "indigenous original" people to "indigenous original peasants", the initial affirmation of the indigenous status, vigorously supported by the government, gradually subsided, as demonstrated by the loss of public trust in the abilities of Evo Morales' government. As a result, the political dimension of "indigenous" pushed its ethnic aspect to the background, and people reflected this shift in their survey responses by concealing their ethnicity (for example, by stating that they were *mestizos*) even though they had identified as an ethnic minority in the 2001 census (Xavier Albó, May 2014, personal communication). In any case, the fact that the question about ethnicity was formulated differently in the 2001 and 2012 censuses as well as the fact that in the 2001 census the question was only addressed to persons over the age of 15, as opposed to asking the entire population in the 2012 census, make the results of these national surveys incomparable (Ramiro Molina Barrios, Xavier Albó, May 2014, personal communication).

Furthermore, in the city of Santa Cruz de la Sierra, the number of people who answered the question about belonging to an "indigenous original peasant or Afro-Bolivian nation or people" in 2012 was a few thousand less than 350,000,

[14] E-mails exchanged between Ramiro Molina Barrios, Xavier Albó, and Tristan Platt, who kindly shared them with me.

which constitutes less than a third of those to whom the question "did not apply", a staggering 1,106,756 persons (INE 2012). On the other hand, in 2001, the question did not apply to over 410,000 people, however – and more importantly – there were over 700,000 persons who could answer the question about self-identification with an indigenous group in the affirmative. In 2001, there were only six possibilities to indicate one's ethnicity (granted, the category "other native" was an agglomerative and reductive one) (INE 2001). In 2012, the census lists 105 different ethnicities as well as the cryptic category "the description does not correspond to a group name" (INE 2012).[15] The answers are grouped into four categories, namely: A – major nations of groups (with only two options: Aymara and Quechua),[16] B – minor nations and peoples recognised in the Constitution of 2009, C – other groups, and D – "other types of declarations" (INE 2012). Approximately 43 of them, including categories A and B, correspond to official names of ethnic groups. The constitution officially recognised 36 ethnic groups, but the list also includes names pointing to identification with a location, such as Javeriano – from San Javier, or Ignaciano – from San Ignacio, or acknowledges the division maintained by indigenous peoples themselves, such as Bésiro and Chiquitano (rather than just Chiquitano), or Yuracaré and Yuracaré-Mojeños (rather than just the latter).

The census data thus becomes extremely complicated. Since it was an open-ended question and the surveyors often had only very basic training (and were frequently secondary-school students – as was the case in my neighbourhood), they would write down whatever answer the respondents produced. The surveyors were given a list of ethnic groups recognised in Bolivia, but under no circumstances were they to read it to their respondents. As a result, for the city of Santa Cruz, the 63-option-long category C includes names of places from all over

[15] See Appendix II for the discussed data from 2012 census.

[16] Canessa asserts that it is more accurate to talk about Quechua- and Aymara-speakers (especially bearing the fact that "various groups have switched from Quechua to Aymara and vice versa" [1998: 228]), rather than Quechuas and Aymaras – although "although in recent years a new Aymara nationalism has developed which articulates an Aymara nation" (ibid.).

Bolivia: there is Belén, and Lipez, and Lagunillas, and Charagua, and so on. It also includes answers such as "intercultural", "peasant", "indigenous", "original", "Qolla" (frequent alternative spelling to *colla*) – but not "Camba" – and "unspecified indigenous or original" (which accumulated over 120,000 responses). The remaining category D is rather limited – it mentions mestizo, Mennonite, Okinawa, and "the description does not correspond to a name of a people/town". This last option was ascribed to over 72,000 people, which makes one wonder about the wording of the exact answer of the respondent. Given that the surveyors were not supposed to suggest answers, the variability is not unexpected. What is unexpected, however, is the fact that partial census results for the provinces differ from the official census, which counts 36 ethnic groups recognised in the 2009 Constitution, Afro-Bolivians, and categories such as "other" and "other unspecified" (INE 2012).

There is yet another twist to the way the data were produced. Prior to the census day in November 2012, I heard on the radio a conversation in which a representative of the National Institute of Statistics, *Instituto Nacional de Estadística*, INE, was explaining to the radio audience that they should not lie to the surveyors about anything. It seemed rather hilarious to me at the time, but I understood the validity of this message when my landlady confessed that she said she was a *mestiza*, despite the fact that she was born in Cochabamba to parents who were and spoke Quechua, which was also her first language. I asked her about it later and she said that she did not want to be associated with *ese huevón, Evo*, this jerk, Evo [Morales], who is famous – among other things – for considering himself indigenous, to the dismay of many Bolivians who feel that his claims to this category are unjustified, which influenced their declaration of ethnicity for the purpose of the census.

The goal of this discussion of the differences between censuses – and in particular between answers in the subsequent national surveys – is to demonstrate the difficulties of establishing hard facts, with meaningful numerical values in the face of the political dimensions which certain categories may have

acquired over time. In the case of the label of "indigenous", in all its Bolivian forms, the change in numbers is more likely to result from people changing the way they use the category, rather than from a massive migration of indigenous people out of Santa Cruz. Indeed, it may seem like the categories of migrant and indigenous are blended in this section. Indigenous people are, however, frequently rural migrants, although it should be acknowledged that the category of "urban indigenous" is gaining formal recognition in Bolivia.[17]

The estimates concerning the number of migrants in the city of Santa Cruz vary and it is close to impossible to produce solid data. The 2001 census asked for place of birth, which could potentially offer some kind of insight. The phenomenon of recent migration, i.e. within the previous five years, was also investigated. Interestingly, both questions were phrased in a slightly different manner[18] in the more recent national survey, which complicates the comparison of the results. Some sources suggest that over 48% of the city's population is composed of migrants, the majority of whom are from the Andean zone (Mazoni 2005: 153). An analysis based on the 2001 census puts this number at 57% for all urban areas of the department of Santa Cruz (INE 2003); there are a number of towns outside the capital, the largest of which, Montero, has approximately 120,000 inhabitants. According to this survey, there were approximately 500,000 migrants in the entire Santa Cruz department, more than 250,000 of whom were

[17] During my fieldwork in 2012-13 I worked as translator for APCOB, a Santa Cruz-based NGO, that was beginning a four-year-long, UN Democracy Fund-funded project titled "Political representation and participation of five indigenous populations in the city of Santa Cruz de la Sierra". The project specifically targeted indigenous people from the department of Santa Cruz who are living in the departmental capital. There are more and more projects of this kind in Bolivia. See also e.g.: Ros Izquierdo (2004); Ros Izquierdo & Combès et al. (2003).

[18] Firstly, the 2012 census included everyone in Bolivia (unlike the 2001 census, which asked many questions only to people above the age of 15). Secondly, the question about place of birth was included, however, a data search with multiple variables includes a side category of "living somewhere else" but does not specify where. For instance, the 2012 census states that out of 56,943 people declaring "living somewhere else" who were in the city of Santa Cruz on the date of the national survey, 1,579 live somewhere else in Bolivia while 68 live abroad. Those 1,579 people are therefore neither calculated in the area where they live nor in the Santa Cruz migrant count (INE 2012).

indigenous (ibid.: 91). Without dismissing the importance of numerical data, there are certain issues to be taken into account when looking at them. First of all, many migrants are not first-time migrants. Thus, many people from western Bolivia moved to Santa Cruz to work on *latifundios*, large estates, after the mid-1950s. After some time, they decided to move to the city, fitting into the common pattern of rural-urban migration. More recently, many people began coming directly to Santa Cruz in search of work. They would come from larger cities in the Andes (sometimes directly, sometimes having migrated there for education) or from rural areas. In the end, as the borders of the city expanded considerably, some people, who have been living in the same place all their lives, are categorised as migrants as they were born outside of Santa Cruz. However, there is more to being a migrant than just the rather technical issue of not originating from the place one currently inhabits.

The category of migrant may have some pejorative overtones, which is clearly noticeable in Santa Cruz. I talked to many people who were technically migrants, and yet had lived in the city most of their lives. In general, there was an entire range of attitudes experienced: from unquestionable discrimination, to indifference, to affirmation and appreciation of their migrant condition, recognised as people who took a chance on their fate. Some would try to speak with the Santa Cruz accent and thought little of these migrants who were not trying to conceal their status. There were some who moved back and forth between different ways of being, from the relaxedness of *cruceño* lifestyle, to never missing the annual fiesta in their home village. Some of the people I met belonged to the somewhat paradoxical category of "second generation migrant". They were technically not migrants, however, their parents' pasts would tag behind them, pushing them ruthlessly towards the stigmatised social group. There is a general recognition of the existence of migrant experts, namely, university educated professionals, who arrived in Santa Cruz mainly from the Andean zone, where the majority of good universities are located, and who came to lend their unique skills in a new location. They tend to blend, reasonably

smoothly, with the *cruceño* middle class. At the same time, they differ significantly from the majority of migrants who come with the goal of finding manual or unskilled labour, joining the economically underprivileged.

Perhaps there is a point to asking whether it is possible to talk about migrants and non-migrants in Santa Cruz de la Sierra if the city itself has been moved a number of times. If the parents' migrant status may tag along behind a child – and sometimes even grandchild – where can the line between migrant and non-migrant be drawn? Are there advantages to being a migrant? In the stories I heard, I could see how those family trajectories individualised the histories of their tellers. Perhaps it is possible to think of this kind of mobility as a way of constructing individual biographies.

Andean zone migrants in Santa Cruz: New opportunities and social landscape

Santa Cruz de la Sierra is like a magnet, pushing and pulling indiscriminately. I like to think that it is also like a magnet because everyone seems to understand that it works but very few people know why it works the way it does. Even if its fame does not travel very far beyond Bolivia, for thousands of people it is still a promise waiting to be fulfilled. The fabulous reputation of the city, I believe, is sometimes strong enough to obscure its darker and shadier inner workings. However, once there, people are quite determined to try and try again, against all odds, and in spite of the numerous obstacles that appear on their way. After all, as with all magnets, if it is pushing you away, it only means that you are on the wrong side of it.

There are many aspects of the city of Santa Cruz that are attractive to a large part of the migrant population. However, the challenges faced by various types of migrants are quite distinct.[19] The lines of division may run across places of origin

[19] It is impossible to precisely establish particular origins of migrants to this city because of the quality of statistical data. The 2012 census asked about the place of birth, equalling it with the department of origin. While these two categories overlap for many migrants, for others they are

– rural migrants may be more challenged by the intricacies of the city transport or semi-official administrative requirements of settling down in an urban area, such as registering at a certain address. For a newcomer from another town, there is a new – although somewhat familiar – logic to be learnt. Another line of distinction related to places of origin may run across probably the most visible divide, that is, highlands versus lowlands. For the former, the struggles often go beyond learning the topography of a new place. Some of the new obstacles can be quite physical: the invisible horizon, the heat and humidity, an almost foreign way of dressing, language filled with strange new words for well known things: *gualele* for "banana," *pitaí* for "skin rash," *tacú* for "wooden mortar."[20] Other difficulties are of a more existential nature, such as ways of being, anticipating, discriminating. For many, some of these issues will accompany them throughout their daily lives in Santa Cruz.

Santa Cruz may be special to migrants from other parts of Bolivia, but in many respects, it draws people in for the same reasons as almost any other large and rapidly developing city. Without delving deep into the details of human migration,[21] discussed at length in an abundance of literature, in the case of Santa Cruz (and probably many other places) it is possible to find a number of the most common migration patterns. Two main types of social and economic class movements can be observed; horizontal and vertical. Horizontal migration involves moving between the same type of area, that is, rural to rural and urban to urban. Vertical migration involves temporary migration (rural-urban and

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imprecise or inadequate. For instance, Julia, one of my main informants, was a second generation migrant: she was born in Santa Cruz but considered herself *colla* and migrant-like, despite the fact that in the 2012 census she was classified as *cruceña*, a person from Santa Cruz.

[20] Each of these words are listed in *Habla popular de Santa Cruz*, Popular speech in Santa Cruz, which lists words classified as Spanish of Eastern Bolivia (Sanabria Fernández 2008). *Gualele* is a variety of bananas found in central South America. *Pitaí* and *tacú* have been adopted from the Guaraní language.

[21] See Kearney (1986) for an overview of literature until mid-80s; for contemporary discussions on the topic see e.g. Castles & Miller (2009), Brettell & Hollifield, (eds.) (2008), or Vertovec, (ed.) 2010.

sometimes back to rural) as well as gradual migration, from rural to more and more urbanised areas. There is yet another type of migration, chain migration, one which is very important to Santa Cruz de la Sierra (cf. MacLean Stearman 1976, 1989).

Chain migration consists in people from one area moving to a place where remunerated work is available, at which point information about the availability of jobs travels back to their place of origin, encouraging more people to migrate. Chain migration may be supported by kinship networks, insofar as relatives may frequently help each other in finding jobs and perhaps even offering some assistance in terms of accommodation and board, especially in the initial phase of migration (cf. MacLean Stearman 1989). In other words, large numbers of people from the Andes did not choose to migrate into the complete unknown – there were already some networks of kin or friends, as well as *compadres*, fictive kin, who could offer a safety net should circumstances turn too unfavourable. At the same time, these relationships should not be idealised. A number of people I talked to told me stories of abuse by their kin. For instance, someone was sold a piece of land by an uncle who asked for a price that turned out to be double the plot's official value. One of the friends of my landlady said that she was taken in by distant relatives as a *doméstica*, live-in maid, and was worked to the bone by them for years before she escaped and broke contact with them. Naturally, there were also stories where those networks of kith and kin would prove life-saving, sometimes quite literally, such as when women who fell ill with *sobreparto* were nursed back to health by a relative, a friend, or a neighbour.

There are multiple factors that contribute to Andean people choosing to stay longer in Santa Cruz – and quite often set down roots, despite the obstacles inherent to migrant life. It would be reasonable to argue that individual motivation, still involving a complex set of factors, is different in each case. Some migrants moved to Santa Cruz to open businesses, such as welding or auto-repair shops, or internet cafés, which ties the source of their income to the place in a way that does not allow them to return without economic consequences. Other

migrants benefit from the intensity of Santa Cruz's commodity market, where they can sell goods brought from the Andes at a good price. They frequently travel back and forth, relying on the differences in supply and demand between the regions. However, there are also migrants whose situation is much more complex. For instance, I spoke to people who moved to the city as children, who saw their position as somewhat paradoxical. They were aware that many people considered them migrants (and they sometimes labelled themselves as such), and yet they had relatively little memory of where they were born and thought of Santa Cruz as their true home. This is not to say, however, that this aspect of their identity was irrelevant – my good friend Blanca would sometimes recall that after her family moved to Santa Cruz from Cochabamba, she would be bullied at school because of her accent. While she no longer has a very strong *cochabambino* accent, neither does she speak like most of the *cruceños*. I wondered to what extent that choice of accent was a matter of conscious decision and consistent daily practice. In any case, the particular life stories of migrants from the Andes to Santa Cruz are informed by complex and individual choices and circumstances, which could not be reduced to economy only, ignoring people's desires to become modern, urban cosmopolitans (cf. Kothari 2008).

Figure 11. Small businesses in *Plan 3000*, 2012.

What often proved most attractive for people who migrated from rural areas may have been the urban aspect of Santa Cruz. With time, the availability of municipal services – such as hospitals, electricity, or running water – often transformed from attractions to basic necessities for inhabitants of urban areas. There are also the less tangible – but highly symbolic – consequences of moving to a large city, such as the prestige associated with the sophistication often attributed to urban lifestyles. Understandably, neither luxury nor refinement were part of everyday life for most of the migrants – rather, they would feature only rarely, but the fact that they were within reach would add some shine to the mundane daily realities. When I asked my research participants about what makes Santa Cruz special or simply different from where they were from, they mentioned, among others, going out to eat in a restaurant, listening to a live concert of *Los Kjarkas* (one of the most famous Andean music bands), or watching a match of the Bolivian football representation at the local stadium. Often, they would also say: *La vida en la ciudad es más fácil*, life in the city is easier. When queried about the reasons for this, people frequently pointed to the availability of services, such as water or electricity, as well as more varied job market that offered the opportunity to actively participate in the monetary economy.

Simultaneously, migrants who spoke to me explicitly pointed to the hardships of being a migrant, especially when one is not wealthy. From discrimination, to being taken advantage of, to not having family or friends around, migrant life can be a trial of will, strength, and persistence. Sometimes individual situations are made even more complex: in 2009 I interviewed a woman, Doña Amalia, who was a migrant from rural Cochabamba. Doña Amalia was about 70 and took care of her four-year-old grandson, Enrique, relying on remittances sent by her daughter Rosalia from Spain. Rosalia had moved to Santa Cruz around 2002, married a *camba* man and had a son with him. The couple then decided to migrate to Spain, but they also wanted to leave their son with Rosalia's mother in Bolivia; their plan was motivated by economic factors. They brought

Doña Amalia to Santa Cruz approximately seven months before their departure for Spain to help the then-16-month-old Enrique get used to his grandmother taking care of him. According to Rosalia, who was back in Santa Cruz at the time of my fieldwork in 2012-13, during those seven months, Doña Amalia "escaped" to her home village in Cochabamba three times. Rosalia recounted how her mother hated the heat, refused to take showers for fear of becoming ill, and complained about everything, from distasteful food to finding sand everywhere. Despite all this, Rosalia and her husband left for Spain, leaving their son with Doña Amalia, who then dutifully cared for her vivacious grandson for over five years. In an interview in 2009 I asked Doña Amalia why she did not simply take Enrique to her village in Cochabamba; she that she was not only taking care of the boy, but also her daughter's house in Santa Cruz. She added that life in the countryside is very hard and that she did not have any money there. I did not want to question Doña Amalia's logic, but I felt that her decision to live in the city to help her daughter, despite the discomfort it gave her, reflected the multiple struggles which migrants to Santa Cruz had to face every day.

Withstanding these hardships requires willpower and strength. Some migrants return home, but many find it in themselves to endure and push through in the hope of a better future. Most of them are accustomed to hard work, it is other aspects of migrant life that prove hard to bear: loneliness, discrimination, or unfamiliarity with the city.[22] They often do not share their difficulties with their families back home, trying to show their lives in a new place as successful ones, or at least bearable, as if they wanted to find a reason to stay beyond straightforward economic motivations. There may also be a sense of pride coming from the ability to persevere. Over time, many of their initial problems unnoticeably disappear, only to be replaced with other concerns.

The Andean migrants in Santa Cruz often fared quite well as far as entering the job market was concerned. Known for their strong characters and work ethic,

[22] See Chapter 6 for ethnographic accounts on migrating to Santa Cruz from the Andes.

they found themselves considered more efficient than the relatively laid-back locals. Many engaged in the trade of goods, bringing products from the other cities or even from abroad and selling them at a profit in multiple Santa Cruz markets; to this day the markets are dominated by vendors with Andean facial features. Their entrepreneurial spirit, good organisation as well as industriousness allowed many Andean migrants to achieve enough economic success to think of settling down in Santa Cruz for longer. There, land was cheap, especially in those parts of town further away from the centre, the weather was pleasant, the business was good. Nonetheless, much as the economic dimension often sparked the idea of migration, people tended to migrate or stay in the new place for emotional reasons or due to social obligations (MacLean Stearman 1976: 10-11).

Chapter 2
What seems to be the problem? Migrant women in the city of biomedicalised pregnancy and childbirth

Introduction

It is very easy to think that, ultimately, pregnancy is a woman's thing. And, in so many ways, it is exclusive to the female domain, especially when viewed through the lens of physiology. Redirecting this particular aspect away from women is indeed virtually impossible, at least in the light of contemporary medical research involving in vitro fertilisation or cloning.[1] Thus, amidst stories of babies arriving in the beaks of storks or found in cabbage patches, human infants required – and will continue to require until the near future at least – a woman's womb to develop in. At the same time, babies are neither made nor born in a social vacuum, and a brief look at the conditions surrounding gestation and childbirth clearly demonstrates the degree to which all genders are deeply involved in raising children, albeit with different levels of impact, both direct and indirect. One of the aspects which concerns pregnancy directly – and is largely dominated by men in Bolivia – is the legislation surrounding reproduction, which involves the national health insurance programme for pregnant woman and their babies as well as official policies to manage the process of gestation through antenatal visits with biomedical health practitioners. Another significant bias lies in the gender

[1] There has been, however, some rather theoretical research on gestation in men via ectopic pregnancies (Teresi 1994).

distribution among the biomedical personnel in hospitals – where most doctors, who often make decisions or influence them greatly, tend to be male.[2]

What about women's points of view, then? What makes the case of Bolivia particularly interesting is that there exists a considerable difference between the eastern and western part of the country, despite identical legislation and the availability of the national health insurance programme. In general, it can be said that, when it comes to pregnancy, women's local knowledge has been overshadowed by biomedicine, access to which is strongly encouraged by the state (see e.g. Loza 2013: 1084).[3] For instance, in Santa Cruz, traditional midwives (both migrant and local), who attend childbirths at home, are hard to find – in addition to the fact that nowadays their services are neither commonly valued nor sought. Hospital childbirths, on the other hand, are vigorously promoted by media campaigns and via state-dispensed small cash stipends known as the *Bono Juana Azurduy* (Juana Azurduy Stipend), as well as through a national health service aimed specifically at pregnant women and their babies, the *Seguro Universal Materno-Infantil*, or *SUMI* (Universal Mother-Infant Insurance). At present, the *SUMI* guarantees free medical care in state-run hospitals to all women who are pregnant or have given birth in the preceding six months as well as to children up to five years of age (Ministerio de Salud y Deportes 2006a). Moreover, women who receive antenatal checks at regular intervals, give birth in one of the designated hospitals, as well as attend postnatal appointments for themselves and

[2] The gender distribution among medical personnel in Bolivia has been undergoing a considerable change. As reported by my friend and a medical student from fieldwork, in recent years the proportion of female to male students at the Faculty of Medicine at the Universidad Autónoma Gabriel René Moreno (the state university in the city of Santa Cruz) was approximately three to one and corresponds with a growing general tendency for women to enter higher education institutions. Simultaneously, very few female doctors choose to specialise in obstetrics and/or gynaecology, which is inconsistent with their patients' preference for female gynaecologists (*El Deber* 2012).

[3] In a fascinating study of the coexistence of biomedical healthcare and Andean medicine in two rural communities in Peru and Bolivia, researchers concluded that "the health-seeking strategies of households in Waca Playa [Department of Cochabamba, Bolivia] and Pitumarca [Department of Cuzco, Peru] are basically independent of the level of access to biomedicine, *except for some specific practices such as childbirth*" (Mathez-Stiefel, Vandebroek & Rist 2012: 10, my emphasis).

their babies qualify for the *Bono Juana Azurduy*, a financial incentive especially attractive to the economically disadvantaged.

The goal of this chapter is to highlight the complex transformations in the ways in which pregnancy and childbirth are perceived in a context where their medicalised view is privileged by the authorities by means of national health care policies, specifically targeting pregnant women in the city of Santa Cruz de la Sierra as well as their babies and young children. Despite the magnitude and far-reaching consequences of the government's decisions, there are numerous other factors at play, including the decrease in the numbers of traditional midwives, views promoted in the media through information campaigns, the availability of private health care at reasonably low prices, as well as the difficult financial situation that so many women (and men) in Bolivia face every single day. These aspects will be discussed in order to bring out their inextricable entanglement, which continually transforms local perceptions of pregnancy and childbirth. However, women are not entirely unresisting in this process; they shape their ideas in an active manner, combining traditional knowledge about pregnancy with what they are learning from sources favouring the biomedical perspective.

Changing landscapes of national health insurance

Even without extensive research into the topic, most people have an intuitive understanding of what happened to the way in which pregnancy is perceived within Euro-American society. The notion has transformed from it being a "woman's thing," to prioritising the authority and expertise of (initially exclusively male) biomedical doctors, to women (re)gaining their say – at least to a certain extent – about what happens with and to their bodies during pregnancy and childbirth. One of the greatest shifts, however, involved positioning pregnancy on the axis of health and illness, and consistently pushing it towards

the latter[4]. Despite the fact that there are very few people who would explicitly equate pregnancy with "illness,"[5] there are likely very few Euro-American expectant mothers who would refuse antenatal checks on this principle alone. Categorising gestation as a "medical condition" does not seem like a satisfying solution; after all, this logic would allow life itself to be considered as "a fatal sexually transmitted disease."[6]

What about Bolivia, then? Bolivia's maternal mortality rates remain high by international standards, despite the implementation of government programmes aimed at pregnancy and infancy monitoring, such as the aforementioned *Bono Juana Azurduy* or *SUMI* (cf. Moloney 2010: 1955; Bradby 1999, 2002: 168).[7] According to the WHO report analyzing data from the 1980–2008 period, the Maternal Mortality Ratio (MMR) for Bolivia decreased from 547 (with 344 in urban areas and 845 in rural areas per 100,000 births) in 1980 to 439 (276–666) in 1990, to 269 (168–413) in 2000, and down to 180 (110–284) in 2008 (Hogan et al. 2010: 1616). The most recent collaborative report by WHO, UNICEF, United Nations Population Fund and The World Bank (2014) estimates it at 200 per 100,000 births. Curiously, another WHO Mortality Country Fact Sheet puts Bolivia's MMR in 2006 at 420 (WHO 2006a). Yet another estimate, prepared in

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[4] See e.g. Strong (2000); Conrad (2007); Wolf (2002); Jordan (1993); Martin (2001 [1987]); Murphy-Lawless (1998); Gélis (1991); or Gaskin (2011).

[5] Platt (2002: 132) observes that in Quechua pregnant women are referred to as *mana sanuchu*, not sane, or *unqusqa*, ill. The root *unqu* means bodily imbalance, and the word *unquy* (illness) refers to both pregnancy and childbirth. I am not sure to what extent this understanding is present among the migrants in Santa Cruz although I remember that when I told my friend Maira that Julia, whom we both knew, had had a baby, she was quite surprised but then said: "Oh, I remember Silvia (Julia's teenage daughter) saying: '*mi mama está enferma*, my mummy is ill,' but I had no idea that's what she meant."

[6] This particular wording alludes to Krzysztof Zanussi's film title "Life as a Fatal Sexually Transmitted Disease" released in 2000.

[7] Kwast (1980: 251) claims that the lack of success of such campaigns should be ascribed to the concept of pregnancy as a natural state rather than a medical condition. It has been suggested that effective healing depends on the choice of the medical system and a degree of shared knowledge between the healer and the patient (King 1998: 22; Bastien 1994). Additionally, Cadden observed that the treatment needs to take place "within the expectations and practices of the patient's family" (1993: 5).

collaboration between the WHO and UNICEF in 1990, calculated MMR at 650 rather than 439 (WHO/UNICEF 1990). In any case, each of the quoted reports consistently pointed to a high maternal mortality rate in Bolivia in comparison to other countries. In practice, it meant that it was not uncommon for people to have known somebody who had died in childbirth or during puerperium. Women I talked to sometimes described cases that they knew of in which a woman *casi se murió*, almost died, in labour.

Difficult or prolonged labour is mentioned as one of the main reasons for going to hospital to give birth. In such cases, a biomedical doctor's decision to perform a caesarean section might be motivated by the convenience of shortening a particularly long-lasting labour; such surgery performed on an already exhausted woman has a slightly higher maternal mortality incidence than regularly scheduled C-sections (Allen, O'Connell & Baskett 2005, 2006; Allen et al. 2003). At times, despite a complicated, lengthy labour and the recommendation by the local midwife to go to hospital, the cost of transportation to a medical centre and the state of the roads are such that the family usually decides against it (Maupin 2008: 374-376).[8] Specific data on rates of maternal mortality, however, vary significantly, as I will try to demonstrate, depending on the department as well as on whether the area in question is rural or urban. Quite unsurprisingly, and just like almost everywhere in the world, maternal mortality is higher in rural areas. Among the Bolivian departments, Santa Cruz de la Sierra stands out with one of the lowest maternal mortality rates and most comprehensive health service coverage (INE 2012; PNUD 2007). Such excellent statistics in comparison to the rest of the country are the result of the fact that a large majority of the department's population live in urbanised areas; if not in the departmental capital itself, then in the nearby towns of Cotoca

[8] According to WHO estimates, traditional medicine is the default health-care system of approximately 80 % of inhabitants of so-called developing countries. It frequently proves to be a more efficient therapeutic method as well as a cheaper one (Bussmann & Glenn 2010: 1-2).

(45,000), San Julian (46,000), Warnes (95,000), Montero (108,000), or La Guardia (88,000), to mention the largest (INE 2012)

There is no national health care for all Bolivians. Instead, certain social groups can enjoy the privilege if they satisfy certain conditions. Such is the case of women during pregnancy and for six months following childbirth. At present, all pregnant women can access free health care (which extends to their children until they turn five) in state-run (public) hospitals, where appointments are made on a first-come-first-served basis. This caveat sometimes makes it impossible for a woman to benefit from this government-offered benefit. Quite frequently, she does not have the choice of leaving her older children in somebody else's care; sometimes they are too young to be left in nurseries and kindergartens (which are neither free nor easily accessible). Single mothers often have to devote a full working day for the doctor's appointment, which deprives them of a day's wages. Apart from factors such as these, which stem from everyday realities, there are also emotional reasons: some women, especially those from underprivileged social groups, frequently experience a lot of anxiety during such visits (cf. Paulson & Bailey 2003: 493). For instance, they can feel physically uncomfortable due to the nature of the examination – performed by a male doctor. Their apprehensiveness could also be of an emotional nature, as a result of the differences in communication styles between the doctor and the woman, when the specialist does not speak the language that the patient knows better than Spanish (such as Aymara, Quechua, Guarani, Guaraní, Besiro [Chiquitano], etc.) or when specialised vocabulary is used to explain the condition to the woman (cf. McNamee 2009: 168; Caprara 2010).

There are significant differences concerning approaches to reproductive health within Bolivia. Generally speaking, people from rural areas are much less adventurous with respect to using various methods of contraception or consulting specialists. Contraceptive pills and condoms are the most well-known methods for preventing pregnancy. Other modern solutions, such as IUDs, contraceptive injections or subdermal implants, are much more popular among

the emerging middle class as well as among the better educated part of the population, who are more likely to live in urban areas. This difference is also visible across genders: women display more interest in learning about their possibilities when it comes to having – or, indeed, not having – children (Paulson & Bailey 2003). With regards to contraception and beyond, women from urban areas experience advantage regarding the choices available to them: in addition to the state-run hospitals, there are also NGO-managed and private health clinics, church-run hospitals (which are not enthusiastic about either contraception or abortion), and, practitioners of traditional medicine. Nonetheless, the decisions to choose one specialist or hospital over another is dictated by a combination of factors, some of which are beyond women's control: these include availability of affordable transport, proximity to the hospital, their financial situation, prior experiences, the advice of friends or family members, levels of fear or anxiety about going to a biomedical specialist, the number of children a woman already has, possible previous caesarean sections, the desire to have more children, and, possibly above all, whether or not she believes she needs to see a specialist. With all these influencing forces in mind, I would like to argue that the implementation of a national health insurance system designed particularly for pregnant women and young children has tipped the scale in favour of biomedicine.

The introduction of the *SUMI* dramatically affected pregnant women's choices. Prior to this, each appointment at a health clinic entailed additional financial strain. Despite the fact that the fees in the cheapest hospitals are not very high by Euro-American standards, they may still cost as much as a solid, home-cooked meal for a large family. Filling in a prescription also incurs additional costs since the Bolivian pharmaceutical industry is not well developed and a large majority of medications, including the most commonly used analgesics, such as paracetamol and ibuprofen, are imported from neighbouring countries, resulting in relatively high prices. Therefore, to a woman who has successfully survived a number of childbirths, antenatal checks may seem – quite understandably – like an unnecessary expense. The *SUMI* changed that

drastically: suddenly, not only are ante- and postnatal appointments free of charge, but they may also be a way of *receiving* small – but regular – amounts of money.[9]

Figure 12. *La Rotonda*. During the strikes held by doctors employed by state-run hospitals, the Ministry of Health and Sports sponsored free medical consultations at a health post in a tent installed on the main roundabout in *Plan 3000*, 2012.

I argue that the availability of free medical care for pregnant women, especially with the recent support of financial incentive, has significantly influenced Bolivian women's ways of thinking about pregnancy, particularly in urbanised areas. The level of authority and the kind of privileged knowledge which is commonly ascribed to biomedical doctors, especially by people without formal education, combined with the state supported health insurance system, clearly marks pregnancy as a medical condition, as well as pressurises women to think of it as such. Curiously, with the pro-indigenous government of Evo

[9] See Smith-Oka (2009) for a critique of a similar health insurance/cash transfer programme in Mexico.

Morales, Bolivian political structures now include *Viceministerio de Medicina Tradicional e Interculturalidad*, the Vice-Ministry of Traditional Medicine and Interculturality, while the Political Constitution of the State promulgated in 2009 officially recognised medical systems other than biomedicine. All these factors, however, often lose their force when confronted by the forceful reach of the *SUMI*.

The importance of being pregnant:
The personal and social implications of impending motherhood

"Do you have any children? Why not?" I was asked again and again, until the only answers I could muster up were in the vein of intentional sarcasm. Frustrated by the question, I would say "*Me cuido bien*," which literally means "I take care of myself" but implies effective use of contraception (or, in a more passive-aggressive interpretation, suggests unsuccessful application of birth control by those who become pregnant). But this question reveals more than what I initially took for Bolivians having no respect for other people's privacy or their inherent inquisitiveness. In the end, it was clear to me that this question was not a personal one at all, it was as ordinary as it gets, unlike my negative response to it. During the time I lived in Santa Cruz I met quite a few women who did not have children. However, those among them who did not desire offspring were truly few and far between. Interestingly, childless women who hoped for a child frequently had very specific scenarios designed for the future: including number of children, gender distribution, and baby names, and sometimes even the methods of delivery. In the end, the phenomenon of women (and men) wanting children is quite common all over the world, so what may be different in the case Santa Cruz – and perhaps in Bolivia in general – is the degree to which reproduction becomes a public affair.

Children are almost everywhere in Santa Cruz (and Bolivia, and probably Latin America), their rumbustious presence filling the air with screams and laughter. They are carried in *aguayos* on women's backs or led by their hands, and

in the overwhelming majority of situations, they are accompanied by women: mothers, grandmothers, sisters, aunts. This, of course, does not mean that men refuse to take care of children, but there is an explicit expectation as to the gender of the primary caretakers.[10] I once had a conversation with a taxi driver who said that his wife had abandoned him, leaving their five daughters behind. The wife had since remarried and he struggled to provide for the girls. I sympathised with him greatly, and yet I kept thinking about some of my informants who never even hinted at the possibility of their husband sharing the unspectacular and mundane task of childminding. On the other hand, a husband who took responsibility for his offspring was explicitly considered praiseworthy. Rather than comparing it to the Euro-American unattainable ideal of gender equality, it is perhaps better to understand it as a reflection of the real-life expectations of female migrants in Santa Cruz.

Additionally, women do not seem to be able to decide to what extent they want to participate in childrearing; to the contrary, there is an unspoken assumption about their willingness to engage in this activity (see Chapter 6). Let me illustrate this with an example from the household where I lived during fieldwork. Don Leopoldo, my landlady's "social husband,"[11] was very good with children. In the evenings, he would sit in front of Doña Paula's shop and sip his cup of *matecito de coca*, coca leaf infusion, chatting with the children from the neighbourhood who were sent to do the shopping for dinner. Even though he liked to gently tease them, he treated kids from the neighbourhood rather seriously: he remembered their names, previous conversations he had had with them, and they seemed to like him genuinely as well. At the same time, the same Don Leopoldo maintained very little contact with his infant granddaughter, Laura. Initially, when she still could not walk, I ascribed it to Doña Paula's unwillingness to part with the baby girl. However, one evening, I came to

[10] See Chapter 6.

[11] Doña Paula and Don Leopoldo never married but had been living together for over twenty-four years at the time of my fieldwork. They took a lot of pride in their stable relationship and the fact that they did not need *papeles*, papers, to make it work.

reconsider my assumption. While I was taking care of Laura, I had to go to the bathroom so I passed her to Don Leopoldo, who took her with his arms stretched out and kept her in that position, letting her wiggle her chubby legs in the air, until I came back. I found it unusual and asked him what the problem was. Don Leopoldo said that he preferred children who walk and talk. With time, and as could be expected, Laura started to walk and babble, which changed Don Leopoldo's attitude towards her: he began talking to her, brought her little gifts and played with her, as if he had never refused to engage with her before. Nobody in the household seemed to mind his lack of relationship with the baby when she was younger. To the contrary, Doña Paula would say: "He doesn't like kids when they are little. He was like that when our daughters were born, too." I will return to the issue of asymmetrical parental duties in Chapter 6, however, what I would like to highlight here was a rather indifferent attitude towards the intentional disinterest of men in some aspects of childrearing.

Rosa, one of my closest friends in the field, told me once, ever so insightfully, that when she found out that she was pregnant, she *felt* triste y allegre a la vez*, sad and happy at the same time, as if a part of my life had ended and another one had begun.*[12] It could be argued that women who become pregnant can at least suspect what awaits them in terms of baby care: relentless sacrifice and perseverance. At the same time, becoming a mother changes the woman, not just in her own eyes, but also in the eyes of others (cf. e.g. Wądołowska 2010: 52; Browner & Sargent 1996: 222; Tremayne 2001: 15). *Yo vivo por mi hija*, I live for my daughter, Rosa told me on multiple occasions. I sometimes thought that it must be scary to completely anchor oneself to another's existence. But there is more to having a baby than just creating a dyad; a new baby links both the mother as well as the newborn to an entire familial and wider social network, where they can participate in multiple potential relationships. Having children is a little bit like creating an ever-growing palimpsest, overwriting the past, but never

[12] See Chapter 4.

erasing it completely, adding new layers of meaning to the text of life, making it more complicated.

Being pregnant in the city of Santa Cruz de la Sierra: Privileging the biomedical point of view

In the initial phase of my research on *sobreparto* in the city of Santa Cruz I had a plan: I wanted to find a traditional midwife and try to become her apprentice. This plan failed miserably, albeit not for my lack of trying. For many months, I could not locate a single traditional midwife. Quite early on, I actually managed to acquaint myself with a couple of midwives who were no longer practising. One had been trained by biomedical doctors although she had some knowledge of certain aspects of Andean midwifery, such as *manteo*[13] or massaging the foetus into the birthing position. The other one was a local *camba* midwife, who also did not attend childbirths anymore and had no knowledge of *sobreparto*, the condition I set out to investigate. Despite these initial difficulties, I remained persistent. I would ask just about every single person who decided to make eye contact with me for the first three months. I was hungry for even the most measly piece of information about any practising *partera tradicional*, traditional midwife, and I memorised these scraps of information like prayers. For months I thought that it was impossible that in a city as large and as diverse as Santa Cruz there were no practising traditional birth attendants, who had slipped through the cracks in the system to welcome babies into the world in the heat of Santa Cruz.

The truth is that I do not know if I was wrong. I still think that it is possible that I was just unlucky, that people did not share information with me. At the same time, this failure of mine to locate a single practising traditional midwife, despite a prolonged and vigorous search, is quite significant. In the end, I managed to find one practising midwife, Doña Faviola. She had been trained by

[13] Manteo is an Andean technique of repositioning the foetus in which the pregnant woman lies down on a blanket, which is moved her by two people. Sometimes the pregnant woman is thrown up in the air (see e.g. Bradby and Murphy-Lawless 2002).

biomedical doctors and spoke very disparagingly about traditional ways of helping women in labour. She used to work in a hospital but now attended childbirths in her neighbourhood on the other side of town to the main area of my study. At the time of my research she assisted one to two deliveries a month even though in the past she would be busy almost every other night. When I asked what she thought the reason was, Doña Faviola replied that she only attends childbirths when a woman in labour cannot make it to the hospital, located about 30 minutes away by taxi from the heart of her *barrio*. This, too, was significant insofar as it pointed to the fact that in the city of Santa Cruz, even in a remotely located neighbourhood, the services of a midwife are nowadays considered a last-resort option rather than a first choice. I will return to this issue below.

Even with my interest focused on *sobreparto*, I understood that it was important to collect entire life histories through multiple and repetitive conversations with a number of women. This decision was motivated by the fact that hardly anyone can produce a perfectly chronological, systematic, and detailed account of their lives when surprised with an impromptu request to recount one's life story – and I did not expect it would be different in the case of my investigation. Additionally, positioning the illness within the context of events preceding labour, as well as following it, allowed more memories to surface.[14] By extending the scope of my interests I was able to gain insight not only into the illness, but also many more subtle changes about women's attitudes towards their consecutive pregnancies. In this chapter I specifically draw on those descriptions of pregnancy and labour which combined both traditional and biomedical concepts.

Narratives about pregnancy were as varied as their authors, but most combined biomedical and common knowledge categories. Generally speaking,

[14] See Chapter 3.

biomedical categories involved technical names for body parts, such as *el cordón umbílico*, umbilical cord, (rather than just *el cordón*, cord), or names of pregnancy-related medical conditions, such as preeclampsia. Common knowledge categories were applied to special attributes ascribed to the foetus; for instance, one of my informants insisted that every time she was pregnant with a boy, she knew it early in the pregnancy since "*el varoncito*, the little boy, was kicking from the second month." In the Andes, it is commonly believed that male foetuses are more active and become formed earlier in the womb, as opposed to female foetuses, who are passive and reach full formation during later stages of the pregnancy (see e.g. Morgan 1997). Another woman I interviewed called her C-section scar with a dramatic-sounding phrase *mi herida*, my wound, and claimed that it had not fully healed even though her baby was over 12 months old.[15] She continued to wear elastic underwear to keep it tightly bound, a modern equivalent of the traditional *faja*, a square piece of fabric, folded into a triangle, used to tie the abdomen after childbirth. In this case, it is possible that discourse concerning past gestations could have been influenced by biomedical knowledge acquired after the pregnancy.

In traditional Andean medicine, it is the *partera*, midwife, who guides the woman through her pregnancy and childbirth. She[16] is knowledgeable and attentive, is able to recognise trouble by checking the pulse on the woman's wrists, puts her ear to the stomach to hear the foetus's heartbeat, and knows how to massage a breached foetus into the proper birthing position.[17] With increasing access to biomedicine, in order to continue to practise openly, traditional midwives have frequently had to attend courses of midwifery, where they are informed about techniques to make childbirth safer, by using sterilised materials

[15] There is evidence that the surgical incision of the caesarean section may in very rare cases lead to abdominal scar endometrioma, which manifests with pain (see e.g. Leite et al. 2009; Minaglia, Mishell & Ballard 2007). I do not know if this was the case with the woman in question.

[16] There are male midwives, called *parteros*, but they are less common.

[17] In fact, this last skill was very fondly talked about as it prevented the necessity for a frequently feared caesarean section.

and washing their hands thoroughly with soap before delivering the baby. Encouragement to adopt these techniques would come in the form of a sterile birthing kit, given to each midwife who completed the course, accompanied by a printed certificate, with the calligraphed name of the – not infrequently illiterate – *partera* (Paz Ballivián 2011; Loza, [ed.] 2012).

Furthermore, contemporary Bolivian legislation concerning reproductive health recognises the importance of midwives, especially in rural areas. At the same time, the manner in which *parteras* are written about in reports or texts outlining standard procedures suggests that they are treated as channels for the biomedical model of pregnancy, childbirth, and postpartum care. Thus, on the one hand, workshops that teach traditional birth attendants about the importance of sterilising materials coming in contact with the mother and the baby during labour have unquestionably resulted in lowering both maternal and infant mortality rates. On the other hand, the same workshops often included information on symptoms of complications in pregnancy (according to their biomedical understanding), accompanied by a direct instruction to seek "qualified attention," that is, a biomedical obstetrician. There is no doubt whatsoever that these procedures have led to a significant decrease in maternal and infant mortality, and they are widely acknowledged as a positive result of the probably unavoidable spread of biomedical knowledge. Simultaneously, the price paid was quite high by all kinds of traditional healers, including *parteras*, who used to be the bearers of specialised and elusive medical knowledge. With fewer women using the services of traditional birth attendants, there is less knowledge about their skills and expertise passed around. Thus, *parteras* have been gradually losing their social standing, in addition to losing patients.

Therefore, although the legislation recognises traditional medical systems as equal to biomedicine, and formally supports them through the structures of the Vice-Ministry of Traditional Medicine and Interculturality, the changes which have occurred in the way that pregnancy and childbirth are now approached have become largely irreversible. The Ministry of Health and Sports, which includes

the Vice-Ministry of Traditional Medicine and Interculturality, published a report stating that it is impossible to educate new traditional midwives (Ministerio de Salud y Deportes 2007: 12; cf. Paz Ballivián 2011: 31-43). This seemingly paradoxical pattern of, on the one hand, acknowledging the value of traditional knowledge and, on the other hand, intentionally restricting its scope of development and influence, had a decisive effect on the approach to reproductive issues in Bolivia. Despite explicit credit given to traditional ways of handling pregnancy and childbirth, women are strongly encouraged to adopt biomedical solutions. This pattern is quite prominent in the city of Santa Cruz, where nowadays only a few women choose to deliver a baby with the help of a traditional birth attendant at home (INE, UDAPE & DFID 2005: 42).[18]

There are very few midwives in the city of Santa Cruz de la Sierra, and even fewer are still practising.[19] During my research I met three midwives, only one of whom still attended childbirths. Doña Faviola lived in a district located to the north-east of the city centre. It was a relatively recently urbanised zone, where only the main roads, largely overlapping with the mini-buses routes, were paved. Houses next to the main streets were built of bricks and surrounded with high hollow tile walls with coils of barbed wire on top. A little further away, however, people lived in small wooden shacks, constructed of bare planed boards with uneven edges, chipboards, covered with rusty pieces of corrugated iron or, preferably, with *duralit*, asbestos-cement roofing material. The latrine was usually

[18] The statistics concerning the department of Santa Cruz vary quite significantly, estimating the rate of childbirth attended by biomedical personnel (including biomedically-trained midwives) from 68 percent (INE 2012; Sistema de las Naciones Unidas & UDAPE 2011) to the 90 percent (Galindo Soza 2010: 116; UDAPE 2004). The patterns found in various sets of statistical data indicate higher rates of hospital childbirth among women who are educated, young, or have few or no children. Women who are over 35 years old or have more than five children are much more likely to give birth at home (Galindo Soza 2010: 114-16; UDAPE 2004).

[19] This is very different to the Andean zone, where traditional midwives issue birth certificates and are relatively easy to be found. This may be rather anecdotal evidence, but during a stay in La Paz I visited the offices of the Vice-Ministry of Traditional Medicine and Interculturality on a random weekday. It turned out that I had walked into a reunion of traditional midwives. I counted seventeen – and I was not even looking for them on that day!

an additional little shed about ten metres away from the house and the shower consisted of a large piece of fabric nailed around four tall poles in a shape of a square cabin near the water pipe and tap. The lots were fenced with two or three strands of plain or barbed wire wrapped around waist-high poles marking the shape of the plot. The most remote houses were located about 25 minutes away from the nearest mini bus stop, which was another good 40 minutes on public transport to the nearest public hospital. Some women in labour would not make it. They were the ones who might seek Doña Faviola's help.

Doña Faviola is one of the *parteras* who completed a biomedically-oriented course and became certified. Additionally, she learnt from other local practising midwives, most of whom were from the lowlands. In the past, she would deliver about 20 babies a month – these days she only attends one or two births in the same period. In theory, childbirths attended by certified midwives (both traditional and biomedical) qualify as "institutional delivery" and, by the same token, for the Juana Azurduy stipend. However, the midwife is obligated to produce a certificate for the woman. Doña Faviola said she did not supply such certificates. Creating formal childbirth documentation is likely to be even less common among midwives who have not been biomedically trained. This is one of the reasons why Santa Cruz women who qualify for the *Bono* are more likely to try to deliver in a state-run hospital. The urbanization of the city suburbs constitutes a significant factor contributing to the change as hospitals are now within easier reach for people from a large majority of the city's districts. At the same time, there are other factors at play: the availability of medical insurance, the potential advantages of a hospital birth for the mother and her baby, as well as the idea that labour and childbirth specifically require medical attention.

It is very important to emphasise that this situation is not uniform in Bolivia. There is much more resistance towards giving birth in hospitals in the Andean zone and in rural areas.[20] Multiple authors report a lot of reluctance towards

[20] Simultaneously, at present, the majority of women in Bolivia (56. 38%) give birth in hospital, although the percentage is higher in urban zones than rural areas (66.49% and 34.43%,

hospital delivery in Bolivia – women are frequently anxious about being attended to by male doctors, about the low temperatures in the hospital rooms which can cause illnesses, or caesarean sections, or even that they will not be given a placenta, among other worries (Bradby 1999: 293, 296-9; Larme 1998: 1009; cf. Platt 2002: 131; Bourque & Warren 1981: 90-95). The city of Santa Cruz de la Sierra may constitute a special case in terms of its almost complete uniformity as regards receiving biomedical attention in childbirth. This homogeneity, however, may prove to be superficial if women's motivations are scrutinised. While a large majority consciously direct their steps to the biomedical institution at the end of pregnancy, their decision-making processes are by no means identical, and neither are their expected or real outcomes.

An analysis of statistics concerning aspects of pregnancy and childbirth in Bolivia points to the fact that the introduction of national insurance covering such situations was an excellent decision with regards to health service strategies. Its first version, Seguro Nacional de Maternidad y Niñez, was introduced in 1994 but replaced in 1998 by Seguro Básico de Salud, and finally by the current *SUMI* in 2003 (PNUD 2007: 97; Galindo Soza 2010: 14-17). Maternal mortality dropped by almost 50 percent between 1990 and 2003 and continues to decrease (PNUD 2007), and this is undeniably a positive change. However, lower maternal mortality rates are not just the result of the wide availability of national insurance. In the context of Santa Cruz, where hospital birth has become virtually the only option, pregnant women are active in making plans for the delivery. These plans are influenced, very importantly, by their own (or their relatives or friends') experiences in previous childbirths as much as by their financial situation and immediate labour circumstances.

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respectively) (INE 2012). These rates may be underestimates since the census takers failed to elicit answers from over 18% of the female population over the age of 15 who had given birth; their responses to the question "Where did your last childbirth take place?" were classified as "unspecified place" (other options were: "hospital or health post," "at home," and "in another place").

Private clinics or hospitals are generally considered to offer better services than public (state-run) hospitals. People say that paying the doctor makes them respect the patient more and that private health service establishments have better medical equipment at their disposal. Because only a small proportion of the population qualifies for national insurance of some sort, potential patients have to pay for a doctor's appointment regardless of the type of institution they choose, meaning that price may strongly guide their choices. A woman's negative experience of childbirth in a state-run hospital may result in her choosing an affordable private clinic for subsequent birth. This decision has further potential advantages, namely, the availability of regional anaesthesia (such as epidural) or a planned caesarean section. The percentage of C-section deliveries in the department of Santa Cruz is over thirty-eight percent (INE 2012), which is more than double the 15 percent rate recommended by the WHO until June 2010 (2010b).[21] A young doctor employed by one of the city-centre clinics stated that between 80 and 90 percent of pregnant female patients undergo caesarean sections in that particular clinic. The remaining 10 to 20 percent are usually Bolivian Mennonites, whose cultural convictions do not encourage elective surgeries. Another doctor mentioned the convenience of scheduling a C-section from the point of view of the professional in terms of the time necessary to deliver the baby (operations can be scheduled and are shorter than average natural childbirth) but also with regards to the remuneration – surgery is priced at three times that of vaginal delivery.[22]

In addition to the state-run hospitals, there is a wealth of alternative options as regards seeking treatment. They differ in privileging various viewpoints, usually ranging from explicitly biomedical to explicitly non-biomedical, with several intermediary options. The new Bolivian constitution, passed in 2009, recognises

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[21] The WHO has suspended this recommendation; its handbook, published in June 2010, for Monitoring Emergency Obstetric Care states that "Ultimately, what matters most is that all women who need caesarean sections actually receive them" (WHO 2010b: 25).

[22] I heard similar claims from a number of health personnel I talked to during fieldwork, as well as from radio advertisements for various clinics.

all medical systems, traditional and biomedical, as equal. As mentioned above, traditional medicine receives institutional support in the form of the Vice-Ministry of Traditional Medicine and Interculturality, which is one of the sub-branches of the Ministry of Health and Sports.[23] As a result of the current legislation, each state-run health institution is strongly encouraged to employ at least one traditional medicine specialist.[24] However, people who have already decided to seek help in a state-run hospital are unlikely to choose a traditional healer over a biomedical doctor there. Such healers are much more popular if their place of work is located outside of a hospital-like institution; for instance, they very often see patients in their little venues at or near the city's main markets.[25] Additionally, they specialise in different kinds of illnesses: particularly those trivialised or not recognised by contemporary biomedicine.

When discussing childbirth during interviews with migrant women in the city of Santa Cruz, I would often begin by asking about their own pregnancies and childbirths, but I also inquired about their relatives and friends' experiences. Although most of my interlocutors had heard of someone who gave birth outside of a hospital setting, only two of the women who spoke with me, both in their early fifties, had had personal experience of home childbirth with their firstborn. Every subsequent pregnancy ended with a hospital delivery, for a variety of reasons, ranging from labour complications to personal choices. Among my younger informants, those in their twenties and thirties, hospital childbirth was the unquestionable standard – although they were aware that this manner of

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[23] The other two branches are the Vice-Ministry of Sports and the Vice-Ministry of Public Health and Development.

[24] This, in practice, has a rather meagre effect. In one state-run hospital I visited, there was one door, near the reception and quite far away from other offices, with a plaque reading *Especialista de medicina tradicional*, Traditional medicine specialist. During the hour I spent there waiting for my friend, nobody went in or out that room.

[25] *La Ramada* is the market in the city of Santa Cruz where traditional healers have their own section of the market specifically designated for traditional medicine. It is possible to come across *curanderos* or *naturistas* in other markets, but not in such numbers.

bringing babies into the world is a relatively new one. At the same time, for them, there is no choice outside of hospital birth, which does not mean that there are no decisions to be made. On the contrary, the woman must decide if she is going to give birth in the public hospital or a private clinic, and in the latter case she has a great degree of influence over the delivery method, including a caesarean section on request.[26]

Childbirth and woman's choices: How much can be decided by her?

Many contemporary discussions about childbirth and woman's choices privilege the perspective of the woman in labour.[27] Simultaneously, there is an acknowledgment that there are other participants in the situation of childbirth, such as the baby (or babies) and the attending person, and that each of them have their own interests. In an ideal scenario, the labouring woman will consider the well-being of the baby in addition to her own, however, the hierarchy of priorities changes when the precarious balance is interrupted by authoritarian biomedicine. Whether attended by a relative, experienced midwife or a biomedical doctor, childbirth is far from peaceful. Both for the woman and the baby, it is violent, irreversible and significantly restricts the possibility of exerting control over what is happening. As a result, the woman may often feel pressured into a solution she had not previously considered: in the case of a hospital birth these may include an oxytocin drip to stimulate contractions, epidural anaesthesia and other forms of pharmaceutically induced pain relief, or a caesarean section.

Despite various levels of enthusiasm for hospitalisation, almost three-quarters of all childbirths in Bolivia occur in biomedical settings (INE 2008),

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[26] Caesarean sections are quite popular in Bolivia: I once heard a radio advertisement for a private clinic which featured a long list of the most popular procedures as well as their prices; along standard blood tests and urine analyses stood the C-section for Bs 1300 (approximately GBP 130).

[27] From WHO recommendations (2006b) to a multitude of critiques of the medicalisation of childbirth (Strong 2000; Conrad 2007), to personal accounts of childbirth (see e.g. Wolf 2002; Cusk 2008; Figes 2008 [1998]).

while half of all childbirths take place in state-run hospitals under the coverage of the *SUMI* (Gálvez Murillo 2009; INE 2008). This means that almost all those deliveries were overseen by some kind of biomedical professional, whose opinion was often given more weight than the woman's wishes. There is a general consensus that doctors "know best," which on the one hand leads to women often feeling less in control, although on the other, it may have contributed to lowering maternal and infant mortality due to quick decision-making in life-threatening situations – such as emergency C-sections.[28] When I discussed decision-making surrounding childbirth with women in Santa Cruz de la Sierra, it quickly became clear that they had very little say in the process. At the same time, their awareness of options grew with each subsequent pregnancy. For instance, rather than use a free state-run hospital, they would save up money in order to give birth in a particular clinic, where they would be treated better by the personnel. Or they would choose a private clinic in order to have an elective C-section rather than attempt a vaginal delivery.

There is some ethnographic evidence documenting fear of hospital childbirth in the Andes (e.g. Bradby 1999; Platt 2002; Bourque & Warren 1981). Nevertheless, considering the current state of affairs in the city of Santa Cruz, I would venture a claim that, irrespective of possible anxiety and apprehensiveness, a hospital is the undeniable first choice for delivery for almost all women of reproductive age. Giving birth was not described as an enjoyable experience, however, the interviewed women mentioned numerous actions they undertook to make themselves more comfortable in the process. These included having a family member around, convincing the nurse to allow them to drink hot herbal infusions, deliberately choosing a private clinic to give birth in, as well as – after childbirth – asking for and receiving the placenta, being able to use *faja* to tie the

[28] It is difficult to estimate the exact number of emergency C-sections as it varies from hospital to hospital (e.g. hospitals with highly specialised maternity wards are much more likely to have higher rates of caesarean sections, both emergency and planned). However, the rate of *emergency* C-section should be lower than 15%, which is a C-section rate (both indicated *and* emergency) recommended by the WHO in the past (WHO 2010b).

abdomen with, having the baby nearby at all times. In general, women are given fewer choices in state hospitals, however, giving birth in such institutions allows them to qualify for the Juana Azurduy stipend and incurs no financial cost although it leaves them at the mercy of the doctor's decision-making. Women who do not qualify for the stipend are more likely to consider a private institution, given that the choice of commercial health institutions is quite broad,[29] as is the range of prices.[30]

While most low-income women express a preference for natural childbirth, there are also female migrants who overtly praise the C-section. I talked to a number of women who had delivered all their children via this method but I also came across some younger, childless women, who claimed that they would opt for this method of childbirth for a variety of reasons. While the latter emphasised their unwillingness to endure pain and sometimes even speculated that it must be better or less stressful for the baby because it takes less time than natural childbirth, women who went through multiple caesarean sections prioritised aspects of this procedure concentrating on themselves rather than the baby. It is important to note here that not every C-section is an elective surgery, although there are more and more elective caesareans all over the world (Gibbons et al. 2010).[31] Whatever the preference, there are many examples of situations in which

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[29] For instance, in 2013 in the eastern section of the city, which was my main research area, there were 41 health institutions: 18 public, 10 run by NGOs (including 5 run by various religious organisations), and 13 private. All of them were situated less than 25 minutes by bus from the centre of Plan 3000 and four of them were located in its centre (Vaca 2013, personal communication). This information has been taken from an interview with doctor Rubén Vaca Vaca in April 2013 as well as from digital materials I received during a visit to *La Red Salud "Este,"* the Administrative Centre of Health Service responsible for the eastern section of the city, with approximately 500,000 inhabitants.

[30] The price of a caesarean section in a private clinic (indicated and elective) varies from the aforementioned Bs 1300 to as much as Bs 14,000. Under the *SUMI*, the state-run hospital receives as little as Bs 272 for performing the surgery (Pérez 2013).

[31] In the past, the caesarean incision was most commonly performed vertically along the middle section of the abdomen. In addition to producing relatively prominent scarring, it also rendered any future attempt at natural delivery virtually impossible (Symonds & Symonds 2004; Silverton 1993). As a result, every subsequent pregnancy had to be concluded via a C-section, irrespective

migrant women exercise their discretion when it comes to making decisions about reproduction. What follows is the story of Julia, one of my closest friends in Santa Cruz, whose reproductive choices reflect her agency and willingness to determine her own fate.

Julia

Julia's history of pregnancies offers an excellent example of how women actively negotiate what happens to them as much as they can, given the circumstances. Julia is a second-generation migrant – her mother, Doña Valentina, is from the department of Oruro and speaks both Quechua and Aymara in addition to Spanish. Julia was born in Santa Cruz and speaks only Spanish, but with a slight Andean accent. Her facial features also point to her Andean origin, but she dresses like a *camba*, a person native to Santa Cruz, in leggings and tight tops. She is a mother of four: two daughters, Nohelia and Silvia, born in 1997 and 2000 and two sons, Marco and Juan, born in 2008 and 2012. She had been married for five years before she became pregnant for the first time. Prior to her first pregnancy she studied law at the Santa Cruz state university, but never graduated, failing to complete the writing of her thesis, which was a final requirement of the degree. Because Julia and her husband Rodrigo had been trying for such a long time, they suspected that perhaps one of them could not have children at all. Following her mother's advice, they went to pray in a church where masses were celebrated in Quechua. A couple of months later Julia became pregnant with Nohelia. Her second daughter came relatively soon and with two small girls to take care of, it was extremely difficult for Julia to find stable employment. She would do odd jobs every now and then, such as cleaning or cooking. When Nohelia and Silvia were finally old enough to be left on their own, Julia became

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of the woman's desires. These days, the comparably shorter transverse incision in the lower part of the abdomen heals better and faster, allowing for future natural deliveries, provided that enough time has passed since the preceding pregnancy, usually five years and not less than two (cf. Symonds & Symonds 2004; Hudić et al. 2012; Nabhan 2008).

pregnant again and gave birth to Marco in 2008. Her last son, Juan, was born two weeks before I arrived in Santa Cruz in 2012. When asked, she said that she does not want to have any more children, and 8 months after she gave birth to her last son, she went to a Marie Stopes International clinic for women to have a subdermal contraceptive implant inserted.[32]

Julia gave birth to her first baby in a state-run hospital. It was a vaginal delivery and she was lucky enough for it to be a relatively short one. Despite this fact, Julia remembered it as a very traumatic event. In a voice trembling with emotion, at times with tears in her eyes, she recounted what had happened that day:

> *I was disoriented, nobody told me what was going to happen to me, I wasn't ready for any of it. I heard screams and after a while I realised that they were women giving birth, and then I realised that I was one of them… that I would be screaming like that real soon. The doctor was* muy bruto *[very rough/brusque], he would put his cold hand down there to check if I was dilated. He made comments and rude jokes about my pain.*

When Julia found out that she was pregnant for a second time, she was determined not to return to that hospital. With the help of her mother and her husband, she started saving up money to give birth at a local private clinic despite the fact that she qualified for a free childbirth in a state-run hospital. When the labour pains came, she went to the clinic and even though she remembered her second childbirth as longer and more painful, she was much more at peace with the way she was treated. *The nurses, they talked to me to calm me down, I didn't feel so alone*, said Julia. With the third pregnancy, as the ultrasound revealed the sex of the foetus as male, it was Julia's husband who insisted on childbirth in a private

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[32] Marie Stopes International is a non-profit organization specialising in sexual and reproductive health. It has a number of clinics in Bolivia, including three in the city of Santa Cruz de la Sierra, and is known for offering solutions to unwanted pregnancies and a wide spectrum of modern contraceptive options, from mechanical to hormonal, at affordable prices. In Santa Cruz, all three clinics are located near major markets, which is convenient for women, who constitute the majority of vendors.

clinic. *So that nothing happens to my only son*, he argued. It was 2008 but she remembered having been treated badly in the first hospital and despite the fact that she had heard about changes in state-run health institutions, Julia still preferred not to risk it.

The shift in her decision-making came during her last pregnancy. In 2009 the government of Bolivia introduced the *Bono Juana Azurduy*, a small stipend paid to the women who fulfil a number of caveat-ridden conditions. Any woman who wants to claim it must have her first antenatal visit before the end of the first trimester of pregnancy, followed by checkups between fourth and fifth, sixth and seventh, as well as eighth and ninth month. Childbirth must take place at a state-run hospital or other certified institution or occur in the presence of a certified midwife. The woman and baby must undergo their first postnatal check-up within seven days of birth. Following that, the child must be examined by the doctor every two months until he or she is two years old. At present the total stipend amounts to Bs 1820 (approximately GBP 182) and can be claimed through the period of up to 33 months. Each antenatal visit is worth Bs 50, childbirth at a state hospital and postnatal examination are valued at Bs 120, while each bimonthly visit with the baby awards the woman Bs 125. The right to receive the stipends can be lost relatively easily by missing two consecutive appointments during the child's first two years of life, by previously losing the right to the Juana Azurduy stipend due to missing appointments, by becoming pregnant less than three full years after the last birth, and by providing false information about one's socio-economic status on the application form.

However, by 2011, when Julia became pregnant with Juan, she did qualify for the programme. In fact, she was quite relieved that the financial strain of pregnancy would not be as serious as before. She attended her antenatal checks religiously, and made arrangements to give birth in the state-run hospital nearest to her home. Julia was facing some obstacles at that time, especially after Doña Valentina, Julia's mother, moved out to help Esmeralda, Julia's younger sister. Esmeralda had recently given birth and needed Doña Valentina's help. This put a

strain on Julia's household economy as Doña Valentina's presence had enabled Julia to engage in some small remunerated tasks. However, Julia was resolved to put herself in the hands of the doctors at the state-run hospital, hoping that things had changed in the last fourteen years. With the end of the ninth month came the labour pains. As they became more frequent and it was time to go to hospital, Julia and her husband got in a taxi and headed for hospital. Unfortunately, a serious power cut in a large part of the neighbourhood thwarted their plans. Since the contractions were becoming more and more frequent, they went to a second state-run hospital, which unfortunately was also without electricity. At that point Julia threatened her husband with giving birth in the street if they did not go to the nearest private clinic, which had a power generator, where the baby could be safely delivered.

There were multiple consequences to this turn of events. The most immediate was the need to come up with the money to pay for the birth at the private establishment. Furthermore, the right to the Juana Azurduy Stipend was lost: it is only awarded to the most economically underprivileged, therefore, women who give birth in private clinics become automatically excluded from this category, in addition to the fact that these clinics do not offer appropriate certificates allowing mothers to claim the stipend. The power cut had deprived Julia and her newborn son, as well as the rest of their family, of a way of supplementing their already meagre income with small amounts of cash. The national insurance scheme for mothers and infants still allows her to receive postpartum checkups as well as to take her infant son for doctor's appointments, but she is much less likely to do so if there is no financial incentive that could at least partially offset the effort of going to the doctor, in terms of transportation costs and the time spent waiting in a queue in the hospital. Frequently, when women do not qualify for the stipend and their newborn seems healthy, they refuse to take them to hospital on the grounds of not wanting to expose the baby to an environment full of sick babies.

The history of Julia's pregnancies clearly demonstrates that biomedical attention was not an issue of major importance in the choices she made for each childbirth. In fact, it remained beyond discussion. Doubtless, it had – at least partially – to do with the fact that her labours generally took place without complications. On the other hand, she did take into account the quality of service provided by the nurses (but not the doctors) as well as the price of the service. Additionally, Julia focused on her own wellbeing much more than on the baby's while planning the delivery. Rather than suggesting that she is an uncaring mother, it points to her recognising that the comfort of the woman during childbirth includes appropriate care of the newborn.

In many ways, Julia is not an average woman. She is university-educated and does not have to maintain her family on her own, which is a situation many women can only dream of. And yet, the stories she told about each of her pregnancies are similar to those I heard from other women I interviewed. They based their decisions on their own experiences as well as the on advice of their friends and relatives. Sometimes, public advertisements can encourage them to choose one private clinic over another – in Santa Cruz private clinics often advertise on the radio, listing their competitive prices. Public information campaigns also play a certain role in women educating themselves about pregnancy and baby care. During my fieldwork I heard a number of short radio broadcasts on the benefits of breastfeeding, and colostrum in particular. Some Andean women do not offer colostrum to the baby, which symbolically teaches the child about scarcity (Bradby 2002: 89; cf. Platt 2002). One broadcast in 2013 took the form of a conversation between a male doctor and a new mother, who spoke with an Andean accent. The doctor informed the woman of the importance of feeding the baby with colostrum and communicated a vision of unspeakably terrible consequences should she not follow his advice. The woman responded in a guilt-ridden tone *¡Ay, doctor, no supe yo!*, Oh, doctor, I didn't know! The dialogue was quite repetitive, which is not unusual for advertisements in

Bolivia, but successfully reiterated the idea of biomedical doctors who hold the key to knowledge.

It is indeed a very prominent characteristic of medical professionals in Bolivia (although probably in many other places as well) that biomedical specialists tend to be authoritative and are considered to have authority. A brief examination of printed materials about female reproductive and sexual rights in Bolivia demonstrates this clearly. The tastefully coloured and beautifully edited booklets, prepared by the Bolivian branch of the United Nations Population Fund, are abundantly illustrated with rather infantilised and repetitive images (UNFPA & FCI/Bolivia 2011). Here, all doctors – who in this context are either obstetricians or gynaecologists – are male while all nurses, many of whom sport impressive cleavage, are female.[33] Apart from the role of doctor, men appear very rarely (once, to be precise). Women in these colourful drawings are very frequently accompanied by children and are dressed either in full traditional clothing or outfits incorporating traditional elements – curiously, the only woman portrayed wearing trousers was a specialised nurse, who also wore a lab coat and was using a stethoscope to listen to the foetal heartbeat. Despite the fact that the brochures mention midwives, they are not present in the drawings. What does appear, on the other hand, is women waiting for doctor's appointments in hospitals and clinics as well as women smiling while holding their swaddled babies.

***Sobreparto*: Postpartum illness outside the reach of biomedicine**

There are multiple medical traditions available in Santa Cruz de la Sierra, despite the fact that biomedicine has dominated the management of gestation (albeit not its conceptualization). The coexistence of various ways of explaining pregnancy and childbirth presents a number of advantages. Should an unfavourable event occur, an explanation – or numerous explanations – are available, exposing the

[33] It is an interesting choice of gender in the light of the fact that 60 percent of Bolivian women who actually go to a gynaecologist prefer a female doctor over a male one (*El Deber* 2012).

mistake of a previous interpretation and offering a new, satisfying clarification. For instance, when a postpartum woman falls ill with *sobreparto* and is given anti-inflammatory medication that does not work, she can blame it on the biomedical doctors' inability to recognise the condition (hence – their incapacity to cure it adequately). What remains quite persistent is the idea that certain conditions can only be treated by some specialists, and not others.

There were very few other aspects of my research on which my informants were as unanimous as about the idea that biomedical doctors do not know how to treat *sobreparto*. Many women emphasised the failed attempts of the biomedical doctors to recognise and, consequently, to cure it. I sometimes asked women why biomedical doctors are unable cure *sobreparto*. Very often I would get an answer along the lines of *Es que no saben, pues*, they just don't know, often delivered in a dismissive tone. I believe that this lack of interest in explaining the inability of biomedicine to deal with *sobreparto* (and many others) points to a complex understanding of an aetiology of conditions nested between a number of systems – medical (in the case of biomedicine) and social (in the case of conditions which biomedicine cannot cure). In addition to situating the cure for *sobreparto* beyond biomedicine, all accounts contained a situation in which somebody else – a friend or relative – would come over to check up on the woman, diagnose *sobreparto* and suggest the cure. This recurring pattern pointed to a dimension of this phenomenon which was beyond the scope of health and illness – bringing to the fore the social aspect of changeable bodily states. I will return to this issue in Chapter 5.

Doña Valentina

Doña Valentina was thirty-seven years old and had already had two children: Rodrigo and Julia, who were five and three at the time, when she became pregnant with Esmeralda. She gave birth at the local hospital, and ended up with some stitches to mend the episiotomy incision. She told me that her husband had died a month after she became pregnant with her last daughter. I later found out

by accident, in an informal conversation I was having with Doña Valentina's older daughter, that he was not in fact dead, but that he had abandoned her a couple of months after she became pregnant with her last daughter. On the day of the interview, we travelled for an hour and a half to a distant part of Plan 3000, where she took care of Esmeralda's three children. She was cooking lunch for them as she told me her story:

> *I gave birth in the morning and they stitched [the episiotomy incision] up but then the doctor realised that they had forgotten about the placenta so they cut me open again and took it out: a lady put a hand in a glove up there and took [the placenta] out, they did not send me back to the clinic. Then they stitched me back again. The doctor said that I needed to rest but I felt so dirty from all the blood, I felt sticky down there and I wanted to take a shower. So I went to the bathroom and started showering but then there was an electricity cut so the water suddenly went cold, but I was already wet so I just finished washing myself with cold water, what was I supposed to do anyway?* – she asked rhetorically. *The next day they let me go home but I wasn't feeling well: I was weak, I had a headache. They had given me some pills but they were not helping at all. My older children were with me at the hospital all the time, I wanted to take them home, too.*
>
> *At home I was still feeling bad, I was shaking, had cold sweats, fever, I still had the pills that the doctor had given me but* no hacían nada*, they were not doing anything. The neighbour came over and told me that I should rub my body with a mixture of chicken fat, rosemary, cumin, mentisán,*[34] *heated up in the sun. It was she who told me that it was sobreparto.*
>
> *It took a week to heal – I did not go out to work for a week. I still washed clothes and cooked at home but I also wrapped my body with a cloth covered with the ointment* [*my neighbour*] *had told me about.*

[34] *Mentisán* is a brand name of a petroleum jelly-based ointment with a peppermint smell, which is used to rub the body in order to heat it up, for instance during colds.

In her account, Doña Valentina mentioned pills given to her by the doctor. She did not remember their names but on the basis of the circumstances, I think that it is safe to assume that it was some kind of anti-inflammatory medication she received for the stitches – perhaps in combination with painkillers, maybe even wide-spectrum antibiotics, although that is rather improbable given the time frame of the events (early 1980s). It is interesting, however, that Doña Valentina stated that the medication did not seem to be helping with the symptoms of *sobreparto*. Another element worth emphasising was the presence of the neighbour who diagnosed the illness and suggested a cure. The motif of the condition being diagnosed as *sobreparto* by somebody other than a biomedical doctor is a recurrent pattern in all accounts I heard in Santa Cruz.

Doña Sofía

Doña Sofía is a soft-spoken herb vendor with smiling eyes. She has been selling herbs, incenses, and other traditional cures for over twenty years in Santa Cruz, where she moved from the department of Oruro in pursuit of work. She opened a small stand at the market, selling fruit and herbs. Initially she worked there on her own, but nowadays her eldest daughter, Blanca, helps her out in the mornings. Doña Sofía was very knowledgeable about herbs and curative plants and was considered an expert at the market where her stand was located. I had known her for approximately six months and had had fortnightly conversations with her over the period of my research before she first mentioned to me that she too, suffered from *sobreparto*. Because of my chosen method of research (see Chapter 3) I only returned to the topic months later, in my only recorded interview with Doña Sofía.

> *I had Inéz* [her firstborn daughter] *when I was eighteen. My husband left me when I was pregnant and I was still living with my parents in Oruro, in the same house, but in a different part of the house. They were not helping me much, they wanted me to ask my husband to come back. She was born at night and she was so big: fat and with large eyes. I was very afraid but I didn't have a choice, really.*

My mother wasn't helping me so I started cooking and doing the laundry. I was also out of gas so I went to buy a gas tank.[35] *It was really heavy but I managed to bring it home – I had to cook and take care of my baby.*

About a week later I started to feel bad. My eyes were hurting, my hands, the clothes felt painful on my skin, as if they had thorns, I wanted to take all of my clothes off because the fabric on my skin was giving me pain but I was cold. I felt a lot of pain on my whole body, on my skin.

A neighbour, I didn't know her very well then, came round to check on me – she said I had sobreparto and told me that I should drink rosemary infusions and wash my body with it. I started doing that and I got better after three days. She came back on the following days and said that I didn't have to see a doctor for this.

I asked Doña Sofía why she thought she got sick – she was quiet for a while and then said:

I didn't know how to take care of myself.

There were many more instances I heard of in which women were quite explicit about not even considering biomedical expertise to diagnose or cure what was happening to them or their relatives. *Sobreparto* is one issue that is very closely related to pregnancy and childbirth, but there are other gestation-related circumstances which call for traditional knowledge rather than the Western medical perspectives. For instance, a foetus in a transverse position could be moved either through massage or a *manteo*, a procedure in which the pregnant woman lies on a blanket held at the corners by two people who then throw her in the air (see e.g. Bradby & Murphy-Lawless 2002).[36] There are also illnesses outside the realm of pregnancy, such as *susto* or *tirisia*, which, very importantly, are conspicuously categorised as falling outside of the scope of biomedicine.

[35] A full gas tank weighs about 30 kilograms.

[36] There are different kinds of *manteo*, used at different stages of the pregnancy. One of my friends told me that her mother asked her father to do it when she could feel the foetus moving too energetically in the womb. That would calm the baby and let the mother sleep.

Simultaneously, other conditions, such as diabetes, are classified as primarily biomedical.

What seems to be the problem, then? It appears that people in Santa Cruz have quite a clear grasp of which condition belongs to which medical realm. Additionally, it is generally accepted that there may be some overlap between options for treatment; when one method fails, it is time to look to a different one.[37] It can be argued, however, that this multifaceted system of seeking treatment is becoming more streamlined due to the consistent, well-funded efforts privileging the biomedical approach. In the case of pregnancy and childbirth, this implies hospital childbirths favouring the point of view of the gynaecologist rather than the patients, which has consequences for the birthing position or the manner in which medication is administered, among others.[38] However, the fact that childbirth has become almost invariably a hospital experience in Santa Cruz de la Sierra by no means signifies that women are passive in the process: if they can, they actively choose the place where they give birth, as well as opt for a treatment method in the cases of conditions ignored by biomedicine.

Moreover, in spite of childbirth becoming largely biomedicalised in the city of Santa Cruz, there are still many aspects of reproductive life which have

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[37] In Bolivia, this phenomenon was described by Loza (2008) in a book titled *El laberinto de la curación* [The labyrinth of curing], where she explores the nonlinear paths of patients with chronic conditions in La Paz. Looking for treatment within coexisting medical systems is common in Bolivia (Escandell & Tapias 2010; see also Fernández Juárez 1999; Castellón Quiroga 1997; Crandon-Malamud 1991).

[38] I discussed this issue with one of my co-workers at an NGO where I had volunteered my services. She said she witnessed a birthing position workshop given by two Spanish midwives at the hospital in the district called Villa Primero de Mayo, in one of the largest state-run hospitals in the eastern area of the city. My co-worker said that most nurses looked sceptically at the presentation while the obstetricians, most of whom were male, giggled and chuckled while the midwives demonstrated possible birthing positions different to the lithotomy (supine position). Doña Felicia, an ex-midwife I interviewed a couple of times, referred to non-supine positions as *como un animal*, animal-like on multiple occasions, and refused to believe me when I told her that it may be easier for the baby to be born when the mother is not lying on her back.

retained their traditional understandings. A postpartum condition, such as *sobreparto*, is an example of an illness that superficially looks like a medical condition, but fails to comply with the biomedical categories to which it is assigned. The consistency with which women in Santa Cruz reiterated the inability of medical doctors to cure *sobreparto* is significant insofar as it emphasises traditional ways of curing this condition. These traditional ways, in turn, involve drawing on the community network in addition to bringing the mindful social bodies of ill women to an equilibrium.

Chapter 3
Anthropology of the previously unspoken: Intimate memories and treasured pasts

Anthropological fieldwork largely consists of thoughtful participation in people's lives (see e.g. Atkinson & Hammersley 2007; Hume & Mulcock [eds.] 2004). It involves careful observation of often unspectacular everyday events, attentive listening to whatever is being said and how it is being said as well as – just as importantly – paying attention to whatever remains unsaid. Erving Goffman wrote about fieldwork as a process of being close to people "while they are responding to what life does to them" (1989: 125). He referred to this process as "tuning-up" (ibid.), thanks to which the ethnographer is able to understand people's responses and points of view more intuitively, as a result of having acquired fluency in the mindful witnessing of the life of others. While I certainly understood the necessity of treading lightly in the field, my research went beyond observing and participating the daily realities. With a focus on *sobreparto*,[1] a potentially fatal postpartum illness traditionally found in the Andean zone, my data collection process involved registering life stories which mentioned bouts of this specific condition. I gathered data on women's experiences of ailments following childbirth compiling individual narratives of their personal histories with a specific interest in the circumstances of their pregnancies.

I did not witness an episode of *sobreparto* during my fieldwork, neither did I seek to observe one when I was planning the research. While I experienced some of the unsatisfied curiosity of a researcher who has to rely on second-hand

[1] See Introduction, Chapters 2 and 5.

accounts, I must also admit that I was relieved that none of my informants who had given birth during my fieldwork experienced a bout of *sobreparto*. As a result, my fieldwork data on *sobreparto* relies on narratives of individual experiences of that illness as told by Andean migrant women who were fortunate enough to recover. This limitation influenced the kind of information I had access to, but, at the same time, opened up different interpretative avenues of *sobreparto*, locating it within the time frame of the entire pregnancy and postpartum (or even beyond that), and linking it to emotions experienced during that period.

James Clifford asserts that "[n]o one reads from a neutral or final position" (1986: 18), and the account of *sobreparto* offered in this thesis will be partial. This partiality of mine is a matter of necessity rather than an ideological bias. What I see, hear, smell and sense is influenced by my personal history. Some of my characteristics helped me along: for instance, the fact that I am a woman consistently worked to my advantage in significantly gendered Bolivian daily realities. On the other hand, my European descent frequently generated a sense of hierarchy within my relationship with the women, with which I felt uncomfortable and struggled to overcome. Often, I was taken as a representative of the place where I came from, that is "Europe", which role I unremittingly continued to deny, rather unsuccessfully. With time, those of my informants that I got to know better began seeing me as more than an outsider with a peculiar interest in a postpartum illness. At the same time, I realise that my point of view shifted throughout my fieldwork, as my life intertwined with the lives of the migrant Andean women in Santa Cruz.

Doña Irene

Let me begin with an account of an interview with Doña Irene, recorded during our very last meeting. This annotated transcript features motifs which frequently recurred not just in the interviews that were recorded, but also in numerous, more informal, conversations I had with my informants. It begins with Doña Irene's first pregnancy at the age of seventeen, however, subsequent events are

not presented on a simple linear timeline. Instead, they are linked to each other through associations which emerge as she speaks, sometimes elicited by my questions, sometimes prompted by the resurfacing memories in Doña Irene's life story. It is possible to argue that this is not at all unique, that people usually speak of their lives in a non-chronological way. What makes these recorded interviews special, however, is the fact that they were about *sobreparto*, an illness of more than just the individual maternal body. I asked Doña Irene about the particulars of her circumstances around the time of her illness in order to understand better the network of processes and meanings in which this postpartum condition was embedded. Nevertheless, the fact that those details resurfaced as a result of my questions was not without significance to Doña Irene, as we learn from this section of the interview, in which she reflects on the reasons for what had happened to her.

Figure 13. Doña Irene and Julia with baby Juancito, 2012.

I met Doña Irene in 2009, when I carried out research in Santa Cruz for the first time. I knew that she was married and had two children, a son Rudy Cristián and a younger daughter Ruth Estel. They used to frequent Luz del Mundo, Light

of the World, a child-minding centre opened in 2003 by Julia, my dear friend, a very knowledgeable informant, and Doña Irene's *cuñada*, sister-in-law. Doña Irene was a skilled pastry-maker and often lent her baking skills for various celebrations at the centre. I frequently chatted with her when she brought her cakes for the kids and was waiting for the baking trays to be emptied. It never took long.

Guapurú is a tree native to tropical areas of South America. It bears sweet, berry-like fruit, which grows directly out of the trunk of the tree, covering it with hundreds of small dark berries. Their skin is thick, in such a dark shade of purple that it almost seems black, shining in the sun, just like dark brown eyes filled with tears. *Ojos de guapurú*, guapurú eyes, I would hear from many women who shared their stories with me the moment they realised that I was trying to stop the tears from trickling down my cheeks. *Ojos de guapurú*, they would say with their eyes welling up, and we would chuckle with simultaneous embarrassment and relief. It was likely that the conversation with Doña Irene would be no different.

We had arranged to meet a few times before but each time something came up. Once it rained so hard that the minibuses stopped operating and I could not make it. Another time Doña Irene received an unexpected order for a birthday cake and she could not afford to do without the additional income. Finally, we managed to meet. We were sitting in the kitchen: Doña Irene nestled comfortably in the armchair, while I perched in a semi-foetal position on a small stool, feeling unusually gangly. The kitchen window looked out to the patio, where about forty children were running around, playing. Doña Irene and I wanted to separate ourselves a little from the hustle and bustle in the patio, so we chose the kitchen. Since both the door and the windows were on the same side of the room, the air was hot and still, and both our faces soon glistened with sweat.

There was a certain dignified glow around her unhurried movements and gentle gestures. Doña Celstina's fingernails were painted crimson red. She wore lipstick, mascara, and eyeliner, an impressive trio in the humid 35 degrees of early

spring in Santa Cruz. Long, glittery earrings jingled when she moved her head while she spoke. "Are you ready for my story?" she asked. I smiled and said: "I sure am. What's your story?"

She took a deep breath before she said anything, as if she anticipated something transformative about our conversation. Here is how she shared her life with me:

> *I first got pregnant when I was seventeen and I gave birth after I turned eighteen. It was a normal childbirth, they didn't operate on me. My other child, my daughter*[2] *was born normally as well. When I was twenty-five. But… well, after I gave birth to my son, I got pregnant again, maybe four months later. So I had a* raspaje,[3] *very soon after.* […] *[A few years later] I found out that I was pregnant again. And everything was going well but then one day, I was about eight months pregnant, you know, you give birth in the ninth month, it was very close, I had a big fight with my husband,*[4] *and I was chasing him off and I was running after him and I fell down, straight on my belly. I fell because I was running. I felt pain in this part of my body* – she said, pointing to her stomach and hips – *as it if it was coming from the* umbligo,[5] *so strong* – she gasped – *so strong! I got up, I went [home], I lay down, but a few days later everything began to go black.*

She pointed to her face, her cheeks and chin.

> *Black, black, black, black, black: everything was covered with black stains. I wanted to vomit, I vomited blood and bile, I saw how the blood was alive. I was like that. For a week, a week passed, then two. And then came the [labour] pains, they began at two in the afternoon and it hurt at the front and the back and the front and the back…* […] *Yes, so strong. [It hurt] bad, bad, bad, bad, bad… all night. At six a.m. I couldn't stand it any longer – I went to hospital and she was born at half past seven a.m., around that time. But I gave birth to*

[2] Ruth Estel.

[3] Abortion by curettage.

[4] He was being unfaithful to Doña Irene at the time.

[5] Mispronounced *ombligo*, navel.

her. But she was already swelling up. She was already dead. Inside my belly. The doctor got scared because the waters were already black. And her head was split here, above her mouth…

Doña Irene gently stroked her upper lip.

And she had bruises all over her little body. It was a little girl. Curly hair, she would have had curly hair…

Doña Irene smiled softly and we looked at each other with our *ojos de guapurú*. I asked if the baby had a name. Doña Irene replied:

Roxane, I named her Roxane. And time passed, my son was already seven. I got pregnant with my daughter [Ruth Estel]. *She was born the normal way.*[6] *But before I got pregnant with her I had nine miscarriages.*[7] *I mean, in the period between my first pregnancy and the last one, I had nine miscarriages, and then I got pregnant. It was so difficult to get pregnant, so difficult, until she appeared. Every day I asked the Lord to help me, and, well, he listened, and I got pregnant.* […] *When they told me that I was pregnant I was happy but I was afraid that something would happen to her* [the baby]. *I only lost this fear when my daughter was born. Now I have a couple [of children], a boy and a girl. But with all these complications that I had had, I was damaged and my menstruation lasted up to a month.*[8] *Until, well, until I had my daughter. I had complications, you know, a lot of headaches, bone aches, cysts, I had a large cyst, they operated on me before I had my son, I was operated when I was sixteen, a cyst, an appendix, and an ovary they*

[6] Through vaginal delivery.

[7] Doña Irene used the word *abortos*, which I translate as "miscarriages" in most contexts (with the exception of the instance when she had an abortion, which she called *raspaje*, at a clinic). In Santa Cruz de la Sierra the word *aborto* is used for both abortion and miscarriage (which is also called *malparto* in Spanish, lit. bad/failed birth). I asked many women about the difference and the answers tended to be rather unclear. One of my fieldwork friends and an anthropologist, Mercedes Nostas Ardaya, explained to me that the difference lies in the phrasing: *tener aborto*, lit. to have an abortion, indicates miscarriage; on the other hand, *hacerse aborto*, lit. to do an abortion (to oneself), indicates intentionally induced early termination of pregnancy (personal communication, June 2012).

[8] It is probable that it was a non-fatal haemorrhage rather than menstruation (Wiesław Złotkowski, MD, personal communication May 2015).

took out, three things at once. But this is how I got pregnant with my son. Despite all this.

[…] *Before [the first pregnancy][9] I bled a lot. When my dead girl was born I bled a lot. Hygienic towels could not take that much blood, I had to wear a nappy. I changed it all the time, all the time. I mean, it was serious.*[10]

[…] *You know, the day I had an abortion? I came home and it's like nothing had happened. I start doing the laundry, cooking, you know, I start doing everything, I touch the knife*[11]*, everything.* […] *You know, I would wash myself with cold water, wash the clothes. And, at [the very same] night, a tremendous pain in my body [began]. I mean,* me vacíaba de la sangre*, I was bleeding out, they say it's sobreparto, I didn't know what it was called, there was something [going on] with my head, it wanted to split open, fever, tremendous pain, bone pain… infinite pain. And what my mum did, she went to see a neighbour, the neighbour who lived next door. She came and gave me a bath, a herbal bath.* […] *Well, there was orange leaves,* cupesí,[12] caré,[13] *you have to boil them all. There is another plant,* tarara,[14] *with large leaves, they are boiled and they bathed me with it. And* cusi,[15] *too. After the bath,* cusi *[oil] is mixed with orange oil. After this vapour, this bath, you rub the body with it, the whole body, with the*

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[9] With Rudy Cristián, Doña Irene's firstborn son.

[10] Doña Irene's narrative draws parallels between two experiences of haemorrhage – her surgery at the age of 16 and the stillbirth – and positions them on a timeline with relation to the pregnancy with her son.

[11] One of the postpartum proscriptions consists in avoiding contact with cold objects, such as knives (see Chapter 5).

[12] *Prosopis juliflora Griseb.*, Sp. *cupesí*, (Lucca Droxkler & Zalles Asin 1996: 15). Online Encyclopaedia of Life identifies it as *Prosopis alba Griseb* and provides its English common name, South American Mesquite (Hogan, [ed.] 2014).

[13] *Chenopodium ambrosioides L.*, Sp. *caré* (Lucca Droxkler & Zalles Asin 1996: 14). At present it is more commonly classified as *Dysphania ambrosioides*, wormseed (Jacinto [ed.] 2014).

[14] *Centrolobium microchaete*, Sp. *tarara amarilla*, a tree belonging to the subfamily of *Faboideae*. Its wood is known as canarywood (Justiniano & Frederiksen 1998).

[15] *Attalea speciosa*, Sp. *cusi*, also known as *babassu*, is an palm whose seeds can be used for the production of oil of wide commercial use, including biofuels. In Santa Cruz de la Sierra, however, *aceite de cusi*, cusi oil, is most famous for its medicinal purposes (cf. Henderson, Galeano & Bernal 1995; Rémillard et al. 2012).

hair and all. I recovered quickly. They say it's like pasmo,[16] *something tremendous that comes to you, even doctors don't know how to save you. There was a lady who died from it, a friend. She had her son in a normal way, she got home, as they say,* valienta,[17] *because she was alone, too, she had four little children, and, you know, she could not stop making food, because her husband had to go to work as well. So, what happened to her, then? She went [to hospital] to give birth to her fifth child and as her husband wasn't there, she went on her own, she went to the maternity ward, she had the baby, she came home, and then, well, she was there, not much time had passed and she started doing chores, and at night she started having convulsions and she died. That was because of what she'd been doing, right? Why would it happen?*

Doña Irene paused and looked at me.

You know, she started doing the laundry herself, putting things away, cooking…

I asked if the woman took any rest.

Nothing! – exclaimed Doña Irene – *Nothing at all! She went through labour, as I was telling you, and, after having the baby in a normal way. I mean, she died even though she had her baby in a normal way.*

[…] *When I became pregnant the first time [with Rudy Cristián], I didn't really want it, I was afraid and I cried because my relationship with my husband wasn't stable and… because when I got pregnant, [not long before] they had taken out the cyst and the appendix and one ovary. I was in hospital for several days, and then four days at home and then I went [to my parents' house]. I got my menstruation and I got pregnant very quickly. But I didn't know that I was pregnant. When I was 4 months along I felt something, there were things I didn't*

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[16] The word *pasmo* translates as shock, chill, cramp, muscle spasm, lockjaw, and tetanus. It is present in local aetiologies of illnesses in the department of Santa Cruz as *pasmo de ombligo*, lit. *pasmo* of the navel (biomedically classified as neonatal tetanus resulting from cutting the umbilical cord with an unsterilised cutting tool, cf. Bastien 1988).

[17] Non-existent feminine form of the adjective *valiente*, brave, courageous, intrepid.

want to eat, sometimes I had no appetite. But I didn't know that I was pregnant. When I returned home to my husband, he beat me up a lot… I mean… we got married very early, we fought a lot but it's not like this anymore right now. We got married in a church and all that. He is more older [sic] *than me. So before, when I got home, he would hit me, I didn't know that he was with another woman, a neighbour told me. So I went [to my parents'] home. I felt something like balls in my stomach, my dad took me to hospital, San Juan de Dios, they gave me an ultrasound – and when I saw my boy on the screen, he was already big, already well formed* – she said with emphasis – *because he was a boy. You could see him clearly.* […] *The girls take a long time. On the other hand, a boy is a boy – the doctor told me: "It's a boy". I was pregnant. But I was worried. I cried a lot because I wasn't with him* [her husband]. *I thought: is he going to be a child without a father? What do I do? But at no point did I think about an abortion either. Only later did the happiness come. The joy came and I began to gather baby things, the clothes, to await him. So… but… when I found out that I was pregnant, every kind of food seemed disgusting, for about two months, and then it got normal again, but as I am telling you, I suffered a lot because of my son. But when he was born I was the happiest woman in the world, because they told me "*es hombrecito*", it's a boy* [lit. it's a little man]. *I heard him cry, I kept feeling pleased, they said "*es varoncito*," it's a boy* [lit. it's a little male]*, I felt happy. But when I let my husband know, he quickly arrived with a bag full of nappies, with his thermos flask, with a mosquito net, with everything in a bag. And, well, he paid for the* [use of hospital] *bed, everything. I was happy, I was pleased. I love him so much, my son.*

At the end of our conversation I asked Doña Irene if there was something she wanted to add. She was silent for a minute and then spoke quietly:

I'm often wondering about the reason of my miscarriages, why it happened to me… I'd have so many children, wouldn't I? A dozen! But I don't know why I was losing them a lot, was it my womb, or, I don't know… I sometimes think

> *about why I didn't have more children, why they were getting away from me, I was thinking about it the other day but I can't find the true meaning of it. Could it be because of my* raspaje[18]*? I don't know* – she looked at me with her pensive eyes.

When the story had been recounted and it felt like there was nothing else to say at that particular moment, Doña Irene looked at me with her big eyes and quietly said, *Nobody has ever asked me about all this. I have not spoken to anyone about it all at once. Thank you for listening to my story.* With my *ojos de guapurú*, I thought that I should be the one expressing gratitude. I wanted to say something meaningful in response to this rather unexpected confession of Irene. I only managed to stammer out some reply along the lines of me being the grateful one, but I could not stop thinking about how I came to understand reciprocity in the field in quite a new way.

The interview with Doña Irene exemplifies the cathartic potential of personal narrative, but also illustrates numerous other dimensions accompanying a postpartum illness among Andean women migrants in Santa Cruz, most notably their emotional state and social situation.[19] These two aspects are intimately related and Doña Irene's detailed narrative shows that her emotional state, to a large extent, depended on her perceptions of her social network. In particular, her feeling of loneliness after childbirth was the result of her impression that there was nobody ready to help her. The time Doña Irene was visited by a woman who came by to check up on her also marked a transformative moment, not just in Doña Irene's perception of her own situation, but also in the dynamic of her immediate social network. The narrative of *sobreparto* reveals that this postpartum condition belongs to a number of realms of life experience, as well as an opportunity for the narrator's self-reflexion.

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[18] Abortion.

[19] See Introduction and Chapter 5.

Packed-away memories:
Illness narratives and remembering the past

The motifs that feature in the above account of my last interview with Doña Irene could be found in many other conversations I recorded, although usually in a less comprehensive form. This fragmentation of information, repetitiveness, broken chronology, jumping from cryptic statements to details that were intimate, are very significant components of recalling the packed-away memories. Speaking about events that had not been discussed for a long time (if at all) was almost like remembering a once-perfected bodily activity that one had not done for a long time, not unlike dancing a long-unperformed dance. The movements are awkward at first, tentative, imperfect, and then the muscle memory is geared up to perform. The conversations about *sobreparto* I had with female Andean migrants in Santa Cruz de la Sierra, with their slowly emerging details about events, situations, or feelings, often reminded me of muscle memory. This association is perhaps less metaphorical than it first appears: after all, speaking is an activity that involves muscles.

When I was planning my research, I prepared a list of questions that I wanted to ask migrant women. However, in the field, despite the fact that most of the conversations were initiated in a similar manner, my informants frequently veered off into topics that I had not anticipated. After three or four months, I modified my strategy: rather than trying to obtain answers to all my questions from all my informants in a single conversation which could serve (and potentially be recorded) as a data-laden anthropological interview, I would ask different sets of questions at different times, whenever it felt appropriate. This change had multiple consequences. On the one hand, even when the question was not initially answered very comprehensively, it had been *asked*, and had become familiar to the interviewee. On the other hand, in spite of the lack of an immediate answer, a seed had been planted, and – in most cases – some memories, stories, or comments would surface sooner or later.

As mentioned above, the research involved establishing relationships with female migrants through the so-called "deep hanging out" (cf. Geertz 2001:

107ff.; Clifford 1997: 56), which very often included taking care of children while their mothers were busy with domestic chores, and multiple, mostly unrecorded, informal chats touching upon those women's general life histories. Because memory also plays a significant role in the way past events are recreated though recounting, we would talk about the same – or similar – events on various occasions. Sometimes the topic was initiated by me, and at other times my conversation partners would bring up a subject spontaneously – although it should be acknowledged that women who spoke to me were aware of the fact that my interests lay in pregnancy and *sobreparto*. Repeating questions and topics of conversations was meant, on the one hand, to encourage the women to cast their minds back to particular events, and on the other hand, to allow for more detail-rich memories to emerge. Repetition helped me organise data, establish chronologies, and finally to better understand the life histories which were shared with me. In the end, the strategy I came to employ bore fruit in the shape of detail-rich, elaborate, and spontaneously intimate narratives, which came to constitute a large part of the data I collected during my fieldwork in suburban Santa Cruz de la Sierra.

The conversation with Doña Irene may serve as an example of the process. This interview, so rich and complex, would have been even more challenging for me to follow had I not been familiar with certain aspects of Doña Irene's life. I knew that she had two children from my interactions with her and – from Julia, my friend and Doña Irene's sister-in-law – that her relationship with her husband used to be much more rocky than at the time of the interview. But I never suspected – even though I think Julia knew and intentionally chose not to share it – that she had lost so many pregnancies or that she had given birth to a dead baby girl. Doña Irene's narrative moves freely through the timeline of her life story, taking small steps and large jumps backwards and forwards, from the first pregnancy to the last and then back to the time from before Doña Irene became a mother. It touches on themes commonly found in Bolivia, such as a preference for male offspring – when she says how much she loves her son but never says

that about her daughter, although she spoke about her in a voice trembling with emotion. It is filled with self-reflection, both concerning individual events as well as her entire personal story, cumulating in a painful, unanswerable question of guilt and blame. It contains active contrasting of one's own experience of *sobreparto* (becoming ill after her abortion) with another woman's experience (becoming ill after normal delivery) and an attempt at making sense of them both. This conversation, at least from my point of view, also came with a confession: of *raspaje* (abortion), the experience of *sobreparto*, and miscarriages, followed by a final self-reflexion, that it was good to talk about it all at once, that there was some kind of unanticipated relief that came with it.

Talking about an illness that followed difficult events in a woman's life was not always straightforward. Some of the memories were being consciously recalled for the first time since the event, and the fact that I was there to hear it meant that I had gained a sufficient degree of my informant's trust, at least in those very moments. A fellow Bolivian anthropologist and a friend in the field told me once that perhaps my unusual status as a childless single woman in her thirties was the reason why I was allowed to hear so much – she explained that they probably did not feel like they were burdening me with their hardships because I did not have such problems.[20] After all, I had no partner or children to take care of, I was healthy, and in the eyes of my informants, I did not seem to struggle economically. Irrespective of whether I felt that this was an accurate description of my situation,[21] I recognised the extent to which it helped me collect data from women who had children, who struggled with economic and relationship problems, and who had a history of illness.

Memory can be unreliable. What the illness narratives describe, therefore, is not necessarily a perfect rendition of the events. Even with multiple

[20] Mercedes Nostas Ardaya, personal communication, June 2012.

[21] The researcher's doubt and anxiety have been problematised in anthropological literature as a part of the fieldwork process, see e.g. Cook (2010).

conversations on the same topic, discrepancies and incongruities are to be expected. Linda Garro noted that

> [r]emembering in everyday life cannot be understood apart from the social and cultural contexts in which it occurs. […] A basic premise is that cultural and social processes, in conjunction with cognitive processes, play a constitutive role in remembering. Cultural and social processes are integral not just to what we remember of the past but to how we remember as well. Remembering, even the remembering of personal experience, cannot be understood as solely an individual cognitive process. Attention to acts of remembering situated in everyday life serves to reveal the inseparability of cultural, social, and cognitive processes. (2001: 105-106)

If narratives, in addition to being considered as constructed memories, can also be thought of as a way of making sense of one's own experiences (cf. Becker 1997; Good 1992), then the imperfect account of the events could be interpreted as some kind of working understanding on the part of the narrator, and not just a proof of how unreliable memory can be.

It is interesting to ask, however, if the fact that these memories resurface is a sign of the person being able to finally deal with them (or some of them), difficult and uncomfortable as it may be. Forging thoughts and memories into strings of words, perhaps imperfect and awkward or inadvertently vague, may become – at least for some – a way of moving forward, perhaps even creating a record of this personal progress. The fragmentation, or even contradictory character, of narratives of distress[22] may point to the fact that these memories are constantly negotiated towards meanings acceptable for the narrator or the social group (Nichter 2010: 401-402, 408). In the story told by Doña Irene, she is unable to provide a definite explanation for her nine consecutive miscarriages.

[22] I use the phrase "narratives of distress" instead of what Mark Nichter called "idioms of distress" (1981). Nichter later recognised that the word "idiom" was inaccurate (2010: 408); "idiom" suggests a comprehensive character of expression but narratives of distress are likely to be fragmented or contradictory (see also Kirmayer & Young 1998).

She tentatively links them to the abortion she had after her first son had been born, but she phrases this connection in the form of a question (*Could it be because of my* raspaje[23]?), rather than an answer. It is also possible that this inability to come up with a perfect explanation for what happened to her also protects Doña Irene from taking the blame for it.

Numerous medical anthropologists have turned their attention to the relationship between socio-politico-economic processes and physical suffering, demonstrating how life's everyday hardships may be reflected in bodily distress.[24] In such analyses, individuals experience political and economic structures through (often chronic) illnesses, such as *nervos* (Scheper-Hughes 1992; see also Farmer 1996). Psychological anthropology, on the other hand, frequently sought to interpret individual suffering both on a personal and interpersonal level, foregrounding the quality of human relationships as an important aspect of the experience of illness (Garro 1992; Good 1992). Although these interpretations differ in the foci of their analyses, it is crucial to recognise how the political, economic, social, and individual processes coexist and influence each other in daily realities. Thus, a multidimensional analysis, acknowledging aspects of illnesses beyond the individual body, may enable a more comprehensive understanding of the phenomenon of bodily distress.

While talking about their illnesses, people weave their experiences of bodily distress into narratives of wider interdependent processes of life. In analyses of such stories, it is possible to look at the episodes of illness as filters, foregrounding the most important aspects of people's experience (see e.g. Yarris 2011: 227; Kleinman 1992). Frequently, illness narratives closely follow the breakages in people's immediate social relationships, which involve kin and close friends, revealing what Maria Tapias termed as "failed sociality" (2006: 402) but also expectations about that sociality (Becker 1997; see also Paulson 2007). At the

[23] Abortion.

[24] See Introduction.

same time, such foregrounding of what is the most crucial in one's existence (Kleinman 2006) is only possible if something else is pushed to the background. Doña Irene's account of *sobreparto* focused on how her "failure of the body" (Das & Das 2007: 69) was caused by her imperfect relationship situation (she felt alone). Her story also shows the dynamic of sociality: a member of her social network took care of her at a time of particular danger and guided her out of the illness. What remains in the background of Doña Irene's account is her experience of childbirth at hospital, marked by precise times (*At six a.m. I couldn't stand it any longer – I went to hospital and she was born at half past seven a.m., around that time*) and the doctor's emotional although unprofessional reaction (*The doctor got scared*).

Since my research focused on the meanings of *sobreparto*, it was almost intuitive to classify the stories as "illness narratives." However, the bouts of *sobreparto* my informants experienced were disruptions in their everyday lives, rather than the pivotal features of their reproductive trajectories (cf. Garro 1992), although sometimes the consequences of *sobreparto* would be felt for years to come. Thus, most of the accounts I collected would be better described as "being about a life disrupted by illness" (Mattingly & Garro 2001: 27) as their timelines extended beyond the experiences of bodily distress, while the details of stories included circumstances beyond the individual ill body. These life narratives – capturing not only the memories of episodes of postpartum illness, but also the particularities of the woman's reproductive history, as well as social and economic situation – point to the complex web of non-medical processes that intertwine with the phenomenon of *sobreparto*.

The narratives of female Andean migrants' lives, interrupted by illness, open up a number of analytical possibilities. On the one hand, they reveal how postpartum illness is a part of a complex network of processes and phenomena at play in people's lives. In addition to understandings of the body and interpersonal relationships, these processes and phenomena also include larger structural influences, such as an increasing level of biomedicalisation in pursuit of what

Bolivian government sees as "modernity." On the other hand, the fragmented character of the stories, including incongruities or even contradictions in the memories, shows how people actively manage the process of remembering the past by creating narratives to make sense of what happened to them. Illness narratives enable people to reflect on their biographical disruptions by locating them in the contexts of what (or who) matters the most in their lives, the contexts of what (or who) they feel the strongest about.

Experiencing feelings: Emotions as data

An increasing number of contemporary anthropological studies acknowledge the influence of the researcher's presence in the process of creating data.[25] Despite the fact that I had nothing to do with the events in the stories on *sobreparto*, it was my questions and recordings that elicited narratives, a particular category of ethnographic data. Given that obtaining ethnographic data involves intensive human interactions, such research may be considered "a profoundly personal enterprise" (Hobbs 2011: 3), with emotions at its very core. As a part of my research focused on the ways women remembered and recalled their feelings, in the spirit of transparency (cf. Curran 2006: 4), I had to recognise that my vulnerability and the willingness to be vulnerable have significantly influenced what was said to me and how I interpreted it.

As an anthropologist trained in the 21st century, I have absorbed reflexivity as the norm in ethnographic explorations. Reflexivity has the power of change; it is expected that the relationships forged in the field with others will alter the ethnographer's way of perceiving both others and oneself (cf. Devereux 1967). Michael Jackson called it "the twofold movement" (2010: 36), consisting in a shift from one's own social world to another as well as a return, as a transformed individual, although this transformation is the most visible to the anthropologist. Such a change in self-perception is not exclusive to anthropological fieldwork,

[25] See e.g. Mattingly & Garro (2001); Herzfeld (1996: 74); but most notably, Clifford & Marcus (1986) and Behar & Gordon (1995).

just as there are no emotions solely typical of field research (ibid.: 35). However, the acknowledgement and inclusion of anxiety, ambiguity, doubt, frustration as well as of elation, happiness, being excited and moved, can be helpful and productive in creating a more complete account of our fieldwork experience. This is particularly the case because the situations which we witness and in which we participate are only small fragments of constant dynamic transformations in the everyday lives (ibid.: 53; see also Crapanzano 2010: 71).

Despite their potential to inform understanding, researchers' emotions do not have a well-established place in anthropology. For a long time ethnographers have been told to be both engaged and disengaged, to participate, and yet to simultaneously act as objective observers. But there can be scientific rigour in self-reflexion, as shown by almost five decades of ethnographic and anthropological writings.[26] Renato Rosaldo's classic essay "Grief and a headhunter's rage" (1989) is an excellent albeit tragic demonstration of how the emotions of the researcher may inform his understanding of the field. The sudden death of his wife Michelle in the field made him understand what the Ilongot described as rage or grief that made them able to kill, experienced after a loss of a close person. Rosaldo's mindful and methodical explorations of his own pain offered him an insight into the Ilongots' perspective on death. Migrant Andean women in Santa Cruz shared their hardships and heartbreaks in their stories, sometimes for the first time ever. If vulnerability, theirs and mine, played a role in the processes of construction and deconstruction of their narratives, it deserves to be openly acknowledged.

The inclusion of the researchers' emotions in the process of collecting ethnographic data (and in the data themselves) may be productive both in terms of the understanding as well as an enhanced methodological framework. James

[26] The key texts of the reflexive turn in anthropology include, among others: Scholte (1972); Hymes, (ed.) (1972); Rabinow (1978); Ruby, (ed.) (1982); Crapanzano (1985); Clifford & Marcus, (eds.) (1986); Rosaldo (1989); and Geertz (1990). The feminist perspective was critically analysed by e.g. Abu-Lughod (1986, 1988); Stacey (1988); Behar & Gordon, (eds.) (1995); Lugo & Maurer (eds.) (2000); Ahearn (2009).

Davies proposes "radical empiricism" (2010: 3), an approach which rejects the epistemological difference between the subject and the object.[27] With reference to emotions, radical empiricism assumes that by recognising feelings as one of the aspects of experiencing and understanding the world, other kinds of knowledge are able to emerge (ibid.: 22-25). Additionally, an increasing number of studies have revealed that focus on the behavioural and discursive aspects of the research situation, on what people say and do, and how they say and do it, or even what they mean, denies the importance of extra-linguistic aspects of cognition, such as bodily sensations (Luhrmann 2010: 217). Tanya Luhrmann emphasises the importance of including somatic experiences in ethnographic data (ibid.: 214) but is also very pragmatic about this approach. She states that personal experience informs understanding, and better self-knowledge leads to more accurate grasp of how one's own experience influences the ways in which others are seen (ibid.: 235). The level of attention directed at expressions of emotions among female Andean migrants in Santa Cruz was motivated by a desire to explore the relationship between emotions and bodily states (see Chapter 4) as well as between emotions and illnesses (see Chapter 5). My being a woman made it easier to speak to women and frequently alienated me from men; my childlessness meant that my understanding of motherhood is limited by my lack of experience; my status as a migrant (both in Europe and, temporarily, to Bolivia) made me more sensitive to migrants' unspoken struggles.[28]

Vincent Crapanzano suggests that fieldwork is characterised by inherent intrusiveness,[29] which consists in the researcher entering another social world with a specific purpose in mind, sometimes without a formal invitation but with a hope of one day being welcomed by the community (2010: 57). While

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[27] For an overview of the history of the researcher's relationship with their ethnographic data see e.g. Davies (2010: 3-14) or Tedlock (1991).

[28] I should probably also acknowledge that for many people I spoke to (especially those whom I did not get to know well), the fact that I was single, was, for a lack of a better word, suspicious.

[29] Crapanzano uses the word "violence" (2010: 5) but I believe that it is unnecessarily hyperbolic in the majority of fieldwork situations.

acknowledging this intrusive dimension of social research, it should also be noted that the researcher is also acted upon, voluntarily or not, which may leave him or her rather vulnerable, at times for long periods. In a small study of negative aspects of fieldwork among doctoral students of social anthropology from UK universities, the informants mentioned feelings of guilt, loneliness, shame, entrapment, and paranoia, among others (Pollard 2009; see also Barry 2009). In a commentary on the study, Sara Delamont dismissed "the misery and incomprehension expressed by the informants [i.e. doctorial students] [as] vivid, but […] not new," stating that these early career anthropological researchers "do not all seem to have recognised and accepted that reality: so they are not yet fully socialised or enculturated into anthropology" (2009: 1). By "that reality" Delamont refers to "a widespread agreement that not everyone can be an anthropologist" (ibid.), a test for which would consist in surviving the fieldwork's difficulties, both mental and physical. It is unsettling that Delamont sees no value in early career anthropologists recognising and acknowledging their ineptitude in dealing with some aspects of the fieldwork situation, which almost seems like a suggestion to reject reflexivity if it reveals personal inadequacies. On the other hand, Okely makes a valid point by indicating that these research obstacles opened avenues for acquiring knowledge (2009: 1), a fair price for enhanced understanding. Thus, while my presence to some degree interrupted the course of everyday life in my field site, I also tried to be humble and patient, continually allowing my own boundaries to be crossed in the hope of gaining more clarity into what I was observing and experiencing.

"Vulnerability isn't for everyone", writes Ruth Behar (1997: 25), recognising that academia is large enough for all kinds of approaches. But she also suggests that being open and reflexive about one's own emotions, belongs to the more demanding methodological stance. Rather than engaging in all-encompassing self-exploration, the ethnographer must filter the research-relevant aspects of his or her own vulnerable self (ibid.: 13). If emotions inform understanding,

concealing them is a form of evasion, despite the fact that their revelation may earn the researcher a label of sentimentalism. But perhaps some stories, some topics, and above all, some people deserve our sympathy and empathy. Perhaps they deserve, in addition to being written about, that our hearts be broken by their stories. Behar writes, "we need other forms of criticism, which are rigorous yet not disinterested; forms of criticism which are not immune to catharsis; forms of criticism which can respond vulnerably, in ways we must begin to try to imagine" (ibid.: 175). I, too, argue that including emotions in the ethnographic data allows us to do just that.

Therapeutic interviewing and the vulnerable anthropologist

When I was preparing for my research, just like any anthropologist, I attempted to envisage difficulties which might come my way. There was an underlying assumption that some memories would be difficult to talk about, an obstacle which could be managed through a relationship of trust between myself and the woman who confided in me. A potentially complicating factor consisted in the fact that in some areas of the Andes complaining is traditionally considered to be a social transgression, which may lead to an illness (see e.g. Tapias 2006: 404-6). There was the possibility that this could be an issue for Andean migrants in Santa Cruz, although I anticipated that it required balancing between the act of telling stories of hard lives and expressing dissatisfaction in an overt manner. Many a time I found the painfulness of the stories emotionally exhausting. While I was fully aware that my informants' difficulties were not my responsibility, I still thought about what I heard, sometimes for weeks on end. With time, however, I realised that what many of my informants appreciated was my listening to their personal narratives, those quasi-therapy sessions with an unqualified anthropologist.[30]

[30] While listening belongs to the sphere of reciprocity, I also offered material compensation to my informants for the time they shared with me: sometimes I brought them food (such as pasta,

Of course, these conversations were not intended to be therapeutic. An idea that they could be perceived as such came to me after a number of long chats about individual life stories, which were followed by an expression of gratitude of some sort, like in the case of Doña Irene's narrative presented in the beginning of the chapter. Sometimes women thanked me after an interview that was recorded with a dictaphone, which made me think that they acknowledged the formal mode of registering their personal histories. Nonetheless, more informal conversations would also sometimes end in similar comments. At times, my conversation partners reflected on being encouraged to freely talk about themselves. On other occasions, they said that their experiences did not seem that interesting to them – and there I was, all ears about what they had to say. Now and then, at the end of the meeting, an interviewee would remark on the relief she felt at being able to put her memories into words and share them with somebody else, as in the case of Doña Irene (*Nobody has ever asked me about all this. I have not spoken to anyone about it all at once. Thank you for listening to my story*). There was more to those conversations than the possibility of talking about oneself to a relative stranger with a sympathetic ear. The fact that most of my conversation partners ventured into topics that were not normally discussed is significant. It is possible that my informants shared information that they knew I would take away with me, which is why it could have been easier for them to talk about it in the first place. If these interviews held any cathartic value to my conversation partners, I would assume that it was different from the cathartic value of their individual cases of *sobreparto*.[31] Furthermore, bouts of precarious postpartum illnesses are more likely to be accompanied by questions of immediate survival, rather than self-understanding. However, the distance from the events, and the fact that my conversation partners survived, allowed them to try to make sense of these events, by telling their stories in terms of cause-and-effect.

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rice, or cooking plantains) or a bag of detergent, at other times, I would go shopping with them after an interview and pay for their groceries.

[31] See Chapters 4 and 5.

When I thought about the conversations, it occurred to me that these women were talking about things, events, or feelings which they would not tell people around them, for fear of being judged or of changing the relationship with their close ones forever. One of the women I interviewed admitted that she had had an abortion at the age of nineteen, some twenty years ago. Since then she has become a born-again Christian and began going to a local Pentecostal church, which she also obliges her five children to attend. Since the church condemns abortion and the children are already rather critical of her religious zeal, she would not admit it to them for fear of their reaction to what they could interpret as hypocrisy. Another woman that became my close friend in the field confessed that when an ultrasound revealed that she was pregnant with a girl, she was suicidal and cried for two weeks as she wanted a boy. She explained that she thought her husband preferred a son, as they had already had a daughter. She said that her own life as a woman was very difficult and she did not want her daughter to be forced to undergo similar life hardships on account of being female. Her partner was quite progressive and convinced her that he was looking forward to having another daughter. They then proceeded to raise two tomboys that I had the privilege of getting to know quite well.

I continually wondered why I was being told about precarious, intimate moments of life, such as failed attempts at abortions, a persistent feeling of not wanting to be pregnant with a girl, or hopes of miscarriage. What was it that made them speak of the hitherto unspeakable? Almost every interview or conversation which contained some "secrets," for lack of a better word, was wrapped in ambivalence. On the one hand, I recognised the privilege that came with being the recipient of somebody else's memories. Heartbreaking as their implications were, it seemed that I had been let in on something confidential and private. On the other hand, however, despite the fact that it had been agreed that the conversation or interview would be recorded (or I would take notes by hand), I frequently felt that I should keep what I heard to myself.

This, too, has at least two aspects. First and foremost, this thought was driven by respect since I was talking to women who were close to me. Furthermore I knew that they were telling me secrets, because they explicitly said that they had not spoken of it to anyone else before, which I understood as a request for confidentiality. Additionally, it can be assumed that when they allowed me to take notes or to record a conversation, they did not necessarily anticipate that our conversation would lead to getting their secrets on record. When recording interviews is analysed in methodological literature, researchers often mention that, with time, interviewees often forget about the presence of the dictaphone and begin to speak more freely. This is true, I believe, but it was also the first time for me that it was accompanied by an ethical dilemma. It was obvious that I was expected not to repeat the secrets to anyone else in the field. What about including them in the writing up of my results – for analytical purposes, of course?

This brings me to the second aspect of why it may be morally problematic to divulge fieldwork research. An anthropologist in the field moves between various roles virtually all the time. Even despite emphasising my role as a researcher through note-taking or the use of the recording devices,[32] the gravity of the topic, its emotional burden at times shifted my position in the eyes of the women I interviewed towards that of a friend or a confidante. Both strangely fortunate and overburdened, I became the treasury and the treasurer of intimate secrets. None of my informants expressed an interest in reading my thesis, even after I offered such an option. It could perhaps be safe to assume that the distance separating their migrant lives in Santa Cruz from the English-speaking academic world could be a safe barrier protecting the confidential information. But the dilemma is of a moral rather than technical nature, which complicates it further. Is it

[32] I could not always be sure, however, what my informants thought I was doing, although I suspect they interpreted my questions and note-taking as something to do with writing a book; on presentation of self see e.g. Goffman (1990 [1959]).

acceptable, I wonder, to discuss intimate, normally unspoken-of details of the lives of others if they have not explicitly agreed to such a disclosure?

I am aware that there is probably no possibility of offering a satisfying template of a solution for such situations. Ethical dilemmas almost encourage the researcher to walk the line of vagueness and stay in the grey area of not revealing too much of the confidential information. It is the privilege of academia to strive for a better understanding of the world, but the question remains of whether or not everything that is noticed, recorded, or described by the ethnographer (or any kind of a researcher, for that matter) can, at least in terms of ethics, be classified as consensually obtained data. Perhaps I am wrong, but I am under the impression that, in anthropology, the process of writing (of theses, articles, books, reports) constitutes an academically-sanctioned way of dealing with the gathered data not just on the intellectual plane, but also on a more personal level, where emotions as well as morality are involved. Much as I would like to arrive at a satisfying conclusion, all I have are open-ended questions. I believe they deserve some consideration despite the fact that they may not have straightforward answers. Can the therapeutic values of anthropological interviews be deemed as unethical if the interviewer is unqualified? How can the anthropologist deal with the unsolvable burden of other people's past? How do we decide that other people's secrets can become anthropological data? What are the contexts that make such revealing acceptable? Must moral ambivalence be a lifelong companion of anthropology? And, finally, how do you live with it?

Life narratives can be very powerful. Those who tell them construct and consolidate memories of the past, arranging reminiscences into chains of connected events, trying to make sense of their experiences. In the case of illness narratives, by focusing on bodily distress, people are able to foreground the most important aspects of their lives, which often include close interpersonal relationships. Speaking of the previously unspoken can have a cathartic value, on the one hand enabling the person to articulate her experience, and on the other,

to share it with a trusted, empathetic interlocutor. This privilege comes with ethical dilemmas for the ethnographer whose roles, from researcher to confidante, shift and overlap in the relationships developed in the field. Herein lies the power of narratives of lives interrupted by illness: they act on those who create them and on those who listen, but they also provide a commentary on different dimensions of peoples' lives, including individual experiences, social relationships, as well as more abstract socio-politico-economic structures.

Chapter 4
Feeling ill: The mindful social body

I was often confused in the field about the way in which people spoke about their experiences involving emotions. Initially, I would blame my imperfect Spanish, but with time I realised that it was the dualistic categories of body and mind which hindered my understanding. In addition to thinking across the categories of body and mind, writing about it can be quite difficult – in fact, the struggle with language choices to annul the Cartesian division probably highlights its deep-seated character, rather than actually managing to erase it. I often find that a conceptual bridging of the somatic and mental states is much easier than properly articulating their categorial merger. While it is rather effortless to think and speak of the mind and the body as two sides of the same coin, it may be more difficult to think that this coin could only have one side, much like the Moebius strip (cf. Grosz 1994).[1] In this chapter I would like to explore an understanding of bodily states as expressions of emotions using ethnographic examples I collected during my fieldwork in Santa Cruz. In these accounts, the co-occurrence of the ill body, the troubled mind, and imperfect social relationships highlights the importance of social networks in the maintenance of well-being. It also points to an understanding of the body as both mindful and

[1] The question remains, however, how to talk about emotions without falling into the trap of body-mind dualism, especially given that the pertinent vocabulary is underpinned by this divisions. Notwithstanding, I am aware of the cognitive metaphors analysis performed by George Lakoff and Mark Johnson in 1980 in their groundbreaking book *Metaphors We Live By*. They suggested that certain ways of structuring cognitive metaphor groups accurately reflect bodily states, as a result they are not entirely figurative, unlike the classic understanding of metaphor. The bodily and social grounding of metaphors was also used for theorising illness by Laurence Kirmayer (1992).

social, which underpins the analysis of the phenomenon of *sobreparto* presented in Chapter 5.

***Aburrida*: The unwilling body**

I would like to start with a story from my fieldwork which, hopefully, will not seem overly tangential by the end of this chapter. It is about a way of labelling situations which seemed confusing or even inaccurate before I began to see a pattern, which helped me towards a different understanding of bodily states, one which emphasises the social character of the body. This story is a compilation of my fieldnotes and describes how I came to learn anew the meaning of the word *aburrida*.

I remember thinking that women I spent time with used the word *aburrida* a lot in Bolivia. In its most straightforward translation, it denotes both bored and boring, among other meanings. I heard Rosa, my landlady's daughter-in-law, use it in situations when she had finished all her household chores, which involved taking care of the baby, cooking for the entire family, doing the dishes, doing the laundry by hand, as well as sweeping and mopping the floor of the house and the patio. In the afternoons when she did not have to get ready for her night shift at the private clinic where she worked as a nurse, we would sit outside on the steps to the patio, eat copious amounts of chilled watermelon, and chat, while watching her daughter Laura play. Rosa often said something along the lines of: *Ay, Karito,*[2] *estoy tan aburrida, no sé que quiero hacer*, Oh, Karito, I'm so *aburrida*, I don't know what I want to do. At the time I thought what she meant was that she did not have a good idea about how to spend an afternoon, and I would suggest various activities, from watching a film to reading or going for a walk. But as my fieldwork progressed, I began to understand this word as a description of a state in which the body is unwilling to do anything, a condition that prevents activity, like weariness – but not only that.

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[2] A diminutive of my first name in Bolivian Spanish.

It seemed that being *aburrida* denoted a certain kind of suspension from engaging with life's immediate realities, a detour from one's usual path of chores and other obligations, a temporary paralysis of will. Typically, within an hour or two Rosa would go back to her daily activities, with her usual level of energy and determination. The passing of time would make "being *aburrida*" disappear, but I do not think it was because people were able to get some rest. Rosa must have been tired most of the time – after all, she did not sleep every second night, when she was scheduled for a night shift at the clinic. She would come home at around 8 a.m. and immediately start taking care of her daughter – feed her, clean her up, play with her. When I stayed home, she would sometimes ask me to mind Laura later in the morning while she cooked a two-course lunch for the entire family of eight. Then, around noon, she would feed Laura again and hopefully put her down for a nap, the family would eat and Rosa would clean the kitchen and mop the floor and patio. By the time she was done, her daughter would be up again. Every two to three days she would hand wash a pile of clothing that included her own uniforms, her husband's uniforms, and – as Laura had a penchant for rolling in the dirt – a mountain of baby clothes. All this was making Rosa exhausted, but she talked about being *aburrida* only sometimes, especially on those rare quiet afternoon moments.

The word *aburrido/aburrida* was also used to describe fussy babies. For instance, when Julia's baby son Juancito looked restless and uncomfortable, she would offer him her breast, check his nappy, or try to put him down for a nap. But when Juancito did not want to eat or sleep and his nappy was dry, when it seemed like he did not know what he wanted, she would say: *Está aburrido, el chiquitín*, he's *aburrido*, the little one. I first heard it when Juancito was approximately five-months old and most interactions with him had a strong bodily component – in addition to being carried almost all the time, he would also play with the fingers, or hair, or ears of his caretakers, who endured it with loving patience. Babies of migrants in Santa Cruz typically have a limited number of caretakers whom they recognise, thus actively embedding themselves in a

social network, and these caretakers are usually able to accurately read the signals sent by the baby. However, a baby was only described as *aburrido/aburrida* after multiple failed attempts by the caretaker to make it feel more comfortable. I would like to argue that it is possible to interpret the fussiness of babies as their unwillingness to engage socially with their caretakers. Given an existing social bond between individual caretakers and babies, it is interesting that the refusal of the babies to engage with a close person, such as its mother, being *aburrido/aburrida,* is articulated in categories of the baby's unwilling body.

This would suggest – I believe – that being *aburrida* is different from being tired or weary, not to mention plain bored. I came to understand it as a comprehensive state, in which one's body does not wish to engage in any behaviour, either passive or active, either relaxing or pending. The state was by no means unfamiliar to me; what was unfamiliar consisted in describing it with a word that (again, to me) denoted mainly mental disengagement. Curiously, I do not remember using this word to describe myself, although Rosa would sometimes look at me and say: *Te ves aburrida, Karito,* You look *aburrida*, Karito. I would silently question her judgement – I thought I was just exhausted. At the same time, it was clear to me that I did not want to be with people, so perhaps Rosa was right, after all.

Still, the paradox of describing a bodily state with a word for a mental one may not exist beyond a point of view where these two aspects are separate. In other words, it was me who saw a discrepancy there – a discrepancy that is not inherent in ways of feeling in themselves. Consequently, there may be a possibility of re-thinking the connotations of words used for emotions or feelings in a manner that, by suspending their separation (from bodily states), uncovers the inextricable interdependency between the body and the mind. If the mind is a result of the brain activity and the brain is both in the body and a part of the body, how could they be separated in a way other than theoretical, analytical, or involving science-fiction? Early philosophical anthropologists, such as Marcel

Mauss and Maurice Merleau-Ponty noticed the primacy of bodily perception within human experience.[3] Perhaps it is only a matter of time before artificial intelligence designs produce a mind without a body, but, at least for now, the Cartesian legacy seems to have significantly crippled not only the vocabulary used to speak about these concepts[4] but also biomedical science itself.[5]

Many medical traditions existing in parallel to biomedicine, however, developed their own approaches to looking at the relationship between the body and emotions, including considering them as indivisible (Bound Alberti 2012: 9). Within the Western medical tradition, it was only in the 19th century that a better understanding of the mechanisms of nervous transmission was achieved. These new ideas effectively replaced the over two-thousand-year old Galenic principles as an explanatory model of illness. As a result, scientific medicine abandoned the idea that the body required will or a soul to function properly, which led to a consolidation of the separation between the body and mind, representing physiological and psychological processes (ibid.: 144). Prior to this, it was commonly accepted that the brain was the organ responsible for reason while the heart was ruled by passions (ibid.: 20; 2009). This conceptualisation of the heart as influenced by emotions points to their dual character, both physiological and psychological. The emergence of secular models of the origin of knowledge enabled the analytical separation of the mind from the body (ibid.: 164). At the same time, Galen's heritage lingers in many European languages in phrases such

[3] Mauss famously stated that "[t]he body is man's first and most natural instrument" (2007 [1935]: 56), while Merleau-Ponty pointed out that "[t]he body is our general medium for having a world" (1962 [1945]: 146).

[4] Margot Lyon noticed that attempts at overcoming lexical limitations very often serve to confirm and consolidate them (2005 [1988]: 45) – and this thesis is not free from this shortcoming.

[5] Although there have been considerable changes in the way patients are approached in biomedicine, the mechanistic view of the body is still often privileged over more holistic approaches, which take into account the patient's general wellbeing. Simultaneously, it should be emphasised that the pressure on fast acting solutions to ailments may emerge on the part of patients as well (cf. e.g. Blaxter 1990; Tiefer 1994). The idea of unification of the body and mind in biomedicine, termed "infomedicine", was first comprehensively proposed and described by Laurence Foss and Kenneth Rothenberg (1987).

as "cold hearted", "phlegmatic", or "hot blooded" (ibid.: 4, 18-19), pointing to a popular, perhaps implicit, understanding of the body and emotions as interdependent. Contemporary definitions of emotions have them as "physiological experiences with a cognitive dimension" (ibid.: 12), which shifts the weight of the phenomenon on the body, without neglecting the mind. It is interesting to ask about the relationship that emotions may have with language – or in fact, whether speaking about emotions is a part of them at all.

The body knows: corporeal sadness and awareness

In April 2012, less than a month into my fieldwork, I became unwell. I had only been living with my fieldwork family a little over two weeks so we did not know each other very well – and I was trying to make a good impression on them. But my plans were thwarted by an unexpected illness. I was constantly nauseated, and felt exhausted: climbing one flight of stairs to my room would give me muscle pains. No amount of over-the-counter painkillers could even briefly relieve my throbbing headache. I had no appetite or energy and, day after day, I would sleep through the entire afternoon as well as the night. For the first few days I thought it was some kind of a strange stomach bug, coupled with the tiredness that accompanies changing climate and time zones. When I did not get better after four days, I started thinking that it was one of the local parasites, equally easy to pick up in lowland Bolivia. The family started to be concerned as I seemed to sleep endlessly and eat very little. I did not want them to be worried about me, but at the same time I was not getting better at all. A few days later I was approached by my landlady's daughter-in-law, Rosa, who was a certified nurse. She asked me what the matter was and I described my physical symptoms to her. She listened patiently and said: *Puede ser tristeza*, it might be sadness.

It was surprising to me that despite her biomedical background as well as obvious familiarity with local ailments, Rosa interpreted my condition as induced by emotions. She suggested that I missed my family and friends, which is why I had become unwell. This possibility, however, had never even crossed my mind

until she mentioned it. A day later my skin became covered with a reddish rash, a sign indicating that what I had was probably a very mild case of dengue fever,[6] a tropical mosquito-borne disease, common in lowland Bolivia, especially in the months following the rainy season. Rosa must have been familiar with dengue symptoms, even through an atypical manifestation, which is what seemed to make her initial diagnosis even more puzzling. At the same time, she must have taken into account those aspects of my situation that I had completely ignored, such as being away from my relatives, in a faraway country, and – by Rosa's standards – alone. However, these apparently biomedical and local interpretations continue to reflect the body and mind division that imposes itself all too easily. What if Rosa's diagnosis is considered accurate, what if *tristeza*, sadness, is a genuine state of the body?

What follows is another example from my fieldwork in which sadness had a perceptible bodily component, despite the possibility of ambiguous interpretations. This story is a composite of the notes I took after a conversation I had with Rosa and Roberto one afternoon, approximately two months into my fieldwork.

Rosa: *When I found out that I was pregnant, I felt* triste y allegre a la vez*, sad and happy at the same time, as if a part of my life had ended and another one had begun. Then I called* Roberto.

Roberto: *I remember when she called me to tell me that she was pregnant. I remember I was out cycling with my friend Marcelino and we went to Urubó* [an upper-class neighbourhood on the other side of the River Pirai, about 15 kilometres from where Roberto lived]. *It was Thursday afternoon and it was very hot. I was wearing a green T-shirt. Marcelino and I were sitting on the main square, drinking Coke*

[6] This diagnosis was given by Roberto, Rosa's husband, who was at the time in his last year of biomedical studies.

and my phone rang. It was Rosa, she said "Berto,[7] tenemos que hablar*, we have to talk. I'm pregnant, we're going to have a baby." It was the happiest day of my life.*

[…]

Rosa: *Laura was born via C-section towards the end of the seventh month. I went for a check-up, they gave me an ultrasound and it turned out that there was too little amniotic fluid*[8] *so they made me stay at the clinic* [where she also worked as a nurse] *and gave me an IV drip. It really hurt, the doctor later said it was steroids for Laura's lungs. The following day I had the surgery* [C-section].

Roberto: *A few days later after Laura was born, Rosa* se veía triste*, looked sad. She would lie on the bed in the clinic, staring at the window for hours on end. I thought it was* "baby blues"*, I had learnt about it* [studying medicine] *at the university. When I asked her if she was* triste*, sad, she said she wasn't. But there was this* tristeza*, sadness in her. Then it went away, after a few days.*

Rosa: *When Laura was born I remembered how I felt when I found out that I'm pregnant. These feelings, they came back.*

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[7] Diminutive of Roberto.

[8] Low levels of amniotic fluid (oligohydramnios) "increases the risk of adverse perinatal outcome" (Hashimoto et al. 2013: 349), and may be an indication for inducing the C-section in the third trimester, especially after the 34th week of gestation and "certainly if it is at ≥36 completed weeks of gestation" (Magann et al. 1999: 1356). Current research indicates that even "mild decrease in amniotic fluid or 'borderline' oligohydramnios in the third trimester has been shown to increase the risk of adverse pregnancy outcome" (Hashimoto et al. 2013: 349). Among the risks for the foetus, resulting from low level of amniotic fluid at various stages of pregnancy, are the underdevelopment of kidneys and lungs, as well as low birth weight, a low Apgar score immediately after delivery, or increased risk of breech delivery (which is also an indication for a C-section) (Hashimoto et al. 2013; Magann et al. 1999). While the majority of medically induced labours are successful (i.e. without uterine rupture), many of them involve a caesarean section due to the unripe cervix (Wing 2011). The ripening of the cervix, necessary for a vaginal delivery (see e.g. MacKenzie 1993), only occurs in the last weeks of pregnancy, thus inducing labour in the case of an unripe cervix usually leads to a C-section (Wing 2011). In the case of Rosa, it seemed like a caesarean section was the safest solution, given the circumstances.

Figure 14. Rosa with Laura on the Mother's Day, May 2012.

It would be easy to dismiss Rosa's low mood following Laura's birth as a standard case of baby blues[9] – although even Roberto, who is a biomedical doctor, had his doubts. Many more months into the fieldwork, as Rosa and I grew close, I learnt that Laura was not her first child. Rosa had been pregnant once before but the boy had died when he was nine months old. Except for Roberto, I was the only other person in the household who knew about this, and I am not even sure if Roberto knew that Rosa had told me about it. That first pregnancy was a part of Rosa's treasured, unspoken history, which hardly ever surfaced. This hidden, heart-breaking past added depth and meaning to her saying "I was sad and happy at the same time" – it is possible to imagine how this sadness was not just about how a new baby would change her life, it was also

[9] Baby blues is defined as a period and feeling of low mood after giving birth; it is experienced by fifty to eighty percent of parturient women and biomedically explained through hormonal changes (cf. e.g. Fray 2005: 152-155; Hrdy 1999: 170-173; Bateman 1994: 58; Harkness 1987: 194).

about a son who would never meet his sister, it was about the daughter who would never meet her brother, it was about a motherhood that did not last. Perhaps Rosa indeed experienced baby blues after childbirth, and I have no doubt that her hormone levels changed. But also, maybe more crucially, there was an important reason for her to feel the way she did (and what Roberto labelled as *se veía triste*, she looked sad) and for her body to be unwilling before she fully assumed the role of Laura's mother.

In both examples sadness is not articulated through words, but is quite readily observed by others. While in the first example Rosa was not close to me at that point, my symptoms were obvious enough for her to call for a diagnosis of *tristeza*. In the second example, Roberto was the person who knew Rosa best and who spent a lot of time with her in hospital after the caesarean section, giving him the opportunity to notice her sadness, unlike other visitors who perhaps did not focus as much on Rosa as on the baby. Perhaps his biomedical knowledge played a part in what he could have noticed as well, but he still took Rosa's denial of her sadness seriously – because she said that she was not sad, Roberto assumed that this was the case. I, too, denied my sadness to Rosa, however, neither my denial to her nor hers to Roberto made a change to our bodily states. Thus, it is possible to look at these bodily states as speaking of sadness in a way that is beyond awareness – or at least linguistic awareness – while the fact that we both got better, without any particular treatment, can be conceived of as a form of coming to terms with the sadness, the unspeakable kind confined to the body.

Doña Paula's heart episodes

Throughout my fieldwork, situations in which the bodily reaction to certain events was noticeable occurred relatively frequently. Sometimes, in contrast to the examples above, people were very vocal about what had caused their condition, although not necessarily about how to cure it. In the example below,

social relationships and their quality inform the understanding of the causes of episodes of heart palpitations.

My landlady, Doña Paula, had been diagnosed by a biomedical doctor with type II diabetes and high blood pressure and took medication for both illnesses more or less regularly. However, sometimes she experienced episodes of severe heart palpitations and shortness of breath, which she attributed to having been extremely upset, usually by one of her children who had said something hurtfully disrespectful. It usually took several hours for Doña Paula to get better, a process involving apologies by the child who had upset her. During the hours of recovery, she was usually accompanied and helped by immediate family and friends. I would sit and talk with her, and she would cry and often recount what had made her so upset, trying to explain her position and reasoning.

> *I want to give them everything* – she would say – *I try so hard and I work all the time, I have this shop and I run it all by myself*[10] *and when I ask Mónica* [her daughter, who had upset her] *for help, she quips, "*Mamá*, I don't have time, I have to study". But she doesn't study* [i.e. go to classes] *on Sundays, she could help me in the morning, Marisol* [her younger daughter, still in secondary school at the time of my fieldwork] *helps me out every day in the afternoon, every Sunday, while Mónica is asleep. She doesn't respect me, and I sacrifice so much for them, this shop, all of this is my sacrifice.*

Whenever I was around during Doña Paula's heart episodes, I listened patiently, partly because I agreed with her that both her daughters should help her, but partly because I felt that what she needed was a sympathetic ear more than anything else. Rosa would often accompany us, with her little daughter Laura running around. We would help around the shop (while simultaneously trying to curb the destructive forces of a toddler on the move), sell things to endless customers, and then perhaps encourage Doña Paula to close her business a little earlier than usual, around 7 or 8 p.m. She was usually feeling much better

[10] Doña Paula did not technically run the shop all by herself, but she did not have reliable regular help apart from her younger daughter, Marisol.

the following day, although often slightly fragile, but she hardly ever mentioned the previous day's events to me.

These episodes happened throughout the year and looked quite serious. Doña Paula, a normally energetic and vivacious woman would turn into a sobbing ball of nerves, desperately panting for air with a handkerchief-clutching hand on her undulating chest. Her son Roberto, who was studying to become a doctor, would measure her blood pressure, say that it was too high and ask her if she had taken her medication. Sometimes he would also tell her that she needed to go to the doctor. Doña Paula feared doctors and went to a lot of trouble to avoid them, so she would look at Roberto, her eyes welling with tears, and ask rhetorically: "What do I need a doctor for if I have you?" Although sometimes it felt like Roberto was trying to scare her into feeling better, abusing the fact that Doña Paula was afraid of doctors and injections, it still seemed like she was convinced Roberto's threats of taking her to the doctor's came from the right place, that despite the fact that he knew she was reluctant to see a specialist, he would have never suggested it unless he thought it was absolutely necessary.

It is interesting that Doña Paula never experienced similar symptoms as a result of other events or factors. These episodes of heart palpitations and general weakness were invariably provoked by her becoming upset as a result of the actions or words of somebody close to her. She sometimes took medication to lower her blood pressure, but only several hours into the episode, when she finally agreed to Roberto taking her blood pressure, which invariably turned out to be higher than the normal range. It also seemed that what Doña Paula required to feel better was a combination of an apology, care, support, and a listening ear – all of which allowed her to recuperate. She acted and reacted in and through her body, which promptly answered to whatever upset her; and it spoke loud and clear. Apart from the largely verbal character of the apology, other aspects of the process of recuperation had prominent bodily aspects as well: holding her hand, sitting close, bringing her hot herbal infusions. There was usually very little discussion on the part of the carers that concerned the source

of disturbance, they would instead speak around it, asking Doña Paula if she was feeling better or if there was anything they could do for her, or find out what she would like to eat, drink, or do.

These events could be interpreted as related to the quality of social relationships, where Doña Paula's intense bodily reactions indicated a perceived transgression of social rules – such as when her own daughter refused to help her in the shop, despite being asked many times. Making Doña Paula feel better involved other members of her social network in balancing her immediate social world by explicitly showing care and consideration.

The importance of home-based attention to relieve an ailment was described among the Saraguro from the southern Ecuadorian Andes (Finerman 1989). Saraguro women suffer from *nervios*, nerves, which are caused by a variety of misfortunes, including domestic problems, either with spouses or with offspring,[11] the sudden death of a relative, or malicious gossip (ibid.: 145). Just like Doña Paula, women suffering from *nervios* are able to pinpoint the causes of their conditions with a large degree of specificity. As far as treatment is concerned, Saraguro women rely on female heads of household, who have the skills and expertise to administer a cure. What mattered for women undergoing *ataques de nervios*, nervous attacks, in addition to being offered an effective medication, was the personalised attention they could receive from people that knew them well (Finerman 1989). It seems likely that in the urban context of Santa Cruz, where social networks are less dense than in their places of origin,[12] this confirmation of social support in the form of being around the ill person also highlights the importance of community and reciprocity in people's lives.

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[11] The fact that Saraguro women are more likely than men to suffer from *nervios* as a result of the recalcitrance of their children (Finerman 1989) also highlights the asymmetrical responsibility for childcare within the marital couple (see Chapter 6).

[12] For a discussion of social networks and migration, see Chapters 1 and 6.

Doña Blanca: Disordered life and miscarriage

Certain situations may make people even more aware of the significance that social relationships and the quality of life have on one's body. In the following example, Doña Blanca,[13] a thirty-two-year old migrant from La Paz, and mother of two, speaks of her miscarriage as resulting from her disordered life. She contrasts it with her subsequent pregnancy when her life circumstances were in slightly better shape, and when she deliberately did not allow her problems to influence her gestation. Doña Blanca's case suggests people's active participation in the process of contributing to their bodily equilibrium, even though sometimes they fail. It is also interesting here that her narrative, so focused on bodily experience, followed my saying "Doña Blanca, I wanted to ask you about the *sentimientos*, sentiments, about *emociones*, emotions, during pregnancy."

> *With my second daughter I felt normal during my pregnancy. But I also felt the difference of having someone inside, the uterus is growing in the belly, the breasts are filling with milk… The first time it was very beautiful. You know, what I was feeling was changing… but the second [pregnancy] was also beautiful, you know, the body is changing, including your character – it is forming,* el carácter de maternidad [lit. the character of maternity]*, the mother's character, you start having more patience, you become more tender towards the baby…*
> *The first time I got pregnant I was twenty years old, I had her when I was twenty-one. I was adult enough then,* ya no era tan muchacha*, not a girl anymore.*[14] *I became pregnant again when I was twenty-five if I'm not mistaken…*

Suddenly, Doña Blanca said:

> *After that pregnancy when I lost my baby, I was pregnant again within a year.*

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[13] I was introduced to Doña Blanca by Julia, the director of Luz del Mundo, the volunteer-run childminding institution in Plan 3000 that I frequently visited.

[14] Finerman (1982) describes how among the Saraguro in Ecuador, a woman, irrespective of her marital state, is referred to as "girl," "unmarried," or "child" until she gives birth to a child.

She finished the sentence with a smile. I almost automatically asked "Weren't you afraid…?" but then I myself became afraid even to complete the question. Doña Blanca finished it for me:

> *That the same would happen again? Well, what happened with my* [miscarried] *baby, during that time I had a lot of worries. Back then I wasn't in a stable relationship either, I had a lot of problems with my husband, I was alone, I had a lot of problems, and I let my problems affect my baby. I exposed my baby to harm because I had lots of* ataques de nervios*, nervous attacks, before. That's what it was! That's what made me lose my baby. In that period of pregnancy one must be as calm as possible, as* equilibrada*, poised, as possible, but sometimes* simplemente no da*, it just can't be done. But then I said to myself that I wasn't going to do it to another baby. Even though I had a lot of marital problems, my baby was born* con hambre*, hungry, and* gordita*, chubby, because I protected her! With Bella* [her younger daughter]*, I didn't let my problems affect my pregnancy, I didn't think too much about them. My baby was very big and very fat! She weighed over four kilograms!*

It is interesting to note in the beginning of this particular example that Doña Blanca very explicitly spoke about how her body was changing, even though the question asked about *sentimientos*, sentiments, and *emociones*, emotions. This points to a bodily understanding of these categories. Further on, the negative thoughts, rather than influencing her mood, had the power of influencing the gestation. Doña Blanca was quite confident in her interpretation of the causes of the miscarriage and that her intentional avoidance of dwelling on problems during her next pregnancy made a difference. She then offered advice on how to behave in order to avoid miscarriage: "one must be as calm as possible, as *equlibrada*, poised, as possible," although she acknowledged the external factors which remain beyond the individual's control. In fact, her marital problems had not been solved by the time she had Bella, and yet, she claimed full control over her new baby's health and vitality, manifested as the baby's chubbiness and appetite. In Doña Blanca's narrative, her marital problems were the causes of her negative

thoughts and *ataques de nervios*, nervous attacks, which in turn influenced the pregnancy. While she was unable to resolve her marriage problems at the time – although when we spoke to each other in November 2012, she was living with her husband again – she felt that she could protect her baby by controlling her thoughts, and thus her bodily equilibrium.

Doña Blanca's absent husband[15] constitutes a reversal of the ideal marital situation. In the dialect of Quechua spoken in the Cuzco area of Peru, the phrase "man and wife" is rendered via the composite word *warmi-qhari*, lit. woman-man (Allen 1988: 72).[16] In the Andean context, "marriage […] confers on an individual the status of person on a social and practical level. Marriage is the union of a man and a woman and it is this union which completes the person. […] [W]ithout a marriage partner an individual is seriously deficient" (Canessa 1998: 239-240). Writing about the Aymara-speaking Laymi in northern Potosí, Bolivia, Olivia Harris states that "[t]he biological roles of the sexes in reproducing the human species are brought to represent the reproduction of the whole social fabric, that is, not only the reproduction of human beings, but also the well-being of the community, the fertility of the soil, and of animals" (1978: 25). For Harris, the complementarity of the married couple extended beyond their reproductive potential, reaching the economic aspect of the household (ibid.: 37). In the context of migrants in the city of Santa Cruz, the household economy is usually reduced to remunerated jobs (rather than agriculture and animal herding) and in the case of Doña Blanca, the absence of a husband had a considerable impact on her financial situation. Simultaneously, an unfavourable economic situation is not the only effect that comes with being a single mother, even if only temporarily.

While there are other reasons for why the presence of a spouse may be important in the context of urban Santa Cruz, I think it is worth considering the

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[15] See Chapter 6 for a discussion of absent husbands and asymmetrical parenthood.

[16] The ethnographic literature on the Andean region usually cites this composite word as *qhariwarmi*, man-and-woman (Quechua-speaking Macha people, northern Potosí, Bolivia, Platt 1986: 241, 244) or *chachawarmi*, man-woman (Aymara-speaking Laymi people, northern Potosí, Bolivia, Harris 2000: 179).

motivations behind the fact that Doña Blanca only spoke of her absent husband – rather than mentioning friends and relatives who helped out when life was difficult for her – and why this absent husband featured so prominently in her narrative. While acknowledging the importance of a spouse in the creation of a complete person in the Andean context, it is also possible to argue that the husband is a shorthand for an entire array of affines, who are likely to join the couple's social network.[17] On the other hand, once the husband no longer fulfils his obligations towards his spouse, the relatives on his side of the family are released from this duty as well (although some may still choose to keep contact with the wife). Even though Doña Blanca points to negative thoughts as the cause of her miscarriage, she also quite explicitly speaks of the reasons for the negative thoughts. The imperfect marital relationship, with the accompanying effect of weakening Doña Blanca's social network, is what brings the trouble.

Laura: *Tirisia*

The idea of the importance of being surrounded by relatives seems to emerge very early on, as I hope to show with the following examples of *tirisia*, pining. Here, it is babies who suffer from strained social relationships, and despite the fact that their modes of expression are largely restricted, their adult caretakers interpret their specific symptoms as *tirisia* quite readily.

Doña Paula was her granddaughter Laura's second most important caretaker after Rosa, Laura's mother; she constantly played with her, spoke to her, encouraged her attempts to walk and talk, carried her in her *aguayo*,[18] fed her bits of whatever she was having to eat, bought her little toys a few times a week, etc. Laura clearly recognised her grandmother at an early age and actively sought her attention and opportunities for receiving treats.

[17] See Chapters 1 and 6.

[18] A large square striped woven cloth used to carry items and children on the back. In Santa Cruz *aguayos* are still quite commonly used, although very often their primary function is now limited to carrying children. The *aguayos* used in the lowlands tend to be made of polyester fabric, which is very colourful and much cheaper than hand-woven, woollen fabrics.

In October 2012, Doña Paula, her daughters, and Doña Paula's neighbour and best friend, Doña Celia, went away for a week. As the two women are merchants, they were planning to go to Chile and buy merchandise. Doña Paula's daughters, Mónica and Marisol, accompanied them as they had never seen *el mar*, the ocean, and it seemed like a perfect opportunity to do so. Their plan was to go to the Chilean town of Arica, purchase merchandise (mainly clothing for sale, as Chilean-made items are considered of superior quality in Bolivia), and return to Santa Cruz. Doña Celia was to return directly to the city while Doña Paula and her daughters would head to La Paz to see Don Leopoldo's parents,[19] the grandparents of Mónica and Marisol. Don Leopoldo went directly to the Bolivian capital a few days after Doña Paula and the girls left; it had been decided that they would all meet in the capital city and visit some other relatives before returning home together by plane.

Three days after Doña Paula left, Laura fell ill. She became very apathetic, lost her appetite, turned sulky, and did not even seem to enjoy having baths, which was one of her favourite activities. The following day she started having a fever, which kept spiking despite the mild anti-inflammatory medication she was given. Rosa was getting worried and I felt I could not do much except help keep an eye on the baby while both Rosa and Roberto, her husband, were at work. Initially, we all assumed that it was a type of a common infection, frequent in toddlers who put dirty hands and objects in their mouths, an activity that often occupied Laura. However, one day Rosa came back from work saying that she had talked to her friend about Laura and that what her daughter was suffering from must have been *tirisia*, pining, a condition in which children, especially babies, become ill as a result of missing a close person, usually a relative. In order

[19] Don Leopoldo was Doña Paula's life partner and common-law husband. They had never officially married and were quite proud of the fact, as if this was something that made their over twenty-year-long relationship more genuine. Thus, Don Leopoldo's parents were not technically in-laws of Doña Paula and she usually spoke about them as *la mamá/el papa de Leopoldo*, Leopoldo's mum/dad, or *los padres de Leopoldo*, Leopoldo's parents (rather than *mis suegros*, my parents-in-law), highlighting the fact that they are not her true affines.

to prevent *tirisia*, the person who goes away should tie a red thread or ribbon on the wrist of the baby, making sure there are three knots (see e.g. Tapias 2006).[20] Rosa blamed herself for allowing Laura's illness to happen by failing to ask Doña Paula to put a ribbon on the baby girl's wrist. She said: *I'm Laura's mother, I live for her, when she's not well, I feel it's my fault*.

Another day passed and Laura was not getting better. Doña Paula was back in Bolivia so Rosa called her on the phone and asked her to talk to Laura, *so she can at least hear your voice*, she argued. Laura seemed to have her attention captured initially but then the conversation was cut short when she tried to eat the mobile phone, and when Rosa wanted to take it away, she quickly threw it across the room. A couple of days later the whole family returned, and the sick girl was handed to her grandmother for the entire afternoon, which she spent in Doña Paula's *aguayo*, mostly sleeping. The following morning the baby's fever finally broke and Laura was back to her old self, happily toddling around, continuously stealing my flip flops only to throw them out of the window, and persistently trying to put her little fingers in electric sockets. Rosa explained this rapid recuperation as being due to Doña Paula's return and I reluctantly felt that there was more to it this just *post hoc* logic.

The aetiology of *tirisia* has it that it is potentially harmful for the baby to be away from his or her main caretakers for prolonged periods of time. This can be prevented by tying a ribbon around the wrist of the baby, which not only evokes the meanings related to the tied thread,[21] but also symbolically acknowledges the place of the baby in the social network. An infant with a ribbon is someone who

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[20] On the day that I was leaving for Europe, Rosa brought out a red ribbon she had purchased especially for that occasion. I tied it around the wrists of Doña Paula, Rosa and Laura, while they tied three ribbons on my left wrist, each with three knots. I did not become ill, but I certainly missed them terribly. The last one broke about three months after I returned, around the time when I stopped having dreams about Santa Cruz.

[21] A red ribbon is possibly a contemporary replacement of a red woollen thread, which should be tied on the wrist in order to prevent people from becoming ill or attacked by malevolent wind. Inge Bolin mentions the powerful notions present in the threads, worn in the Peruvian Andes around wrists, ankles, and sometimes waists (2006: 18-19).

is already attached to other people, who already recognises its closest relatives and who could fall ill if these main caretakers are away for too long. On the other hand, failing to tie the ribbon implies an infant who is not cared for. Doña Paula's "forgetting" to do it was sending a false message, but a message nevertheless. Even though Rosa was unaware of that custom prior to the conversation she had with her colleague, it was clear to her that Laura fell ill with *tirisia* because she missed her grandmother, one of her main caretakers,[22] who seemed to have "forgotten" her.

I also spoke about *tirisia* with Doña Dolores, a single mother raising two small children. When I asked her about the meaning of *tirisia*, she said:

> *It's when the children are sad. About their father. Like… when my partner and I fought, when I discussed something loudly with their father, he would go to stay with his cousin, or at times I would kick him out, "Go away!" I would yell, and he would leave for about two or three days. The kids would turn really sad, sometimes they would even get fever. They would be sad and they would have fever, the kids. Their father would call me on the phone to say hello to them, I would pass the telephone to the kids, and click!* – Doña Dolores expertly snapped her fingers – *they would be happy. That's why a psychologist in the nursery told me that the boy misses his father more. She said that he really misses him a lot and when his father calls, I should not deny him the possibility of communication. That's what she said.*

Doña Dolores suggested that contact with the father may be more important for the boy than the girl; she based this interpretation on the children's respective reactions to their father's phone calls. The enthusiasm of the three-year-old

[22] Rosa was married to Roberto, Doña Paula's son, who also took care of Laura. However, because he was working part-time at the same clinic as Rosa and finishing his last year of biomedical studies, when he was at home, he mostly slept. When Roberto was asleep, Laura was taken care of by other members of the family, which made Rosa, Doña Paula, and Marisol, Doña Paula's youngest daughter, the undisputed main caretakers of baby Laura.

Vladimir remained unchallenged by an understanding that his father is not a permanent figure in their household. Additionally, Doña Dolores hinted at the need for the boy to have a male role model (this conviction is manifested in the fact that she entrusted the care of her first son to one of her brothers who stayed in Potosí).[23] Perhaps in this particular case, the convergence of an understanding of *tirisia* and the nursery psychologist's recommendation made this interpretation much more probable for Doña Dolores. But this would not negate the fact that the children would start to feel happier when they saw their father again or when they spoke on the phone to him. Simultaneously, maybe this interpretation also expressed something that was important for Doña Dolores herself – a relationship with a man who would also take care of the children – despite the fact that she was not lucky enough to be in such a relationship.

There was one more context in which I directly witnessed preoccupation with *tirisia*. When Juancito was about three or four months old, Julia would tie a red ribbon around her son's wrist every time she was going out for a few hours to run some errands. At these times Juan would be taken care of by his capable teenage sisters, Silvia and Nohelia. Julia could not leave him for a very long time – she was still breastfeeding and knew that Pablo would soon become hungry again. Additionally, her breasts would start to feel sore from the accumulating milk, which would also prompt her to come home and feed the baby. I asked Julia what could happen to Juan had she not tied the ribbon on his tiny hand. She answered that he could start crying because he was missing her and then he could get a colic, which is very painful for little babies, especially when they are still breastfed. She added that she did not know if he could fall ill with *tirisia* if she only left for a couple of hours, but she preferred not to run this risk. After all, it was her obligation as a mother to protect her baby from the dangers of the world.

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[23] Doña Dolores's life story is described in detail in Chapter 5.

Julia was Juancito's main adult caretaker, which is why it is understandable why she wanted to keep him healthy – a sick baby can be much more demanding. But, above all, Julia loved Juancito and her feelings were embodied in everyday acts of motherly care and tenderness, in an almost constant presence. Highlighting the precariousness of the caretaker's absence for an infant, *tirisia* is an illness caused by babies missing their caretakers, which may be interpreted as a longing for social relationships – and not just a source of food, and comfort, and clean nappies.

Conclusions

Each of these examples is slightly different, but I hope that they illuminate the links between emotions and the ways in which bodily states are interpreted. Thinking about these events as occurring in (or through) mindful social bodies of Andean migrants to Santa Cruz allows us to account for the connection between the breakage of social relationships and people's well-being.[24] What the situations described in this chapter have in common is a co-occurrence of the ill body and the troubled mind (at least in an interpretation where the body and mind are separate), and imperfect social relationships, regardless of how aware of them one remains. Tom Boellstorff and Johan Lindquist propose an "understanding of emotion as embodied yet foundationally social" (2004: 440), and this perspective seems to be a productive means of capturing the relationships between people and emotions. When Rosa suggested that what I felt was *tristeza*, sadness, I wanted to intuitively reject it, but then I started considering my situation from her point of view and I could not deny that, in some way, Rosa's diagnosis made sense as well. After all, I was alone, far away from my family, in a foreign country, with a prospective piece of research in front of me – an endeavour whose outcome I could not have possibly predicted at that time. I am still convinced that what I had was a mild case of dengue fever, but I also think that Rosa's

[24] Cf. e.g. Pandolfi (2007 [1991]: 451, 457).

insight was not entirely wrong, even though there is no way for me to remember now whether I actually missed my family in some subconscious way. It is easier for me to perceive the link between emotions and the body in examples that do not involve me personally, perhaps because I am not projecting onto them this culturally constructed separation, so deeply embedded in my body. It is like swimming against the current: even if the body and mind are defined as inseparable, the legacy of dualistic thought lingers in the polarised vocabulary, one category semantically implicating the existence (and oppositeness) of the other.

Perhaps it takes a special kind of body to be able to feel this kind of manifestation of emotions. Perhaps it also takes a special kind of idea of illness. It seems like a combination of the mindful body (Scheper Hughes & Lock 1987), embodying its thoughts (Rosaldo 1984), which is also social (Boellstorff & Lindquist 2004) could open up new possibilities, despite the vocabulary petrified by the body and mind dualism. If it is widely acknowledged that emotions have a bodily component, why is it not so easy to think that bodily states *are* in fact emotions as well? Naming and labelling what one is feeling requires a level of awareness and a degree of practice. It could be argued, therefore, that this naming and labelling is also secondary to the feeling itself. What if the body becomes the starting point of the analysis? What if the body emotes in the first instance? This explanation allows for some interesting ways of understanding certain illnesses, especially in contexts where emotions – such as sadness, pining, missing someone, or being upset – are openly thought of as being able to cause sickness. Perhaps, then, in certain contexts, where verbalising of emotional states is not encouraged, it is possible to feel and effectively deal with complex emotions in ways that emphasise their ultimate corporeality. Sometimes, it is possible to, quite literally, feel ill.

Chapter 5
Sobreparto, the postpartum body at risk

Pregnancy may be a very common phenomenon in Plan 3000 of Santa Cruz de la Sierra, but it does not go entirely unnoticed. Eat this, do not do that, sit here, skip the queue: restrictions, privileges, and rights appear almost organically, while the body is transforming, faster and faster. In Santa Cruz, gestation is not considered to be an illness, although it may be brushing dangerously close to this category. The strict rules of postpartum behaviour, such as the ones undertaken to avoid *sobreparto*, constitute a testament to the precariousness ascribed to reproduction. A closer look at ethnographies focusing on the issues of childbearing in the Andean region suggests that the concept of the mindful social body may be a productive means of conceptualising the inherent complexity of women's reproductive and social trajectories. What interests me here, therefore, is whether it is possible to analyse the remembered emotional trajectories of pregnancies (including the time before and after gestation) from the point of view of the mindful social body.

There are multiple dimensions of comprehending the significance of *sobreparto* in women's lives. It is almost intuitive to categorise it as an illness – especially bearing in mind how *sobreparto* is usually presented with reference to competing traditional and scientific/biomedical systems. Furthermore, the biomedical point of view, encouraged both by free, state-offered health services and by the proliferation of private biomedical clinics, promotes an understanding of a patient as an individual (rather than as a part of a reciprocal social network) who is largely responsible, if not explicitly for their condition, then at least for making attempts at getting better (by using biomedical services). This makes it

even more complicated to remove *sobreparto* from the discourse of aetiologies, symptoms, and diagnoses and to position it as a life event, which is strongly intertwined with the local social network, the importance of reciprocity, and the intentional testing of one's own capacities. I would like to argue that interpreting *sobreparto* as a life event (rather than just an illness of the body) may shed new light on the social dynamics of *sobreparto*. In fact, looking at this condition as a situation in which social networks are tested – not just by and for the woman, but also by and for others – offers insights into people's lives without reducing their bodies to medical objects.

Reciprocity, biomedicine, and well-being

In order to better understand the relationship between the postpartum illness in question and the position of a woman who has just given birth in her social network, it is necessary to look at the way in which the concept of the body has traditionally been constructed in the Andes. It was clear during my fieldwork that there were few – if any – Andean migrants in Santa Cruz whose understanding of how the body functions did not include at least some elements of the biomedical model. At the same time, an analytical separation of these understandings may offer an insight into medical conditions falling beyond the scope of biomedicine, such as *sobreparto*, illnesses whose aetiologies are not restricted to individual bodies.

According to ethnographic literature, an Andean body is a manifestation of a balance between humanity, the environment, and the spiritual world (cf. Bastien 1978, 1987; Allen 1982). There is a web of reciprocal duties, which connects people, spirits, mountains, earth, and stars. These mutual obligations are fundamental to well-being and are satisfied with acts of reciprocity, which characterise traditional Andean social relations (see e.g. Miles & Leatherman 2003; Tousignant 1989). While the occurrence of rules of reciprocity is by no means confined to highland Bolivia, Andean migrants in Santa Cruz may struggle

while trying to satisfy the requirements of such interchanges due to the pressures of living in a large city.

The corollary of understanding the body as interrelated with other bodies and elements of the landscape is that reciprocity – and following other social rules concerning other people, the spiritual world, and the landscape – ensures health and protects from illness. On the other hand, a disruption of the social harmony or a transgression of accepted rules, for instance through refusing communal duties or the expression of negative emotions, exposes the body to a reprimand from the spiritual world, often in the form of illness (Cooley 2008: 138-139; Greenway 1998a, Larme 1998). Hard work and sweat strengthen Andean bodies, while giving in to laziness and sleep weakens them and makes them prone to sickness (cf. Bastien 1978, 1987; Larme 1993; Larme & Leatherman 2003).

In the case of Andean migrants to Santa Cruz de la Sierra, whose social networks are frequently already weakened as a result of relocation,[1] the situation becomes more complex. While family networks usually remain very important sources of support, and are actively acknowledged through visits, phone calls, and family parties, the demands of city life (such as the time people spend working and commuting) limit the amount of time, energy, and enthusiasm that people are able or willing to devote to this part of their lives. Within the household where I lived during fieldwork, mutual help between family members was both intensive and generously dispensed: Doña Paula's daughters and her daughter-in-law assisted her in the shop, her partner, Don Leopoldo, accompanied her in the mornings to the markets to restock supplies, and hardly ever did anyone refuse to take care of baby Laura for hours on end. While helping each other was constant, it did not remain unquestioned: sometimes comments were made about giving or accepting more than necessary, or taking advantage of a situation. For instance, it was acknowledged that Rosa and

[1] See Chapter 1.

Roberto, who both had jobs, had the right to ask someone to take care of Laura when they were both at work at the same time (Roberto, a medical student, was then in his last year of the university and also had a part-time job while Rosa worked as a nurse). However, when they asked Roberto's sister Marisol to babysit Laura when they wanted to go out for dinner with friends for the second time since their 11-month-old daughter was born, the request was met with fierce opposition. It is interesting that it was Rosa (rather than the couple, or Roberto himself) who decided that they did not have the right to insist on this kind of help, a favour more than a real necessity, from the immediate family members, who were Roberto's blood relatives. In the end, Rosa asked me (at that point I had only been living with them for three and a half months) and I happily agreed, but I heard some comments about my decision which were directed towards Rosa and Roberto who apparently were *disfrutándose demasiado*, having too much fun, and *aprovechándose de mi*, taking advantage of me.

An interesting difference in attitude could be observed in situations when Sara, Doña Paula's distant niece, visited the household. She was always accompanied by Gloria, her three-year-old daughter. Initially, they would stay for an afternoon but then Sara began to drop Gloria off for long hours, without informing anyone when she would be back. Because Sara never really explained why she needed somebody else to take care of Gloria, Doña Paula and Rosa inferred that she probably had some business to take care of and lugging her fussy daughter along through the city offices would slow everything down. Although this speculative explanation might have been considered probable, Rosa once said: *Pero eso ya es abusivo, de Doña Paula y de la niña*, but this is already abusive, of Doña Paula and the girl. It is interesting that she left herself out of this situation of "abuse," despite the fact that she would usually undertake a part of the activities related to caring for Gloria, such as feeding her, offering her a jacket when it got chilly in the evening, sometimes even putting her down for an afternoon nap. Still, Doña Paula and Rosa had little enthusiasm for taking care of Gloria, which made them complain to me about Sara's behaviour. For instance,

they would say to me that they too were busy but did not resort to dropping Laura off with other relatives (i.e. not her main caretakers). I never witnessed a direct confrontation between Doña Paula, Rosa, and Sara, and the most aggressive phrase I heard (although I was not always present when Sara finally returned to pick up her daughter) was when Rosa said to her: *su hija le estrañaba*, your daughter missed you.[2] In general, it seemed to me that although reciprocity and family obligations are readily recognised aspects of social life, there are often perceived difficulties with satisfying these demands on a daily basis.

Living in a city such as Santa Cruz may contribute to the notion that doing favours, such as those described above, is rather troublesome. In other words, helping each other in everyday activities is not taken for granted beyond the closest family and friends. However, there is another factor undermining the importance of reciprocity, traditionally understood as ensuring personal and community well-being. The validity of such a positioning of reciprocity in social life is challenged by the increasing presence of biomedicalised notions of health and illness in Santa Cruz, which do not take reciprocity as a factor of well-being into account. Moreover, while biomedicalised understandings are readily combined with traditional ones, certain fundamental contradictions remain. One of the fundamental contradictions between biomedicine and traditional medical systems is the individualisation of the patient favoured by the former. In other words, while the quality of interpersonal relationships is sometimes recognised as a factor in the healing process, it is hardly ever understood as a cause of an illness *per se*.

There are two general tendencies which feed into each other in the process of transforming the way in which health and illness are conceptualised by

[2] This translation does not (and cannot) reflect the use of the polite – or distancing – form of address, *Usted* (*Ud.*) (3rd person singular). *Ud.* is often used synonymously to *tú* (2nd person singular, equivalent of singular "you" in English) in Bolivia. In fact, *Ud.* is acceptable between spouses or friends (and not just strangers) when politeness is an important aspect of the interaction. In this situation, the use of *Ud.* by Rosa implies social distance, unwarranted between affines and women of similar age.

migrants from the Andes to Santa Cruz. On the one hand, people frequently believe in both non-biomedical and biomedical explanations in roughly equal measure but also recognise that some medical systems deal better with certain conditions than others. For instance, there was a common consensus among my informants that biomedicine does not know how to cure *sobreparto*,[3] but that it is able to deal with certain conditions which require surgical solutions, such as an appendicitis or a complicated delivery. On the other hand, the authority of scientific biomedicine increases due to the privileged support it receives from the Bolivian government, not just through legislation, but also through informational campaigns in the media or developments of health infrastructure, such as constructing new hospitals. In other words, people's knowledge about the fallibility of biomedicine makes them aware of its inability to cure every medical problem; nonetheless, its strong presence in everyday life normalises it as the first resource when it comes to issues of health and illness.

In this respect, Andean migrants in Santa Cruz experience two kinds of tensions. First, they find themselves torn between the demands of the city life and the importance of mutual help and support in the community network. Second, they experience the contradiction consisting in considerably different ideas of health: one that is a matter of social harmony, achieved through reciprocity among other factors, and another, in which health is, to a large extent, dependent on individual choices or misfortunes, as biomedical science would like to have it.

Caring about the body: Perils of the postnatal period

In such a context, pregnancy leads something of a double life. In the shadow of biomedicine,[4] there are restrictions concerning the postpartum period, which

[3] This conviction is also common in the Andes, see e.g. Loza & Álvarez (2011); Larme & Leatherman (2003); Bradby & Murphy-Lawless (2002).

[4] See Chapter 2 for a discussion of the biomedicalisation of pregnancy in Santa Cruz.

reflect traditional understandings of the body in multiple ways.[5] In the Andes the postpartum body is traditionally considered to be open. This female openness is due to the additional orifice, the vagina, which is seen as a channel through which illnesses may find their way in (see e.g. Cooley 2008: 141; Bradby & Murphy-Lawless 2002: 46-47). Childbirth, accompanied by the loss of blood, leading to a certain level of bodily disequilibrium, exposes the woman to additional dangers, such as *wayras*, illnesses carried by cold, malevolent winds (Larme 1998; Platt 2002). The woman should be kept warm both during and after childbirth, which is achieved by heating the room in which labour takes place as well as covering her with thick blankets. Exposure to cold air, winds, or even excessive exposure to sun should be avoided. The heat must also be maintained through appropriate nutrition; various kinds of broths (e.g. mutton or chicken) and other foods considered hot, aid in restoring bodily equilibrium.

Conversely, foods categorised as "cold" are prohibited – these, depending on the region, may include: *ají* (spicy condiment), onions, potatoes, plantains, papaya, etc. Furthermore, contact with water (especially cold water) is explicitly stated to be dangerous: it is commonly referred to as *no hurgar/agarrar/tocar agua*, not to poke [one's fingers in]/hold on to/touch water. This restriction requires the woman to refrain from taking showers (although she can wash her body with a cloth soaked in a warm herbal infusion, with rosemary as the herb most often mentioned) as well as doing the laundry. The first prohibition requires a lot of willpower in the sultry Santa Cruz summers, when almost everyone showers at least a couple of times a day.[6] What makes the second prohibition difficult to

[5] The information in this paragraph is compiled from the following sources: Loza & Álvarez (2011); Bradby & Murphy-Lawless (2002); Arnold, De Dios Yapita et al. (2002); Arnold & Murphy Lawless (2001); Yon Leau (2000); Leatherman (1998); Larme (1993, 1998); Luerssen (1993); Gonzales et al. (1991); Lira (1985); Plath (1981); and Frisancho Pineda (1973). This summary focuses on elements which occur in multiple ethnographic accounts. For particular distribution of cited data see Appendix III.

[6] Some of the research participants expressed ideas about the danger of showering too often, irrespective of weather. One said that even though the water in Santa Cruz seems warm, it is not truly warm. According to her, frequent showers could lead to arthritis in future. When I told her

observe for prolonged periods of time, in addition to the speed with which babies are able to generate dirty clothes, is the fact that it is specifically women who are expected to hand wash the laundry.[7] In fact, doing the laundry was amongst the most common causes of *sobreparto* mentioned by migrant women in Santa Cruz in our conversations about this condition.

Ethnographic data collected in various parts of the Andes generally contends that once the placenta is birthed, it should be inspected for missing pieces (which is indicative of complications, such as postpartum haemorrhage). If it were expelled in its entirety, it should be buried or burnt – which will prevent the baby from developing infections (cf. Bradby 2002: 183; Platt 2002: 133, 144; Murphy-Lawless 1998: 5-6; Gonzales S. et al. 1991: 26).[8] Contemporary Bolivian "intercultural health"[9] regulations concerning childbirth recognise the existence of local significances of the placenta for certain indigenous groups in the country (Galindo Soza 2010: 164-165; Ministerio de Salud y Deportes 2006b); however, in practice, it is still the prerogative of particular hospitals to comply with their patients' demands (Rubén Vaca Vaca 2013, personal communication). When I

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that the baby living in my house was bathed two or three times a day during heat waves, she commented that this baby would be sick a lot in future due to excessive exposure to the coldness in the water.

[7] One of my research participants has a husband who is willing to do their family laundry to help her out – however, he always hangs a large sheet next to the laundry sinks so as to conceal his activity from people in the street, which he fears would be detrimental to his *macho* reputation. While some studies in the Andean zone document occasions in which men are likely to help their partners in times of need, including situations related to parenting (see e.g. Platt 2013; Dibbits 2003), there is a very strong *macho* ethos in Santa Cruz, to which migrants sometimes gravitate, which in turn influences their intimate relationships.

[8] There is, however, ethnographic evidence that incorrect handling of the placenta may influence the mother. For instance, Platt (2002) documents a belief in *q'ara wawas* (Qu. naked babies), predatory spirits or goblins in Macha, Potosí, Bolivia, which emerge from a placenta which was not disposed of in a correct manner or aborted foetuses. "Without the Christian salt of baptism, [buried aborted foetus or unbaptised placenta] grow into a 'naked baby' ([Qu.] *q'ara wawa* or *q'ara uña*) or 'goblin' ([Qu.] *twinti*, Sp. *duende*), which kills its mother by returning to eat blood in the womb and continuing to eat until it consumes the heart ([Qu.] *kurasun*, Sp. *corazón*)" (Platt 1997). Similar beliefs have been documented for other areas in Latin America (see e.g. Morgan 1997).

[9] See Chapter 2.

asked migrant women in Santa Cruz about it, they talked about a wide range of experiences: some claimed that it is disgusting and *muy del campo*, very much countryside-like, others did not even know about this custom. There were women who asked for, received, and buried their baby's placenta, but also others who complied with the tradition with their first couple of children and abandoned it with the following ones. Finally, some migrants were given the placenta without requesting it, and they threw it out with other rubbish. Based on the data I collected, it is clear that there is knowledge about the traditional significance of the placenta, however, it is becoming increasingly less common for migrants to follow Andean customs concerning its disposal.

The transformations of ways of handling the afterbirth reveal considerable influences of rationalism, understood as science-based knowledge and reasoning, fuelled by biomedical sciences. From the point of view of biomedicine, the role of the placenta ends abruptly once the foetus leaves the uterus (see e.g. Hrdy 1999). While it is very important that the placenta is expelled in its entirety or that measures are taken to clean its fragments from the uterus, once it is out, it becomes medical waste. Some hospitals in Santa Cruz do just that, irrespective of the government's intercultural health regulations concerning other medical traditions.[10] Most hospitals in Santa Cruz, however, are willing to accommodate requests for the placenta although it is significant that these requests are frequently considered to be non-standard, especially outside of impoverished neighbourhoods. This further reinforces the dominance of the biomedical stance with respect to how this aspect of childbirth is viewed both by Andean migrants in Santa Cruz and by the remainder of the city's population.

[10] Based on my conversations with migrant women from different social classes, private clinics tend to disregard any traditional manners of disposing of the placenta as superstition. On the other hand, both private and public health institutions in Plan 3000, where a large part of the population is of Andean origin, readily accommodated people's requests for the afterbirth (or simply handed the placenta to the families without asking whether or not they wanted it, see Chapter 2).

While proscriptions concerning the afterbirth may have been losing their significance for the migrants in Santa Cruz de la Sierra, the belief that the puerperal female body should be bound in a certain way remains very strong. Despite the fact that women I spoke to were often aware of the difference between the practice and the rules, they usually had a considerable degree of clarity as to what should be done regarding the postpartum binding of various body parts. Firstly, it is generally advisable that the head remains covered with some kind of a headscarf or a hat to protect it from exposure to the cold, wind, or sun (although my informants in Santa Cruz often confessed to not following this rule too scrupulously[11]). Secondly – and more importantly – the abdomen should be bound for a period following childbirth (my informants suggested periods between a month and six months as ideal) in order to prevent a variety of ailments related to the shifting of internal organs.

There are differences regarding the item used to bind the abdomen, although it tends to be referred to as a *faja*. It could be a thin, woven strap, in which case its primary function is stopping the womb from moving upwards in the body and asphyxiating the woman;[12] alternatively, it could be a large square piece of fabric, folded diagonally in half to form a triangle, wrapped two or three times around the woman's abdomen. These latter kinds of *fajas* in Santa Cruz were also said to keep the loose skin tighter and to help restore the pre-pregnancy figure. Many women who spoke to me would attribute or explain the presence of abdominal fat (in themselves and other women) to not having bound their abdomens with *fajas* in this crucial postpartum period or not having done it for an appropriate length of time. A few of my younger informants used a modern version of *faja* in the form of shapewear, a cross between a one-piece swimsuit and underwear, made of elastic fabric in colours suggestive of lingerie. Some of my research

[11] Neither did they distinguish clearly between kinds of malevolent winds causing different illnesses (Sp. *sopla*s, Qu. *wayras*), described in ethnographies of the Andean region (see e.g. Larme 1998).

[12] See e.g. Arnold & de Dios Yapita (2002: 91); Bradby & Murphy-Lawless (2002: 43-6); Gonzales et al. (1991: 28); Suárez (1974: 45).

participants explained that *faja* alleviates the pain felt during the *re-acomodación de los órganos*, the movement of the internal organs during the postpartum, when the uterus is shrinking and the organs, can, as one of my informants phrased it, "finally go back to their right places". In any case, it seems that the binding of the abdomen remained a more observed postpartum behaviour than the burying or burning of the placenta, although it has acquired new important functions for women, consistent with ideas more popular in urban areas – such as regaining one's pre-pregnancy figure after childbirth.

While the postnatal period is considered special, in particular with regard to the restrictions surrounding a woman's behaviour, it constitutes only a small part of a person's life. Moreover, this person is implicated in an intricate web of the lives of other people, who impact and transform each other through interactions. *Sobreparto*, a condition following a transgression of postpartum rules, constitutes an instance of such an impactful event.

Embodiment of emotions and postpartum illness

If it can be argued that a healthy Andean body is a matter of mindful negotiation and persistence, then what about pregnancy? According to Andean medical systems, pregnancy is a hot state; childbirth, on the other hand, usually accompanied by the loss of blood, is a cold one (see e.g. Bradby 2002: 179). While this understanding was never expressed explicitly in this form by any of my research participants (although the anthropological literature on the Andean region regularly mentions it), they unanimously emphasised the importance of keeping warm in the period following childbirth in order to mitigate the puerperal risks or complications (for instance, of haemorrhaging). This would involve staying inside, wearing warm clothes, especially socks and a hat (or binding the head with a scarf), drinking herbal infusions and taking certain kinds of foods – women who spoke to me frequently mentioned meaty broths and

chicken or beef stews,[13] i.e. dishes which are eaten hot and take a long time to prepare. Additionally, there is a set of prohibitions which complement the postpartum proscriptions: a woman who has recently given birth should avoid exposure to cold air or drafts (referred to as *aire*), touching water (for instance, by doing the laundry or showering), as well as manipulating metal objects.[14] These actions are taken to keep the woman warm and to ensure that the body is restored to equilibrium. However, I would like to argue that it is significant that women I spoke to often transgressed the postpartum restrictions in a manner that was deliberate, and that their consequent falling ill with *sobreparto* may be symptomatic of something more than just a failure to observe the rules of puerperal care.

An analysis of accounts of *sobreparto* I collected draws attention to a recurring feature: the traumatic experience or difficult conditions faced during pregnancy, often relatively close to childbirth. The event of childbirth was then followed by a violent illness, whose diagnosis and treatment involved making use of social relations with neighbours or relatives. After getting better, the problem would somehow dissipate or move into the realm of relative insignificance, into the background of women's life histories. Perhaps I am projecting my own expectations of some kind of dissolution or a closure for life events, but it often seemed as though the bouts of *sobreparto* had cathartic characteristics: each was violent, its outcome was uncertain, and it tested reality in an unapologetic manner. The Quechua term for *sobreparto*, *kutipa*, means "return" (Cuaresma Sánchez [ed.] 2005: 216). One of my informants explained the pain felt during *sobreparto* in the following manner: *It's like another childbirth, but worse, because you're already in so much pain after the first one. But the doctors don't know how to cure it. They give*

[13] Chicken (*pollo*) and beef (*carne*) are the main kinds of meat available in Santa Cruz because of the hot climate.

[14] Metal is considered to be "cold" and is thus able to cause illnesses. Those women in Bolivia who express fear of giving birth in hospital pointed to the fact that hospital rooms are very often chilly (especially in comparison to the traditional childbirth setting, where the room is purposefully well heated) and that the beds are made of metal, which adds to the general perception of hospitals as "cold" places (see e.g. Bradby 1999: 293, 296-9).

you anti-inflammatory pills, but they don't work, but you're suffering and suffering, as if you were to die… Sometimes women die… The anguish and a considerable lack of control over it, coupled with the emotional turmoil of having a new baby in one's life (and, hence, new responsibilities of and towards the social network) manifests itself though the peculiar suspense in the course of life created by a postpartum illness.

In various accounts of *sobreparto* which I collected during my fieldwork, those episodes of illness are located within a wider framework of life circumstances as well as on a longer timeline, one which involved not only the entire pregnancy and childbirth but also the situation of the woman before she became pregnant. The stories that I heard shared some features, one of which was that there was almost invariably another person – a relative or a neighbour – who diagnosed the ailment and offered a cure, which points to the significance of the social network. At the same time, basically everyone with whom I discussed *sobreparto*, both men and women, insisted that biomedical doctors do not know how to cure it and only make unsuccessful attempts with anti-inflammatory pills, which informs an understanding of this condition as remaining beyond the scope of biomedicine.

The accounts which follow were slightly edited for the purposes of this chapter, nonetheless, their style, chronology, and saturation with details remained mostly unchanged. I asked women about their experiences multiple times during fieldwork in casual conversations, but had to rely largely on my memory as I often did not anticipate the turns that our talks would be taking. I recorded interviews with most of my research participants towards the end of my fieldwork – the accounts below are based on the audio recordings and supplemented with the field notes I took throughout my fourteen months in Santa Cruz.

When I listened to these recordings, I realised that my interlocutors addressed my questions in ways that initially could seem slightly off-topic. I would ask: *¿Y <u>cómo</u> se sentía Ud. durante su embarazo?*, And <u>how</u> did you feel during your pregnancy?, but the answers described chains of interconnected and

accumulative events, ending in an illness, from which my informants were fortunate enough to recover. The stories I heard typically contained very few unprompted descriptors of emotional states – although it was not uncommon that the woman recounting it had tears in her eyes or spoke in a way that was different from her normal way of talking: sometimes more quietly, sometimes in a trembling voice, sometimes looking away.

When I asked about what they were feeling at the time of pregnancy,[15] those women would give me various answers, some of which seemed more insightful than others. For instance, it was intuitively easy for me to understand replies which explicitly mentioned emotions, such as fear, joy, or anticipation, but I was startled when my question was answered with *Me sentía normal, no me dolía nada*, I felt normal, nothing hurt me. In the beginning, I thought that it would be fair to assume that the answers which mentioned emotions were inspired by social standards of how one is supposed to feel in a similar situation, that I was being told what they thought I wanted to hear. However, perhaps it is more significant that the women did not articulate their emotions in categories which I had been anticipating, such as joy or fear, but instead talked about their painful or pain-free bodies, and about being alone. What if, I wonder, asking about how they felt was a mistake made as a result of a wrong assumption about what emotions are? What if they were telling me about their emotions all the time, but I just failed to understand it because I was expecting to hear specific words? What if being lonely was not how they were, but how they *felt*?

***Sobreparto*: There is more at risk than a woman's life**

Sobreparto occurs after childbirth, which, in addition to being important, is also quite dangerous in the Bolivian context, where maternal and perinatal mortality rates[16] continue to be very high by world standards.[17] Childbirth is a precarious

[15] *¿Qué sentía Ud. durante su embarazo?*, What did you feel during your pregnancy?

[16] World Health Organisation defines perinatal mortality as "the number of stillbirths and deaths in the first week of life (early neonatal mortality)" (WHO 2015). The basis for calculating

moment of change, especially in the suburbs of Santa Cruz where mothers (rather than the couple or the father) are expected to take care of children.[18] Therefore, it is not difficult to envision the potential threat an illness of the mother would pose at that special time, when the newborn baby requires constant care and attention, some of which – such as breastfeeding – are not easily delegated. *Sobreparto* creates a suspense in the life paths of both the woman and her infant. Perhaps it is possible to think of this suspense evoked by an illness[19] as a test of one's realities, a time where the strength of one's social network is verified. People who show up to help are not necessarily the closest relatives – most of my research participants were diagnosed by a neighbour, a colleague, a friend, a sister-in-law – but they were not complete strangers either, which emphasises the significance of relying on extensive social networks created in new places, in this case by migrants to Santa Cruz.[20]

The cure for *sobreparto* consists in drinking hot herbal infusions as well as rubbing the body with chicken or beef fat. The infusions are made using herbs considered to be hot in Andean medicine (Balladelli 1988); my informants provided different lists of ingredients for the cure for *sobreparto* – the only plant

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maternal mortality rate is the number of maternal deaths (see e.g. WHO 2014), defined as "[t]he death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (WHO 2010a).

[17] See Chapter 2.

[18] This is changing, and I should say that I have met fathers who participated in child-rearing. However, the transformation is rather slow-paced (see Chapter 6 for a discussion of paternal involvement in childcare).

[19] See e.g. Irving (2005).

[20] One of my informants, Doña Inéz, was diagnosed by her sister-in-law on the phone. Doña Inéz telephoned her sister-in-law a couple of days after giving birth to her second baby and complained about the pain, chills and shivers she was experiencing. Her sister-in-law recognised the condition as *sobreparto* and advised drinking and washing her body with rosemary infusions as well as rubbing the body with fat. Doña Inéz's neighbour helped her to buy the ingredients for the cure and assisted in the treatment. While this is an example somewhat contrary to my argument (the person who recognised *sobreparto* in the symptoms did not visit Doña Inéz), it is clear that people who are physically near-by can help in a much more tangible manner, by bringing food or doing the laundry, thus alleviating the burden of daily life.

which appeared in most of them was *romero,* rosemary.[21] Fat, next to blood, is a vital liquid in the human body for Andean medicine and people are wary of losing it in an uncontrolled manner.[22] Joseph Bastien states that "[b]lood and fat empower the body: blood (Qu. *yawar*) is the life principle and fat (Qu. *wira*) is the energy principle" (1978: 45) and that "images of fat-snatching and blood-sucking are used by Andeans to describe causes of sickness" (2003: 173).

In the accounts of *sobreparto* I collected, women were often alone (or, perhaps more importantly, felt alone) around the time when they gave birth. After childbirth, they were visited by a relative or a neighbour, who would notice their illness, diagnose the condition as well as, more often than not, offer or seek out a cure, guiding the woman out of her illness. The part of the cure which included rubbing the body with some kind of fat or even commercially-produced ointment, such as *Mentisán*,[23] is significant beyond the curative powers of fat. The body of an ill person is massaged by another person, who makes sure that the fat

[21] In highland Bolivia, rosemary infusions are considered to be able to cure colds, general body and joint pains, *maldición* (curse), and pains after childbirth (Macía, García & Vidaurre 2005: 344). In highland Ecuador, the uses of rosemary infusions included *mal aire* and *mal viento*, ailments caused by cold, malevolent winds entering the body (Cavender & Albán 2009: 5).

[22] Cf. e.g. Bastien (1978, 1987). Although none of my informants mentioned this explicitly, Andean mythology contains a figure of the "grease stealer" (see e.g. Bradby 1999: 293). This malevolent – and, more importantly, non-human – being, usually referred to in Aymara as *lik'ichiri* or *kharisiri*, is said to act at night and steal fat from sleeping people which causes them to lose strength and even die if the condition remains untreated by a healer (Sikkink 2010: 78; Canessa 2000: 705ff.; Bastien 1978: 54). Andrew Canessa discusses the phenomenon of *kharisiri* in more detail. He states that rather than the (usually invisible) blood it is (visible) body fat that is considered to be the vital force in the Andean culture and that *kharisiris* only steal fat from people in the prime of life (which coincides with reproductive age) rather than "[c]hildren or old people [who] simply do not have enough fat" (2000: 713; see also Rivière 1991: 27, and esp. 28-29, for an excellent ethnographic comparison of *lik'ichiri* in various parts of the Andean zone). Other authors emphasise medical (and other) properties of another type of fat, *linki*, the vernix caseosa covering the newborn's skin (Platt 2002; Molinié Fioravanti 1991). It seems, however, that in the case of women who have given birth, the fear concerns the removal of their own body fat which could disappear unnoticed unless too late.
Some researchers emphasise the relationship between blood and fat and indicate that in certain areas in the Andes *kharisiris* are believed to steal fat as well as suck out blood (see Canessa 2000: 718; Abercrombie 1998: 64-5; Wachtel 1994: 72-74). Fat and blood have also been interpreted as idioms used to talk about social politics (cf. Crandon-Malamud 1991).

[23] A type of mentholated topical ointment.

or ointment is distributed in the right areas, the touch being a demonstration of unquestionable physical closeness. This mode of treatment has another significant aspect as well: being taken care of by somebody else, on the one hand, allows the woman to rest, and, on the other hand, constitutes a tangible, palpable demonstration of support on the part of one's social network.

Nonetheless, the bodily aspect of *sobreparto*, such as cold sweats, chills, fever, general weakness, should not be overlooked. The undeniable somatic character of *sobreparto* reminds us of the way the anxiety, precariousness, and incertitude are deeply grounded in the body, almost beyond control. If it is possible to think about "childbirth as the ultimate involuntary act [where women] have no choice but to surrender [their] bodies" (Figes 2008 [1998]: 28), perhaps *sobreparto* could be considered as an extension of this surrender into the social network, a time taken to make a decision not only to bring a child into the world but also to bring it up. And since children are not raised by individual people but within social networks,[24] it is important to make sure that other people are there to help the mother in that decision-making process.

Inéz, one of the women who spoke to me, told me a story of her aunt Adriana who died of *sobreparto* after a long period of illness. Doña Adriana became pregnant and decided to have the baby despite her husband's strong opposition to bringing another child into the world (they had already had three boys). After the doctors failed to perform a complete cleaning of the fragments of the placenta from the uterus following childbirth, she developed an infection. Doña Sofía, Inéz's mother and a herbalist, diagnosed Doña Adriana with *sobreparto* and took care of her, giving her rosemary infusions and rubbing her body with chicken fat. Doña Adriana regained some of her strength within two weeks and began working and taking care of her baby. However, despite the treatment, she continued to suffer from intermittent haemorrhaging. A year passed before she consulted a *curandera*, traditional healer. That treatment was

[24] See e.g. Barlow & Chapin (2010); or, for an evolutionary perspective, Hrdy (2009, 1999).

only partially successful, as the haemorrhages became less frequent and not as abundant, but she also began having headaches. When she consulted a biomedical doctor several months later, he advised immediate hospitalisation. Inéz said:

> *But she didn't listen to the doctor. She didn't listen to him because maybe she didn't want to waste any more of her husband's money, out of fear, I'm sure that it was fear more than anything else. Because my aunt didn't want to spend more on doctors. He* [the husband] *was making Bs 400* [about GBP 40] *a week and that wasn't enough to pay the doctors. Either you pay the doctor, or you put food on the table, or you spend it on the children. So I think she realised that and she didn't want to go to the doctors anymore.*

Doña Adriana's choice not to seek further treatment was preceded by a complex chain of events, which included making a decision about having the baby, about whether or not to seek treatment, and, when she finally decided to ask for help, about who should provide a solution. Furthermore, once solutions were being offered, Doña Adriana tried a few, from both the *curandera*, traditional healer, and biomedical doctor, before she began to consciously reject them.[25] This is not to say that Doña Adriana's reasoning was fallacious, but that the reasons that Inéz mentioned, such as financial difficulties or "fear", could be just a part of what Doña Adriana took into consideration: after all, it was she who would be raising a child that she thought her husband did not want.[26] Perhaps, for Doña Adriana, ceasing to try to find an effective treatment, rather than being a proof of giving up, was just a logical decision, given her circumstances. This ethnographic case shows how *sobreparto* is positioned within a much wider framework of diverse processes, connected through various human relationships.

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[25] See e.g. Belliard & Ramírez-Johnson (2005) for a discussion of making complex treatment choices using various medical traditions.

[26] See Chapter 6. Inéz told me later that the husband was taking care of all those children on his own but that, in her opinion, they were not well-raised.

Despite the fact that she was taken care of by Doña Sofía during her bout of *sobreparto*, Doña Adriana continued to experience the failure of her body, which may have influenced her subsequent decisions concerning seeking help.

It is vital to remember that all this occurs in a context where speaking about emotions (outside of the anthropologist's inquisitive questioning), just for the sake of speaking about them, is not a widely occurring practice. It is clear that so many people have a hard life that dissecting it with words may potentially have an unintended adverse effect; spilling one's guts could be interpreted as complaining or burdening others with one's problems, especially if those problems do not really have solutions. Time and time again, I would hear *No me puedo quejar*, I've got nothing to complain about, [lit. I can't complain], or *No me gusta quejarme*, I don't like complaining. But, as the experiences of migrant women in the city of Santa Cruz de la Sierra show, there may be ways of feelings – and dealing with feelings – that need no words.

Loneliness, embodiment, and postpartum illness

The case studies collected during my fieldwork consist of accounts of women who migrated to Santa Cruz de la Sierra from the Andean zone in Bolivia and who fell ill with as well as recovered from *sobreparto*. I argue that the condition of migration, with its inherently reduced social network, may accentuate the precariousness of women's circumstances, especially the feeling of loneliness, and make *sobreparto* more likely on the one hand, and more significant, on the other (cf. Loza & Álvarez 2011). In fact, in the urban context of Santa Cruz, women I interviewed spoke of loneliness as much as their bodily experiences. The three accounts of *sobreparto*, as told by Doña María, Doña Sofía, and Doña Dolores, will hopefully illuminate the complexity embedded in reproductive life, beyond the postpartum illness.

Doña María

I had seen Doña María many times before we properly met. She had a small stand, selling home-made *empanadas*, fried dumplings, filled with cheese or meat, and *refresco*, sweet drink made from fruit juice, such as lime or passion fruit, iced water, and copious amounts of sugar. Her stand was located just next to one where I used to buy fruit for the children in Luz del Mundo (LDM), and she often teased me about how much I must love to eat fruit when I awkwardly waddled away with a bag filled with sixty bananas or tangerines. One day I noticed a boy and a girl next to her stand – they looked like primary school pupils but I did not know them from LDM. I stopped and talked to her about the institution and a couple of days later I found Doña María chatting with Julia, the director of LDM, her two children running around and playing with the rest of the kids.

After that I would stop by her stand more often to talk while sipping the cold sweet drink she sold. Even though I told Doña María that the reason I was living in Santa Cruz was because I was interested in understanding *sobreparto*, it was only a couple of months after that she confessed to me that it had happened to her. It almost felt like she had decided that it was time I asked her about her story.

Doña María, now in her fifties, came to Montero, a town nearby the capital of Santa Cruz, from Chapare in Cochabamba department, when she was only fifteen. She met her first husband there and had her first three children with him, all boys. The couple divorced and Doña María became pregnant by another man, who left her a year after their daughter was born. Armed with willpower and Pentecostal faith, Doña María worked very hard to make a living and provide for her four children. Several years later, she began a relationship with a new partner and became pregnant again. The new man was gone before the baby Noelia was born. Doña María saved money to give birth in a private clinic. She proudly said:

> *All my children but the first one were born in a clinic – with the first one, they didn't take care of me well in hospital, so I didn't go back there, I didn't want to*

risk that they treat me badly. For example, with the second son, he didn't want to come out, he was born after ten months and ten days and weighed 5800 grams, but I gave birth the normal way, the normal way. They wanted to operate on me, but I didn't want them to operate on me. But in a clinic, I could decide, I could tell them: No, I don't want surgery [C-section]. *So they didn't operate.*

I asked what happened after Noelia was born.

They didn't operate either. But it was different that time. ¡Ay, me puse mal! *Oh, I got so ill! When my daughter was born, Noelia, the one that weighed 3800 grams, then, it was then when I fell ill with sobreparto. Because when I give birth, I don't like* [to stay in] *bed! I just don't like it. I am a hard-working woman. Any other day, any other day I can go home tired, I lie down, I sleep, but on the day when I give birth to a baby, it seems like my blood smells bad, I feel… I don't know.* She paused for a good minute. *Well, I take a shower immediately, I wash myself, I start cleaning myself. My relatives were saying: "You're gonna get sobreparto,* este sobreparto duele feo,[27] *this sobreparto hurts like hell, it's worse than childbirth," but I didn't listen to them at all. I would tell them: "You are lazy, dirty, how can you stay in bed, lazybones, lying down all day!" But the day when I fell ill with sobreparto I understood it, I understood that they were right.*

It was like this – Doña María stopped to take a deep breath – *I left the clinic as usual – normally they make you stay for 3 days but I went home on the same day, the same day when Noelia was born. So my daughter was born at a quarter past five in the afternoon and I was ready to go home by eight or nine o'clock. I told the doctor that I knew what was going on, it's a familiar situation, so they didn't keep me in the clinic.*

The next morning I started doing what I normally did – I began cleaning myself, the whole house, I cleaned everything, I did not stay in bed, oh no! Then I washed myself, I had a shower, but around 10 a.m., or maybe around noon, I

[27] Lit. it hurts ugly.

started feeling escalorfrío*, chills and shivers, they would not stop. "Oh, – I was asking myself – what's going on with me?" I was having* escalorfrío*, a lot of* escalorfrío. *My spine hurt again, this part* – she placed the palm of her hand on the lumbar curve. *My bones hurt. And it* [the pain] *wasn't going away, and it wasn't going away. And it was a strong pain, very strong. But it was like when the labour's coming, you know, the labour pains, it would hurt like this, stronger, and stronger, and stronger, until I couldn't bear it anymore… Like contractions, although nothing was coming out, there was only the bone pain. How can I explain it to you?* – Doña María looked at me quizzically – *I didn't understand it myself at the time.*

My head hurt but the bones hurt even more, it was as if I was being squeezed or crushed, as if I was being wrung, everything hurt, I thought I was going mad, I couldn't stand it any longer, I was shouting and shouting, my teeth, my teeth were chattering from the cold, I didn't understand, I cried and cried because it was unbearable, from here – Doña María pointed to the top of her head – *to here* – she bent to reach the tip of her big toe with her finger. *There was pain in my head and in my bones, and inside me. And because I didn't know, I drank water and I took* novalgina,[28] *because back then there was* novalgina*, so I bought myself one pill of* novalgina,[29] *but one lady said: "No, Doña María, no…" And I felt cold and the* escalorfrío*, but she said "That's not what really hurts, that's not it," she said. "You are having sobreparto," she said. That's what she called it: sobreparto, "Because you are not taking care of yourself!" the lady scolded me.*

I asked if that lady was a healer. Doña María quickly said:

No, no, she wasn't. They say that she had this illness, sobreparto, this is why she knew what to do. ¡Jovencita! *She was so young! She would tell me: "The doctors don't know it, they had no idea how to cure it when I got it the first time!"*

[28] A type of analgesic, antipyretic, and anti-inflammatory medication.

[29] It is common in Bolivia to buy medication per pill rather than the entire packet.

It was she [the young girl]*, she said, that she got ill with it, and this is how she knew what to buy and what to do.*

She came to my house and rubbed my whole body with Mentisán*, even the head, she rubbed the head well, and also, she brought all kinds of stuff, they sell it in the market, you know, I don't know what it was exactly but they sell it in the market.* El sahumerio*, an incense, I think. She did something like this: she lit the incense mixture on fire and when it was burning, she fumigated me with it, she waved it over me, she covered me with a thick blanket, she told me to lie down on my bed again, and then she scraped my nails.*

Doña María saw my puzzled look, took a small vegetable knife and scraped the surface of my thumb nail with the sharp edge, muttering softly as the blade glided over my nail:

Así, así nomás. Like this, just like this.

Tiny scrapings of my nail fell to the ground.

Figure 15. Ready-made *sahumerios* for every occasion, Doña Sofía's stall, Santa Cruz, 2013.

She made a small fire in the room with all kinds of herbs and something else that they sell here – but I don't know what it was. She took a burning twig and held it in her hand, like this –

Doña María extended her right arm in front of her, holding the imaginary twig at the level of her knees.

And she made me stand above it, with my legs spread apart, and she moved it [the burning twig]*, here, so that it enters the womb, so that all this smoke is absorbed.*

Doña María was standing now, her legs apart, her hands moving her skirt energetically to direct the imaginary smoke towards her womb.

Then she rubbed my head towards the back. They [women who heal] *know. And then she grabbed me and put me down on my bed and covered me with the same thick blanket. Then she scraped my nails.*

I asked if the lady used a knife. Doña María shook her head.

No, con vidriecito*, with a piece of glass, she did it with a piece of glass and I heard her saying, she was saying: you have to toast half of it* [the nail scrapings] *and leave the other half untoasted. Then she took a bit of my hair from here –* Doña María touched a small area behind the left ear – *my own hair. Then she sent to buy somebody's nails, I don't remember – no, I do, I remember, it was pig's hoof.*[30]

As I was feeling very bad, I just heard her sending someone to buy those things, I think maybe she sent my son to do it. And they did it as well, they did all that, they made an infusion of all those things. And they made me drink it calientito*, hot! She told me not to get up, they put socks on my feet, they put a jumper on me, they put… They bound my head, my hair, all that. Since then I stopped getting up from bed to do things* [after childbirth]*, I started being afraid. This is how, this is how I had my sobreparto, what they say it is.*

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[30] In Spanish, the words for nail and hoof are similar, *uña* and *pezuña* respectively, hence, Doña María could categorise hoof, *pezuña,* as some kind of nail, *uña.*

I asked how long the treatment took.

> *Since noon, I cried for three hours. But they cured me fast, very fast. I slept well that night, I was already healthy. They cured me fast because… It's good to live here, you know, people help you, there were lots of neighbours, so I didn't live alone, I didn't have to live alone. When I got pregnant again, I was afraid about it. I left the hospital, I showered and I would buy rosemary, my aunts were telling me about it, that you have to wash yourself with rosemary* [infusion] *before washing yourself with water that isn't pure. So I washed myself with rosemary infusion, hot rosemary infusion. Because I was afraid.*

Doña María looked me in the eyes and repeated under her breath:

> *I was afraid.*

In her narrative, Doña María positions herself as a single mother, a woman on her own, who can – and must – primarily rely on herself, and for whom this strength and independence are a source of pride. These features of her personality seem to be the reason for her emphasis on the speed with which she recuperated from her bout of illness. This image is contrasted with other people supporting Doña María in her time of need – and she is explicit in appreciating the value of a tight-knit community in the neighbourhood. Before she suffered an episode of *sobreparto*, her indirect knowledge of this condition was based on her relatives' critical comments about her reluctance to observe traditional postpartum proscriptions. Nonetheless, when she became ill, it was other people who came to the rescue – and I argue that the demonstration of the reliability of the social network is no less important than the appropriate cure. In the absence of a life partner, it was the community she joined and co-created as a migrant in Santa Cruz that proved to be able to offer help and support. These motifs appear in other life stories I collected, such as Doña Sofía's experience of *sobreparto*.

Doña Sofía

I met Doña Sofía, a herb vendor, through Don Eloy, a fellow NGO-worker, who one day informed me that he had already told her about me, my research (which slightly alarmed me because I did not remember telling him about it), and that I would visit her soon. I felt somewhat cornered, but followed Don Eloy's instruction without delay. Doña Sofía turned out to be a wise and caring woman, whose patience and knowledge I relied on during my time in Santa Cruz. The first time I found Doña Sofía's stand was also the day that I met two of her daughters, Noemi and Blanca, as well as her four grandchildren. I visited Doña Sofía a couple of times a month during most of my stay in Santa Cruz , but there were very few occasions on which she was unaccompanied by a family member.

Because Doña Sofía is very knowledgeable about curative plants and substances, many of our conversations focused on the properties of herbs, oils, or ointments. Doña Sofía contributed to my data on *sobreparto* and other illnesses quite generously, showing me the appropriate plants, dictating recipes for herbal infusions with infinite patience in her soft voice, correcting my notes when I read them back to her. I had known her for approximately six months before she confessed that she too suffered from *sobreparto*. It took us another two months to be able to talk about it for the first time.[31]

One day, we were unusually alone and discussing herbal remedies for a variety of conditions. I was taking notes and photographs but I was also recording the conversation as I did not want to miss anything about the recipes. We covered *susto*, *pasmo*, *arrebato*, *recaída*, *entuerto*,[32] when Doña Sofía began to speak even more softly than normally:

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[31] See Chapter 3 for a discussion of the process of earning my informants' trust, collecting and organising non-chronological data.

[32] The aetiologies of these illnesses vary across various parts of the Andes. Babies and young children are claimed to be the most susceptible to *susto*, although pregnant women are also considered vulnerable; in which case the consequences of *susto* are suffered both by the pregnant woman and the foetus. *Arrebato*, *recaída*, and *entuerto* are usually located at the intersection of reproduction and bodily disequilibrium, although in some regions *arrebato* is considered to be

> *When I got sick with sobreparto, it was like… as if these clothes* – she pinched her alpaca wool cardigan between her fingers – *were covered with needles. Needles, needles everywhere. Can you see this cardigan? It's very soft.* When I agreed, she continued: *These clothes were like needles, nee-dles! My body hurt so much, so much. The tips of my fingers were white, my skin was sensitive, it seemed like the skin didn't protect anymore. I would touch my clothes like this* – she gently patted her forearm – *but it hurt, my skin would become very sore.*

She continued speaking under her breath:

> *I got ill with it when my oldest daughter was born, Inéz, Blanca, thirty-four years ago, more or less. I was touching my clothes like this, ouch, ouch, it hurt! Like needles! And my eyes hurt, I could not see, I could only look straight, I could not look to the sides. So I took some rosemary infusion, half of it toasted, another half without toasting, and that's what I drank, rosemary water… and nothing more, really. Half of it toasted, another half without toasting* – Doña Sofía made sure that I wrote it down. *I bathed myself with rosemary infusion and nothing more. I washed my skin, I washed my face, and I slept.*
>
> *My fingertips hurt, my eyes, my body, everything was sore. And that* [rosemary infusion] *was what cured me, that's what I would take. I healed quickly, I was well on the next day, healthy and all.*

I asked why she thought she became ill with *sobreparto*. Dona Sofía lowered her voice again.

> *Well…* – she said hesitantly – *nobody would do things for me, make my food or anything. There was no one to do the laundry, that's why* – she whispered. *It didn't last long, though, it was over within a week, after that I would carry gas cylinders*[33] *without any problem.* I asked where her family

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able to befall newborns and/or men. *Pasmo* is sometimes classified biomedically as neonatal tetanus (Bastien 1988), but most of my informants, including Doña Sofía, associated it with *wayras*, malevolent winds, entering the open postpartum body.

[33] There are relatively few places in Bolivia where gas is delivered through a pipeline, however, in 2013 this was changing in the suburban areas of Santa Cruz. The transformation has been

> was. *Se fue él, he* [the husband] *was gone*, – she responded quickly. *He went away, to his work, to his other woman, he went away, simply. I was alone, I ran out of gas, I ran out of patience, I went to get a cylinder, and I got ill. My neighbour helped me then. With the second one* [child] *I knew better – I was alone but I was ready, I learnt how to do it* [take care of herself]. *Then… it was sort of easier, he* [the husband] *came back, I wasn't alone* [with the subsequent pregnancies].

In that first recorded conversation on *sobreparto* with Doña Sofía I never learnt her husband's name. With time, I learnt that he used to beat her up, which is why she ultimately threw him out. When their first child was born, they were still living in the same village in Cochabamba department as Doña Sofía's parents (where they had moved to from Oruro department), but for reasons she did not explicitly articulate in that interview, she felt she could not count on their help. I later learnt that she thought her parents were dissatisfied with what they perceived as Doña Sofía's inability to keep a husband. On the other hand, she was very unambiguous about their final separation:

> *When I kicked him out* – she confessed on another occasion – *my life became peaceful, peaceful. Because before I was afraid when he would beat me up*… She paused for a long moment – *I still am afraid of him* – she said and looked me in the eyes.

Doña Sofía's account of her experience bears many similarities to Doña María's story – there is the presence of the cold, the heat, and rosemary infusions, as well as loneliness, especially acute when one is surrounded by people, including relatives. For Doña Sofía, *sobreparto* was a corollary of her experience of acute loneliness, and not just transgressing rules of postpartum care. The helpful

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met with some resistance in the neighbourhood where I worked, expressed through stories of explosions as well as complaints about the city engineers only installing gas pipes in brick buildings (which put an extra financial strain on the poorest of Santa Cruz, who often live in wooden shacks). Everywhere else, people buy gas in metal cylinders, which are heavy – a full one weighs approximately 30 kilograms.

neighbour is mentioned very briefly, perhaps because the aid dispensed by a non-relative was almost embarrassing in comparison to a complete absence of assistance on the part of the family who lived nearby. Additionally, this situation exposes the weakness of Doña Sofía's social network, where the relatives fail but unrelated people occupy prominent roles. Although kin are not necessarily the closest persons in people's lives, the fact that my informants mentioned not having received help from them during the postpartum period is significant, as it reveals unfulfilled expectations. While loneliness is mentioned in ethnographies of the Andean region as a state which may lead to dangerous consequences (see e.g. Bolin 2006), there are also researchers who connect loneliness, sometimes phrased as "living alone", with postpartum illnesses, such as *sobreparto* (see e.g. Loza & Álvarez 2011; Bradby & Murphy-Lawless 2002). The story of Doña Dolores, unique as it is, echoes the perils of loneliness.

Doña Dolores

I met Doña Dolores when I was travelling back to Santa Cruz after a week in la Chiquitanía, a region to the east of the city. There were about thirteen of us, squeezed into a van designed to hold eight people. As usual, I offered my lap for one of the child passengers and Doña Dolores gratefully accepted, especially because it meant that the driver could not ask her for extra money since her daughter no longer occupied a separate seat. I introduced myself, which prompted my neighbour to do the same. We started chatting, she complimented my Spanish, I returned the compliment, which made her chuckle and lightened our conversation. We only saw each other twice after our first meeting before I headed back to Europe. Two lazy afternoons, two slow-paced interviews, one lacework of a life.

> *I first came to Santa Cruz, to the department, when I was thirteen. I went back after, when my mother died, I went back to Potosí. I returned to Santa Cruz when I was eighteen. When I was eighteen I lived here, I lived in San Javier* [in la

Chiquitanía, a region in the eastern part of the department]. *Here, in Plan 3000, I've been living for at least six or seven years. With those two* – she pointed to her two children playing nearby – *with Nélida and Vladimir. Nélida is five, she will be six in March, he is only three years old, the little one.*

I asked how many children she had, which seemed almost counterintuitive.

Two…

Doña Dolores stopped for a moment and then hesitantly said:

Three! Three, because one is in Potosí. His name is Miguel Ángel. Nine, he's nine years old – she sighed.

I suddenly felt like I was prying. Wanting to take a step back from the intimacy of the recollection I had just prompted in Doña Dolores, I asked her why she came to Santa Cruz in the first place.

Well… when I was thirteen, my brother brought me here to study in San Javier, it wasn't really San Javier, it was a place nearby. But when my mother passed away, I went back [to Potosí] *to take care of my sisters who were still very little back then. Later, I came back to Santa Cruz. Why?* – she repeated my question with a hint of surprise in her voice – *I came back because… you know, in the countryside one needs to work a lot, if you don't do anything, there's nothing to eat. So I came back looking for work and I stayed. Then I went back again. I went back and forth for a while. But now, I've been living in the same place for seven years, without moving once, you know?*

I asked how many siblings she had.

There are nine of us. Quickly, she added – *there used to be ten of us, five sisters and five brothers but one sister died. The eldest brother lives in San Javier. Then there are others who live in Argentina. Five of them, I think. I don't know anything about one sister. There's one brother that lives in my house in Potosí. The youngest one – he's the one who's taking care of his father. He's got a wife and children. He's the only one who stayed there. He's helping and taking care of my father. And there's me – I live in Santa Cruz.*

Doña Dolores continued to meticulously describe the details of her family situation.

> *When I first moved here, I was selling food on the corner, you know, where I met you today?* She waited until I confirmed that I remembered the place. *But I gave up the spot to another lady, the food didn't really sell very well. Now I work as a* doméstica*, maid. It's hard. But I am alone, with these two –*

she tenderly looked at her children. I asked if all her children had the same father.

> *No, the first one has a different father. But we didn't live together – it was a moment of…*

– she never finished the sentence. Instead, she took a deep breath and said:

> *His father is from Potosí. I got pregnant when I was seventeen, I gave birth when I was eighteen. Then, more recently, I had my daughter. With her father, we did live together. But we started living together when my daughter was four months old. He came to live with me, he acknowledged her* [i.e. he figures as Nélida's father in her birth certificate]. *Both of them are acknowledged, Nélida and Vladimir.*

"What about the other son?" I wanted to know.

> *No, he* [the former partner] *never helped me with him, not even to help me see him. That man never gave me a single peso for the other son, oh no!*

I saw Doña Dolores's jaw muscles tighten.

> *He's recognised by my brother who lives in San Javier, his own father didn't even bother recognising him.*[34] *I would work and save money and go to see my son because his own father never gave me any money to do it. Never ever! I mean, I didn't have this support, I worked, I saved up, I went* [to Potosí]*, I go at least*

[34] Doña Dolores is referring to the fact that in the boy's birth certificate, her brother figures as the boy's legal father.

> *once a year, but last year I didn't go. But, God willing, I will go this year. The worst thing is that my daughter goes to school now and I can't go because she will fall behind if she misses school because of the travel. She's already behind because we went to San Javier. But I hope to see him this year,* ojalá*, hopefully, God willing* – the wistfulness was almost palpable.

For a while, neither of us said anything. We were sitting outside on plastic garden chairs, listening to the noises of the neighbourhood, sipping sticky-sweet *refresco*. I did not really know what to say, so silence seemed like the easiest option. After the longest five minutes of the afternoon, Doña Dolores turned to me and asked if I wanted to know about *sobreparto*. I nodded and asked how she became ill with it.

> *I got it with Nélida, I fell ill with her. I got* arrebato – she caught my look and quickly added – *they call it* arrebato *or* sobreparto*, it's the same thing. At home in Potosí they simply called it* arrebato.

I asked how it happened.

> *Because I lived alone. I was alone all the time when I was pregnant, then I was alone when she was born. Then, when I left the hospital, I didn't have anyone who could wash her clothes, my clothes, so I started washing clothes and cooking as well and touching water, and this is why I had a headache and cold sweats, and* escalorfrío*, and I felt cold. It began three days after childbirth, maybe four.*

I asked if she knew that it was *arrebato*. She hesitated –

> *No, because I didn't ask anyone because I lived alone.*[35] *Only that I was cold and I felt cold and I had a headache and… So I would buy myself paracetamol, I don't remember well, but I would cover myself with many, many blankets and I would still be shaking from the cold. I would cover myself with multiple blankets but I didn't feel warm. Only cold, cold, all I felt was cold. That's what it was like*

[35] In this part of the narrative Doña Dolores states that she did not know she was ill with *arrebato* at the time of her illness. The last section of her account, in which she recalls seeing her mother taking care of herself after childbirths in Potosí, may explain how Doña Dolores came to understand her own experience as *arrebato*.

– she spoke quietly, looking away. *I felt like this for about three or four days, maybe more, maybe the whole week.*

I asked if anyone came to visit since it is common for relatives, friends, and neighbours, to visit the mother and the new baby at home. Doña Dolores declared –

No, because I lived alone. She paused for a moment and then said – well, my girlfriends came to visit, but I didn't tell them about it.

I asked, with disbelief, how come the friends did not realise that she was ill. Doña Dolores replied quietly, her voice filled with embarrassment and dismissiveness –

No, because I felt worse at night or in the afternoon, after I showered. But they came in the mornings. But when I showered [in the afternoon]*, I felt worse.*

"How come nobody helped you?" I asked, rhetorically more than anything else. *Don't know, I really don't know* – Doña Dolores uttered under her breath, with her *ojos de guapurú*.

I asked how she knew that she was pregnant. Doña Dolores pondered for a while.

Well, I would normally feel nauseous, as I told you, I had vertigo, I wouldn't get my period when I was supposed to, you know? I would get nausea three or four weeks in, I'd say. […] *When I wash clothes, my kidneys hurt if I'm pregnant. That's it!* Doña Dolores clapped her hands with joy at remembering something crucial – *before I'm even one month into the pregnancy, when I wash clothes, I can't sleep at night, I am in so much pain – this is how I know that I'm pregnant. Then I don't get my period and there you go, I'm pregnant. I know early on, about three or four weeks in.*

Also, I get uncomfortable very soon. My daughter moved a lot in my stomach. One month in – I couldn't sleep on my belly anymore. I thought it would be a boy – they said it was a boy. In the end, at five or six months, I would lie on my back, put a stuffed toy on top of my belly, and she would make it fall off, that's how

hard she kicked. I would put the toy back on, she would kick it off, as if she knew something was there. I felt my daughter moving from the second month. Not so much with my son, though. But in the end he moved as much as she did.

I asked Doña Dolores where she gave birth to her children.

My children were born in a [medical] *centre. There's a midwife in the* barrio*, she told me "If you don't want to go to hospital, I'll help you" but I didn't dare. I went to the medical centre because I didn't have to pay, I had insurance.*

I asked if she had ever had a caesarean section. Doña Dolores shook her head –

No, they were born the normal way. But when my daughter was being born, when I was waiting for her to come out of the uterus, I don't know… she was born cold, she was shivering with cold. It seems that this is why I got arrebato*, I had what she had. That was the only time I felt cold during childbirth. Only with her.*

I wanted to know if there was anything special about the pregnancy with Nélida. Doña Dolores was silent for a while.

They told me not to touch water so much. For instance, when I was pregnant with my daughter, I washed a lot of clothes [for a living]. *I maintained myself washing clothes. I washed clothes all the time and they would tell me that my baby is going to be born with a cold, you know? It seems like it's the truth, because my daughter was born with a fever. They told me "It's because you washed clothes". I would get cramps as well, in my feet. Because I would stand in the water. Here, they would start here* – she pointed to the soles of her feet – *I would get cramps here. But at night they would move here* – she pointed to her groin – *and here, under the knee. And it hurt! It was worse when I was pregnant with her because I washed clothes. On the other hand, with that one* – she gestured towards her little son – *I didn't wash clothes so much because his father helped me a little – but he helped me.*

They say that you have to take care of yourself for at least one month after childbirth. My mother used to tell me that. I mean, I saw how my mother took care of herself – she wouldn't touch water, for about three weeks, she wouldn't

> *cook, eat foods with onions so that the baby's wound healed and my mother's wound as well, of her parts* [genitals]. *So that it doesn't get infected, that it heals fast – this is how one can get sobreparto. I shouldn't go out at night without covering my head and I shouldn't go out in the sun because it can give you sobreparto, my mother used to say. That's what my mother used to say. On the other hand, I couldn't take care of myself because I didn't have anyone to whom I could have said: "Bring me water" or "I want this or that." I would cover my head, I wore a* faja *as well. But I only did it for a month, I could not stand being squeezed any longer. But I had to work when I was pregnant and after as well. I cooked with firewood, in the sun, without shade, I would go to one lady to cook for her, so that my daughter gets her milk and so that I eat as well. I did it with her and I did it with him. Always like this* – she sighed heavily.

In many ways Doña Dolores's story is similar to the previous two accounts. Here, too, loneliness figures as an important determinant of existing options and choices to be made. Her case is unique because she survived the episode of *sobreparto* despite the lack of help on the part of others. Doña Dolores tested herself: she hid the illness from the friends who came to visit by not mentioning her symptoms to them even though she recognised her condition as *arrebato*. There was more at stake than Doña Dolores's life, as exemplified by the manner in which she talks about her pregnancy with Nélida, which suggests that she had already developed a relationship with the baby before she was born. The way in which Doña Dolores narrated the story of her bout of *sobreparto* points to the presence of two quite different desires in her life – on the one hand, she speaks about wanting to have a stable partner (with whom she would be willing to have more children), on the other hand, loneliness is a paradoxical source of her strength (similarly to Doña María's account) since it is both a familiar and consistent aspect of her daily existence. It is difficult to be a single mother, but it is far from impossible, and Doña Dolores proves it every day. The episode of

postpartum illness tested the possibility of existing between these desires – of having people to rely on and of being able to do it on one's own.[36]

Doña María, Doña Marina, and Doña Dolores – and many more migrant women – see their existential condition wrapped in what they perceive as being alone. This is not to say that they ignore their children or do not recognise the fact that they have relatives, friends, or neighbours. At the same time, rather than implying literal aloneness, being lonely means not having anyone who could cook, and do the laundry, someone who could relieve the burden of everyday life in difficult times. They would say: *estaba solita*, I was alone, implying lack of help but also loneliness rooted in only being able to rely on oneself. While there is a specific word for "lonely" in Bolivian Spanish (*solitario/solitaria*), it is very rarely heard. On the other hand, *solito/solita*, the diminutive of the word *solo/sola*, is used frequently to express notions of both aloneness and loneliness. These states may partially overlap by definition; however, in most of the life stories my informants shared with me, their feelings of loneliness emerged despite being surrounded by people. Loneliness, for those women, meant making potentially dangerous choices – be it touching water, going outside to bring in gas, or taking a shower – in spite of the knowledge of the possible consequences. This loneliness, despite the fact that it may look like strength and independence, embodies vulnerability and precariousness, and culminates in an episode of illness whose course asks and answers the ultimate question of the woman's position in her social world, the question of whether she is truly alone.

[36] Cf. Platt (2013) for an analysis of different types of relationships between the spouses in rural Potosí, Bolivia.

Chapter 6
The loneliness of a mother: Social network in the suburbs

Estaba solita, I was alone – this phrase was often used by migrant women who spoke to me about their experiences of *sobreparto*. In their interviews, female Andean migrants in the city of Santa Cruz explained how what they experienced as the lack of others' readiness to help at the time led them to the transgression of postpartum rules. Such rules prohibit, for instance, touching water, cooking, carrying heavy loads, using knives,[1] and their breaking may cause a bout of *sobreparto*. While my informants did not explicitly point to their loneliness as a direct cause of their postpartum illness, they tended to point to this state as their reason for undertaking risky behaviour. Women who said that they were feeling lonely during that particular time of their lives indirectly expressed a dissatisfaction with their social relationships. In particular, the feeling of loneliness referred to a perceived discrepancy between feeling unsupported by others during that period and an ideal of being accompanied by people to rely upon. In other words, while women's accounts of cured episodes of *sobreparto* demonstrate that their social networks proved supportive in times of illness, the feeling of loneliness during the puerperium points to an unfulfilled expectation of reliable support (cf. de Jong Gierveld, van Tilburg, Dykstra 2006: 486).

[1] These activities are also often forbidden or considered potentially dangerous during pregnancy in the Andes (see e.g. Bradby & Murphy-Lawless 2002; Platt 2002). My informants sometimes mentioned these tasks as contributing to difficult labour or, indeed, *sobreparto*.

Women express loneliness as a corollary of negatively evaluating the status of their current social relations, including intimate relationships. This feeling also importantly signals an idealised relationship standard, one of a stable, heterosexual couple. This type of relationship is only one of the household arrangements found in Bolivia. According to the census data from 2001, only 32.5% of Bolivian households were classified as "complete nuclear families," implying a heterosexual couple and their children (INE 2001; see also Paulson 2007). This means that the ideal of a stable monogamous relationship does not often occur in practice. The following census in 2012 did not include the same question, nonetheless, some comparable statistical data can be drawn from the available information. For the city of Santa Cruz, approximately 49% of households included a couple.[2] In her analysis of alternative bonds in Bolivia, Susan Paulson attributes the understanding of "monogamous heterosexual marriage […] as the universal cultural form" to "centuries of colonial governance mechanisms and Christian missionizing" (2007: 241). This idea, coupled with a continuous practice of officially labelling household arrangements which do not fit the nuclear family model as non-standard, helps to perpetuate a relationship norm which does not correspond to the way people form, transform, and dissolve their intimate social relations. Labelling households run by women as "'headless,' 'incomplete,' 'single-mothered' or 'broken'" (ibid.: 242) demonstrates the pervasive force of the normative nuclear family model.[3] As reflected in the 2012 census results for Santa Cruz, household members often include relatives beyond the nuclear family, such as sons- and daughters-in-law, nephews and nieces, as well as non-kin, such as employees or flatmates/tenants (see Appendix IV). In other words, while some women live in a household

[2] Elaboration of 2012 census data. Value obtained by dividing the number of people over the age of 15 living in the city of Santa Cruz de la Sierra who defined their civil status as married or common-law married (*concubino/concubina* or *cohabitante*) by the total number of people asked in that area (data elaborated by Dr Dominika Kuberska on the basis of INE 2012).

[3] Research in psychology and sociology suggests that the "normative climate in and of itself can be conducive to loneliness" (de Jong Gierveld, van Tilburg & Dykstra 2006: 491).

without their partner, they often share their homes with a number of other people, such as other relatives or friends, who play the role of family. In this light, the label *madre soltera*, single mother, becomes particularly interesting, as it combines two important dimensions of sociality, relationship and reproductive statuses, only to point out the inadequacy of such an arrangement.

It is not the case that single fathers in Santa Cruz do not experience loneliness – they may just as well feel very alone. In fact, I spoke to a number of Bolivian fathers who were raising their children in the absence of a life partner.[4] Although these men complained about the hardships associated with this role, they often emphasised how *valiente*, brave, they were for undertaking it. Women who raise children on their own, on the other hand, are not considered to be special in Bolivia. The mother-child dyad is the lens through which childcare is predominantly viewed and legislated, as evidenced by national insurance policies which only take into account the female parent (Paulson & Bailey 2003: 490-491, 494).[5] My focus on the loneliness of mothers, as opposed to that of both parents, is dictated by the fact that any postpartum illness, including *sobreparto*, can by definition only happen to women. This chapter will examine themes which occur in the individual biographies of women who shared their histories of *sobreparto* with me. These themes include a history of migration and building social networks, the ambivalence of mothering responsibilities, as well as the loneliness of asymmetrical parenthood.

The challenges of migrant women in Santa Cruz: Building a social network

By living in one place for a long time, meeting neighbours, making friends, establishing a family, working for someone, or running a business, an individual

[4] By "life partner" I understand any kind of stable partner, including spouses and common-law spouses, as well as boyfriends or intimate partners, especially those who had children from these relationships. My informants often used the word *pareja*, partner, or *marido*, husband, *esposo*, spouse.

[5] See Chapter 2 for a discussion of the *SUMI*, Universal Mother-Infant Insurance, in Bolivia.

becomes embedded in a diverse social network.[6] Such an extensive heterogeneous social network in a city includes kin and non-kin. The latter category may comprise both close friends, neighbours and acquaintances (that is people whose importance would be marginal in comparison to close kin and friends). In other words, a well-developed and established social network consists of ties of varying intensity – from strong to weak. This dynamic heterogeneity, research suggests, may constitute a protective mechanism against loneliness for members of such social networks (de Jong Gierveld, van Tilburg & Dykstra 2006: 490).[7] In the context of migrants from the Andes to Santa Cruz, the process of social network building may frequently be initially slow and difficult insofar as, following arrival, it must be produced with very few, if any, anchor points.

Many migrant women come to the city alone. This does not necessarily imply that they do not have any relatives or at least contacts to make their transition easier, but it may mean that their support system, which relies on their social network, is weak at best, especially immediately after arrival. Often, for those who move from the countryside, the difference in the way people relate to each other in the city may seem quite trying. Even in suburban zones of Santa Cruz, where life did not seem to move very quickly, many people were quite busy with their own lives and did not easily find time to socialise or meet new friends. In other words, while it is not unreasonable to expect that, with time, a migrant's social network grows large and strong enough to make them feel relatively safe and supported, the initial phase of migration may be accompanied by almost

[6] I use the phrase "social network" rather than community, because people in the city may be connected through bonds defined by factors other than geography, which is an important aspect of a community. Although there are communities in Santa Cruz de la Sierra, overall, people maintain links with members of larger structures of relationships.

[7] Sociological research conducted in Europe has demonstrated that "people with networks that consist primarily or entirely of kin ties are more vulnerable to loneliness than people with more heterogeneous networks. Those who are dependent on family members for social contacts because they lack alternatives tend to have the highest levels of loneliness" (de Jong Gierveld, van Tilburg & Dykstra 2006: 490; see also Dykstra 1990; Silverstein & Chen 1996).

unprecedented loneliness, which makes one seriously question the decision to move.

Figure 16. Suburban Santa Cruz, 2012.

When I think about lives of migrant women in Santa Cruz, I think about my landlady, Doña Paula and her best friend, Doña Celia, who came to Santa Cruz in their twenties. Both women work as merchandisers: Doña Paula runs a grocery shop and Doña Celia sells clothes she imports from Chile in the city markets for four days a week. Doña Celia met her husband Teofilo during her first months in Santa Cruz and their two daughters were born in the city. Doña Paula had already had two sons from previous relationships. The first of her sons was brought up in Cochabamba by his paternal grandparents, who decided to accept the responsibility their son did not wish to assume. She came to the lowlands with her infant second son,[8] and her third partner, Don Leopoldo, with whom she later had two daughters. Despite the fact that both women came from poor, rural families, where few people considered going to secondary school, they made sure

[8] Doña Paula was pregnant (by another man) when she met Don Leopoldo. Roberto calls Don Leopoldo "father," but he has his biological father's last name.

that all their children went to university and became *profesionales*, professionals.[9] Doña Paula and Doña Celia saw to it that their work did not interfere with child-rearing, starting their own businesses so that they could take care of their offspring while at work. Despite being in stable relationships since their arrival in Santa Cruz, they felt that they were personally responsible for the upbringing of their daughters and sons. Doña Paula and Doña Celia were quite satisfied with their lives, despite mild annoyances every now and then, which they told me about during the long hours of chatting. What struck me was how often their ethnicity came up or was alluded to in everyday conversation, as if it could never fade into the background of everyday life, no matter how long they had lived as migrants, no matter how reliable their social networks had become.

When I first carried out research in Santa Cruz de la Sierra in 2009, I spoke to a lot of people about the motivation behind their migration from the Andes to the lowlands. I was interested both in why they left their previous places of residence and why they chose Santa Cruz as a destination.[10] Among my research participants there were people from many walks of life: from taxi drivers, maids, and street vendors, to affluent middle class representatives and professionals. Although there were as many stories of coming to Santa Cruz as there were individuals, it was impossible not to see patterns in what migrants said about these experiences. People often spoke of the long process of finding personal grounding in a new place as well as of the prominent imbalances between various aspects of their lives in the first phase of migration, between the camaraderie of workplace and the loneliness experienced during their free time. For instance, in 2002 Paulina came to Santa Cruz from Cochabamba because she was offered a job as an IT technician in one of the central branches of the Banco Nacional de

[9] *Salir profesional*, literally to turn into a professional, is a phrase repeated by those in Bolivia who have high hopes for higher education. A diploma from a university, especially a state-run one (private universities are suspected of "selling" their qualifications), is frequently a guarantee of a good post. This situation is changing as the job market has become saturated with young people who have been awarded bachelor's and master's degrees.

[10] See Chapter 1 for a discussion of motivations for migration.

Bolivia, the National Bank of Bolivia. Her entire family was living in Cochabamba, either in the capital or in the countryside. Paulina explained that she was feeling adventurous, so despite not knowing anyone in Santa Cruz, she accepted the job offer. She was picked up from the airport by Roberto, a friend of a cousin, and dropped at one of the *residenciales*, cheap hotels by the main bus station. As she had not booked accommodation beforehand, she was at the mercy of Roberto, who could not think of another reasonably-priced place. Paulina spent about a week there, before she found a room for rent closer to her new place of work. In the *residencial*, she would watch TV alone in her room and laboriously write long text messages to her relatives in Cochabamba – only to delete them without sending them. At one point in our conversation Paulina confessed: *No sé como lo aguanté*, I don't how I was able to stand it. Another month or two passed before Paulina made some friends at work and her loneliness began to subside. During our conversation she barely let her expensive mobile phone out of her fashionably manicured hand, answering incessant texts and calls, making plans for later that evening. The Paulina I met was not the same person who arrived in Santa Cruz, who had no one to rely on or even speak to.

Figure 17. Cheap hotels near the main bus station in Santa Cruz, 2009.

This loneliness accompanies many migrants at the beginning of their lives in a new place. Sometimes it lasts for a long time. It struck me how patience, resistance, and hope somehow seem to make this unaccustomed loneliness at least temporarily bearable. Let me illustrate the complexity of these feelings or attitudes by means of the following story.

Once, I was travelling to La Paz on an overnight bus. A young woman occupied the seat in front of me. In the morning, when we could not sleep anymore and the hairpin bends on the road were getting too sharp to sit comfortably, we started chatting. Patricia was from El Alto[11] but she had been living in Santa Cruz for over a year, working in a fast food chicken restaurant near the sixth ring road. She did not particularly like the job, but she made Bs 1300 a month, almost 10% above the minimum wage in 2013 (Toro 2014; INE 2014). She told me that she was going to El Alto (where the bus from Santa Cruz stopped on the way to the capital) to have some dental treatment. Even though I knew the answer, I asked if there was nowhere in Santa Cruz that she could trust. After all, I argued, it could not possibly have been cheaper bearing in mind the cost of transport. Patricia replied that it was also an opportunity for her to see her parents, siblings, and friends. I asked how often she went back. It turned out that she travelled to El Alto every three to four weeks, for a few days each time. I wanted to know how she could have so many days off in a row – Patricia explained that she did not take days off in between but accumulated them so that she could go to El Alto. It was a painful conversation for me, despite the superficial lightness of exchanging simple facts about each other. I did not want to seem exceedingly inquisitive by asking too many questions, which could have made Patricia think that I disapproved of her life choices. At the same time I really wanted to understand why this young woman had left her family to work for three weeks in a row in a faraway place, only to go back to them for a mere couple of days. Patricia asked me if I missed my family. I hesitated slightly before

[11] El Alto is the second largest city in La Paz department, adjacent to its capital. Buses to and from the east of the country pass through El Alto.

answering that I did. But I did not think that I missed them in the same way. Rather than concentrate on the difference between Patricia's and my attitudes towards our respective families, it is perhaps more interesting to ask why she inquired about my feelings towards my family, who lived even farther away than hers.

Recent migration studies have begun to include emotions in their attempts at making sense of people's decision to move far away from home and stay in a new place (Faier 2011: 108). In fact, focusing on emotional expression allows for a better understanding of multiple social and material aspects of migration, such as sending remittances, saving money, labour choices, or curiosity (ibid.: 108-109). In a recent study of Bolivian migrants living in Spain and families of migrants who live in Bolivia, Xavier Escandell and Maria Tapias (2010) describe how these individuals consciously conceal information which could cause worry among their family members in another country, for instance, illness, financial, or employment problems (see also Tapias 2015: 105ff). Migrants must manage multiple realities (Faier 2011: 110-111) – some more immediate than others – and in the process take into account their feelings towards people embedded in these realities. Thus, in addition to measurable considerations of daily life, emotions – including loneliness – play an important role in the way people understand their existence. Paulina and Patricia's lives in Santa Cruz make sense for them for a variety of reasons, which are underpinned by the individual emotional landscapes of their unique biographies in this lowland city.

For many women, migration to the city of Santa Cruz was often filled with opportunities for making autonomous decisions, despite the limitations of the everyday routines. It is perhaps especially true for women such as Paulina and Patricia, who moved to Santa Cruz on their own, challenging the traditional gendered scripts (cf. Crain 1996: 146; Bastia 2011: 1516) and attempting to establish themselves in a new place as more autonomous individuals. This could be particularly relevant in the case of female migrants from rural areas, who – if

they stayed in their home villages – would be more likely to have their behaviour monitored by male relatives[12] and be expected to fulfil their responsibilities as kin. Thus, before undertaking tasks of their choice, women would be required to assume their wifely or daughterly obligations. For such women, the act of migration was liberating and opened the doors to previously inexistent options. Some researchers, however, emphasise the fragmented or temporary character of the changes caused by migration. Not infrequently, returning to the place of origin and reconnecting with the family network caused women to reconstruct the patterns which the act of migration allowed to break (Bastia 2011: 1527; see also Pratt & Yeoh 2003). With this in mind, female migrants whose social situation improved as a result of migration, having escaped an abusive partner for example, may not be willing to return despite the difficulties related to being a migrant (Bastia 2011: 1516; see also Kothari 2008).[13] Many people who moved from the Andean zone to the city of Santa Cruz mentioned the challenge of being separated from an established and familiar network of kith and kin, having to face various forms of racial or ethnic discrimination, the pressures related to the need of absorbing a lot of information about the new place and its people, and, finally, a possible feeling of general inadequacy stemming from not being fluent in all things Santa Cruz.

I heard multiple accounts of experiences which illustrate this pattern. For instance, Inéz, one of my friends who came to Santa Cruz with her family when she was around twelve, told me that for the first few months she only played with her siblings because she did not know other girls living in the neighbourhood and her classmates often mocked her *cochabambino* accent. As mentioned above, Doña Paula, my landlady, came to Santa Cruz department with her partner, Don

[12] Older female relatives may also want to regulate young women's behaviour, especially if they do not make choices typical for their age and gender (see Crain 1996).

[13] Paulson & Bailey (2003: 492) state that in a study conducted in El Alto over 60% of the women who experienced violence at the hand of their partners used separation as a coping strategy, which is especially interesting in the face of the ideal of intimate relationship in Bolivia (cf. Paulson 2007: 251; INE 2001).

Leopoldo, because he had been offered a job with the military in Camiri, a town approximately 300 kilometres to the south of Santa Cruz, but Doña Paula, who highly valued her independence, had bought a plot of land with a small house in the departmental capital from her uncle.[14] After the transaction was completed and the money had changed hands, Doña Paula discovered that her uncle had overcharged her for the property. Despite the fact that she did not have a lot of kin in Santa Cruz at the time, she refused to speak to her uncle and they only became reconciled fifteen years later.

There are many stories of troubled kinship relationships. One of my main informants and a friend, Rosa, came to Santa Cruz in her late teens to live with her mother in the city. Before, she lived with her grandparents in rural Chuquisaca department, but when she was fourteen, they sent her to Sucre, the capital of the Chuquisaca,[15] to work as a *doméstica*, a live-in-maid. According to Rosa, she was lucky: her *patrona*, employer, made sure that Rosa graduated from secondary school. After that, she suggested that Rosa learnt a proper profession. Rosa wanted to become a nurse. In order to be able to pay for nursing school, she needed financial support. It was offered by her mother, who had moved to the city of Santa Cruz with her younger children. Rosa joined her mother's household in January 2000. She moved out a few months later because of the sexual advances from the mother's new partner. When Rosa confronted him in front of her mother, the mother took his side. To make a living, Rosa found a part time job as a *promotora*, product demonstrator, in a supermarket and shared a rented room with a friend from the nursing school until she graduated. During my fieldwork, Rosa was back in touch with her mother, although, to me, their relationship seemed stiffened with unresolved resentment. On the other hand, Rosa's relationship with her brothers, including one half-brother, was much more relaxed and filled with mutual care rather than a sense of obligation.

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[14] That was the very same plot of land where we lived during my fieldwork, although the original house was demolished and replaced with new buildings.

[15] Sucre is also the constitutional capital of Bolivia.

These fragments from stories of the first months or years after migration to Santa Cruz highlight the precariousness of the initial phase that newcomers must face as they re-position themselves in new, complex communities. For Doña Paula and Rosa, their kinship relations proved the most brittle; for a twelve-year-old Inéz there was the struggle to understand that friendships were to be forged in future. The initial phase of migration offers few anchor points and those available are not always reliable, even if based on family relationships. In the case of migrants who also have children, which includes an overwhelming majority of the female population in Bolivia,[16] the almost inescapable weakness of any social network in a new place is weighed against the necessity of making a living and caring for offspring.

Double shifts: Motherhood and work opportunities

The effort of mothering is frequently taken for granted. A study conducted in urban Mexico on motherhood and extra-domestic work revealed that women, especially younger ones and those who are able to rely on their partner for economic support, tend to fit work around the necessity of child-rearing (García & de Oliveira 1997: 379). In the suburbs of Santa Cruz de la Sierra childcare seems to remain the women's domain as they are expected to be the primary carers for their offspring, especially in terms of the mundane everyday care. This visibly gendered and unequally shared burden of childcare translates into more complex structural inequalities in the city of Santa Cruz (cf. Bastia 2011: 1516). Women are expected to care for offspring, however, when the migrant women in Santa Cruz also need or want to work for a living, they often find that the available childcare infrastructure does not meet their needs in terms of cost, quality of care, and hours of operation. Negotiating between the necessity of providing income and their mothering responsibilities, caring for the children

[16] The last census states that 15.5% of women over the age of fifteen do not have children, but only approximately 30% of them (about 5% of the population) are twenty-five years old or older. Only 1% of women over the age of 40 is childless in Bolivia (INE 2012).

themselves or finding a suitable solution in their absence, means that women may be forced into less advantageous and more unstable forms of employment.

Women are different kinds of migrants than men, despite the fact that their motivations or struggles may frequently overlap (e.g. Buijs 1993: 6). As many of them are unqualified to perform the so-called skilled jobs, they often work in the informal sector – as *domésticas* (live-in maids), cleaners, laundresses, nannies, and in other similar, low-paid, low-prestige positions. Since most of these posts are arranged through verbal agreements, there are no guarantees for the employees regarding the duration of employment, payment of the wages, or benefits.[17] Simultaneously, it also allows workers to abandon their jobs with no consequences, which can prove very convenient. Nonetheless, these posts can be abusive, for instance when women have to face sexual advances or threats of violence. What makes it difficult to leave such a job is a temporary loss of income, which for poor people can be a decisive factor for staying.

There are cases of *domésticas* being treated well by their employers, even to the point of becoming valuable members of the household. Nonetheless, in many more instances women are barely remunerated. This kind of employment was often described as extremely exploitative by women who had performed such services in the past. At the same time, they also mentioned how easy it was to enter this line of work and that it was one of very few jobs available where it was possible to bring a small baby along. Women who are mothers often make decisions which prioritise their children, and migrant mothers are no different in this respect. Without the child-minding support that stronger social networks

[17] For instance *Subsidios de lactancia*, Lactation subsidies, dispensed monthly to mothers for a year after the baby was born (provided other provisions of Bono Juana Azurduy have been fulfilled, see Chapter 2). *Subsidios* consist in a quantity of dried, nutritious foods, such as quinoa, lentils, beans, as well as baby formula. In theory, every mother should receive an amount of food to the value of a monthly salary (about GBP 120 in 2012-13) (Ministerio de Salud y Deportes 2011). In practice, women who are employed receive more subsidies while women who are poor sometimes only receive baby formula. Rosa, who worked as a nurse at a private clinic, received so much food that she sold a part of it. On the other hand, Julia, who was unemployed, would receive one tin of baby formula a month – when baby Juan began drinking the formula, it was enough for merely a week and a half.

offer, migrant women are usually left with even fewer employment options as they require jobs which also let them take care of their children.

Rosa was lucky: her employer insisted on Rosa's continuing her education, which allowed her to move on to a much better job. More commonly, women find it difficult to move on to better employment. The position of a *doméstica* frequently comes with room and board, which makes the paid earnings, officially at the level of the national minimal wage, seem reasonable[18] (INE 2015). At the same time, a live-in-maid is expected to work very long hours,[19] from early morning until late at night. Since the working week usually lasts six days (if not longer), employees are left with very little time to rest, let alone explore alternative possibilities. Furthermore, they hardly ever learn skills which would allow them to find more gratifying employment, either in terms of remuneration or working conditions. This vicious circle is characteristic of most jobs within the informal sector. In many instances, women lose or abandon these jobs with little warning. Sometimes they are dismissed suddenly, which forces them into a difficult position of having to find another job very quickly. Alternatively, they may become pregnant and move in with their husbands or partners. In best-case scenarios, they manage to secure a different position through the connections of the social and family networks they have succeeded in joining or establishing after their arrival to Santa Cruz.

[18] However, situations where inexperienced *domésticas* are taken advantage of are not uncommon. Diana, a seventeen-year-old girl working in my fieldwork household was working part-time for Doña Paula in exchange for Bs 400 (GBP 40) a month as well as meals. She was expected to work between 7 a.m. and 12:30 p.m. six days a week. In comparison, my rent was set at Bs 600. At the same time, Diana sometimes did not come to work for a day or two and then showed up again without any explanation or excuse. Doña Paula grumbled with irritation but never fired Diana. The girl finally quit when she graduated from high school in December 2012.

[19] Not infrequently between 12 and 15 hours a day (Sandoval 2008).

Figure 18. Female vendors at *La Ramada* market, 2009.

There are few possibilities outside of the informal sector which enable women with children to pursue a professional career without relying on a kinship network or an expensive private institution for childcare. As a result, women opt for jobs which allow them to keep an eye on their children. Women migrants very frequently choose to find or create employment as market vendors, because of the large degree of flexibility it offers with regard to dividing time between work and childcare. In fact, small-scale commerce is a sector of the economy where a large majority of the workforce are female (INE 2012; cf. Sikkink 2010, 2001).[20] Sometimes a stall or a shop is located in the household, or in its immediate vicinity, so that women may share their time more efficiently between domestic, childminding, and economic activities. In the case of poorer migrants, nurseries and crèches are largely inaccessible, either due to the limited number of

[20] The 2012 census estimates that about 25% of women work in commerce (as opposed to 11% of men). In the city of Santa Cruz de la Sierra, almost 30% of women (and 19% of men) work in commerce. This category included wholesale, retail, and vehicle repair shops. It can be argued that the last subcategory included mostly men, which shifts the proportion of female vendors in the markets in women's favour even more.

spaces available, their bad reputation, prohibitive prices,[21] or because female migrants may believe that child-rearing should not be delegated to an institution. Relying on kinship and friendship networks is common; in fact, almost every woman who spoke to me mentioned the indispensability of other people in the organisation of daily childcare. They argued that it was important for them to be able to leave a child with someone else for a few hours to run errands or engage in domestic work.[22] The core economic activity that mothers choose to pursue, however, has to allow women to both earn enough money to support their family and leave them enough time to care for children, without excessive reliance on others.

It has been noted that "[s]ome of the poorest and most marginal households in Bolivia are run by single women, a fact that reinforces the assumption that the non-normative family status[23] is the source of their troubles" (Paulson 2007: 255). A single migrant woman who is a mother, and who must fit her work around childcare, is more likely to choose the irregularity of casual jobs. The convenience of employment flexibility frequently translates into unstable income. Consequently, single mothers who are poor frequently stay poor. While the situation is analogous for single fathers who raise children on their own, there are fewer men whose household structures closely match this description.[24] Research

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[21] During my fieldwork in 2012 a friend of mine sent his 9-month-old daughter to a private crèche, which cost Bs 1100 a month. This was more than the minimum monthly salary at the time, in 2012 set at Bs 1000 (approximately GBP 100) (Ministerio de Economía y Finanzas Públicas 2012), which was increased to Bs 1200 in the following year (Toro 2014).

[22] These tasks are considered to belong to the female domain, which in turn encourages women to undertake (poorly) paid employment as *domésticas*, live-in maids. There is research suggesting that the high demand for cheap migrant domestic workers in Europe and the USA contributes to maintaining the perception that such activities should be performed by women. As a result the range of women's work is confined to domestic chores and childcare. On the other hand, this demand allows migrant women from poorer countries to enter the labour markets (Bastia 2011: 1527; Benería 2008).

[23] According to labels imposed by administrative institutions, that is.

[24] That such circumstances are rare can be indirectly evidenced by the fact that the 2012 census lacks such information, i.e. only women were asked about the number of children they had (cf. INE 2012).

also shows that, in urban areas, non-indigenous people tend to be better off than indigenous people (McNamee 2009: 167; Psacharopoulos 1993). In the context of Santa Cruz, indigenous people are very often migrants, including second generation migrants, which contributes to linking migration with indigence. [25] Doña Dolores's story, described in Chapter 5, is an example of how poverty, migration, motherhood, and being single feed into each other, perpetuating economic and personal struggles.

Single fathers, on the other hand, are not as visible – sometimes quite literally. Such was the case of a family renting a flat from Doña Paula. The family had three members: a couple of girls, Mélany and Vanesa, aged thirteen and eleven, and their father who was rarely around. I inquired Doña Paula about their situation once as it seemed unusual. She explained that the family moved to Santa Cruz from rural Chuquisaca in 2007 but in the following year the girls' mother emigrated to Spain. Doña Paula also speculated that the mother had "another husband" in Spain. The girls had not seen their mother since her departure, although they often spoke on the phone. Mélany and Vanesa's father worked long hours as a builder on a construction site, and the girls were on their own a lot. They would hang around Doña Paula's shop but not buy anything, play in the street with other children from the neighbourhood, or watch TV until late at night. Doña Paula said that Mélany and Vanesa were *maleducadas*, ill-mannered or spoiled, because they were not being raised properly by their mother. I later noticed a middle-aged woman who came to their house to cook and clean every couple of days. It turned out that it was their aunt Mónica, their father's sister, who lived in a neighbouring *barrio*. She was not paid for her work although I sometimes saw the three of them share a meal Mónica had prepared. I did not see the father much, and – more importantly – neither did Mélany and Vanesa, although, admittedly, they were old enough to stay home alone.

[25] See Chapter 1 for a discussion of the categories of second generation migrants and urban indigenous.

This single example is hardly representative of the general situation of all single fathers in suburban Santa Cruz, which requires a systematic study. However, the fact that a female relative would regularly visit to do housework in a household headed by an effectively single father may suggest that certain domestic tasks are considered the female domain. Moreover, the father worked a job which was much better paid than anything a *doméstica* might expect and regularly received his wife's remittances. Perhaps he was only able to work as much as he did (as opposed to trying to fit his work around childcare and household duties) because, on the one hand, his daughters were old enough to be left on their own, and on the other hand, because he could count on his female relative for help with domestic chores.

Many poor mothers have similar problems, irrespective of whether they are migrants. However, migrants are not able to rely on others for providing solutions to these problems in the same degree. Weaker family and friendship networks of migrants, at least in the initial stages of migration, make depending on the help of others more challenging. Female Andean migrants frequently belong to more impoverished groups in Santa Cruz and live in marginally located neighbourhoods, such as Plan 3000. The necessity and cost of commuting[26] limits opportunities to access services and find employment. Mitigating their disadvantaged position would require effort and resources which migrant women often simply may not have.

Instead, women resort to immediate and short-term solutions, which are satisfactory on a day-to-day basis. For instance, rather than devoting time to looking for a stable employment with a monthly salary, they choose the informal economy, earning money by performing tasks for usually smaller but immediately paid wages. Instant access to cash allows them to cover daily expenses, such as

[26] A single minibus fare cost Bs 1.8 (GBP 0.18) in 2012 and was raised to Bs 2 in April 2013. Bus drivers argued that they often did not have Bs 0.20 to give change anyway (Condori 2013). There are no monthly or weekly tickets and passengers have to pay for every bus trip, which doubles the price of travel. A family with single income may end up spending a large part of the wages on bus fares alone.

food for their families. These casual jobs may require flexibility and humility, but they are also effective in meeting immediate economic needs. Casual and irregular employment allows the women to manage their time in a less structured manner, making double shifts of childcare and economic activities possible. In the end, many women focus on what is expected of them – rearing children and maintaining the household – rather than trying to develop a career – be it as a street vendor or a lawyer. Doña Celia and Doña Paula, whose stories were presented earlier in this chapter, exemplify this strategy: they chose to run their own businesses and made sure that their children were fed as well as educated.

Asymmetrical parenthood: Where are the men?

Migrant mothers I worked with in Santa Cruz were often single, which to a large extent determined the parameters of their parental responsibilities. At the same time, women who were in relationships often assumed a significant part of these obligations. It seemed as if they considered their partners unreliable or even incompetent, irrespective of the men's actual behaviour. It is not a unilateral strategy, however. Although women may treat men as not entirely trustworthy when it comes to childcare, men often do not make an effort to contradict this assumption, complacently accepting being treated as inadequate carers of their own children. I would like to begin this section with a story which, epitomises the complexity of relationships between mothers, fathers, and children.

Julia and Rodrigo had been married for over fifteen years and had already had two daughters, aged nine and seven, when Julia became pregnant again and gave birth to a boy, Marco. Rodrigo was over the moon. She told me that he carried Marco around and repeated to anyone who would listen: *Mi hijo, mi hijito, ¡miren a mi hijo!*, My son, my little son, look at my son! Rodrigo spoilt Marco tirelessly, bought him sweets and favoured him over his daughters. He was very proud when Marco began babbling and he said *papá*, daddy, before he could utter *mamá*, mummy. Marco grew up convinced that he was special and enacted that conviction in everyday life by requesting from his caretakers both undivided

attention and copious amounts of sweets.[27] When Marco was almost four, Julia became pregnant again and gave birth to another boy, Juan. Although Julia and Rodrigo had told Marco that he would have a new little brother (to which, as Julia recalled, Marco reacted with an ominous "no!"), he was by no means prepared for such a change in his life. When the new baby arrived and began to receive a lot of attention, Marco did not handle it well. He began acting out a lot: he shouted, played his toy trumpet for long periods of time, tried to intentionally frighten the baby by making sudden loud noises, ran away from his parents into the street, etc. Calming him down usually required time and an occasional bribe. I talked about it with Julia, as she was very worried about Marco's inability to accept the new family member. She said that Rodrigo, previously so in love with the boy, said to her: "What happened to *your* son? Do something with *your* son!"[28] Julia looked at me sadly and spoke quietly: "It's like he doesn't want to be Marco's father anymore. *Cosas así me rompen mi corazón*, things like that break my heart."

The situation in the household where I lived offers a slightly different example. Rosa and Roberto shared the parental duties for Laura, with the help of their immediate family. The division was unequal,[29] which was dictated by the fact that Rosa spent less time away from home: she had 12-hour-long night shifts every second night[30] (an arrangement she requested at work to be able to take care of Laura). On the other hand, Roberto was still at the university and working

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[27] He often greeted his grandmother with *¿Qué me trajiste?*, What did you bring me?, using the second person singular form of the verb, as opposed to the more polite third person singular, *Ud.*, as in "*¿Qué me trajo?*". His grandmother would scold him for it but also handed him little bags of treats, while rarely acknowledging her granddaughters in this way.

[28] Julia's emphasis.

[29] At the time of my fieldwork it was Rosa who spent more time caring for Laura and who provided the majority of income in their nuclear family. For reasons mentioned above, both Rosa and Roberto considered this situation to only continue for a limited time (until Roberto would graduate from medical school, complete his residency, and find stable employment), although they could not have been sure as to how long exactly it was going to take.

[30] In addition to that Rosa did a lot of domestic chores (see Chapter 4).

a part-time job in 2012 and then in the first year of his medical residency training in 2013.[31] However, when Roberto was at home, he took care of the baby in a way that looked competent to me – and he did not seem unhappy about it either. Because of their busy schedules, Rosa and Roberto did not always manage to meet to hand the baby over to each other, but when they did, she would give him detailed instructions about how to take care of their daughter. Those instructions appeared obvious if not redundant: feed the baby when she was hungry, prepare the formula in correct proportions in a clean, scalded bottle, change nappies, put her to sleep at appropriate times. Once I asked Rosa why she reminded Roberto about those duties. She replied that she was worried he would forget. I asked her if she thought it was possible to "forget" such things. Rosa answered: "I don't know. Maybe. But I am her mother, Roberto is just her father." What Rosa was pointing out was a divergence in parental roles: her responsibilities not only varied from those of Roberto, they were also of a different calibre. To Rosa, the father could be trusted with certain singular activities of which childrearing is made up. However, it was the mother's duty to supervise the overall process of caring for the baby while delegating particular tasks as needed.

I never spoke to Roberto about that conversation as I did not want to confront him. At the same time, when Roberto was around, he was able to take care of his daughter. Nonetheless, he did not do as much as Rosa. For instance, I only saw him do the laundry a few times, mostly during the week in which Rosa had a serious bout of purulent tonsillitis and she was so weak she could not stand for more than a few minutes. When Laura started eating solid foods, his efforts at introducing new products into his daughter's diet were much less intense than Rosa's; under Roberto's care, Laura usually walked around with a peeled banana or piece of bread in her little hand (as opposed to e.g. soft-boiled eggs, mashed soups, grated apple which her mother would prepare). While I do not think of Roberto as an incompetent caretaker, it was clear to me that he did not seem

[31] That meant alternating 12-hour-long day shifts and 36-hour-long shifts, with alternating 12- and 24-hour-long breaks.

entirely competent to Rosa. The only exceptions were situations when Laura was ill, where his expertise as a medical doctor would prove valuable (although Rosa still consulted a paediatrician at the clinic where she worked).

These motifs echoed widely in many everyday interactions I observed. Specific, detailed instructions given to fathers who were supposed to care for a baby point to an important tension inherent in their parental role. On the one hand, mothers recognise that men are able to fulfil their obligations towards their babies, but on the other hand women do not entirely trust fathers to perform these tasks on their own volition. These processes are part of wider social patterns in Bolivia and are by no means restricted to migrant social networks. However, for those Andean migrants who cannot rely on many people's help in caring for their offspring, such a partial exclusion of the father's assistance may translate into restricting the mother's time as well as her economic opportunities.

The fact that mothers largely assume most of parental duties is especially interesting bearing in mind that migrant women in Santa Cruz understand and acknowledge the fact that "the project of mothering may involve many participants" (Barlow & Chapin 2010: 333).[32] The everyday minding of children in the suburbs of Santa Cruz is a demonstration of that understanding – babies and young children are taken care of by a number of people cooperating in sophisticated, continuously negotiated patterns. These complex arrangements are, however, dominated by female carers, including young girls. While boys are not discouraged from taking care of babies, they are sometimes made fun of when they seem to engage in it too much. Carlitos, an eleven-year-old boy, whose family rented one of the flats from Doña Paula, liked to play with Laura a lot and Rosa would sometimes ask him to keep an eye on her daughter for a few minutes. One of Laura's aunts, Mónica, sometimes mocked Carlitos for it, calling

[32] Sarah Blaffer Hrdy's extensive, evolutionary perspective-driven research demonstrates that cooperation in childrearing is not only common in most human populations, but also across species which care for infants, such as the primates. She calls it "allomothering," highlighting the gendered character of infant care (see esp. 1999, 2009, see also 2005, 2008).

him *niñera de Laura*, Laura's (female) nanny. This insulting tease was supposed to undermine his decision to play with the baby, supposedly atypical of his gender.

Figure 19. Nohelia (left) and Mélany taking care of Juancito, Nohelia's baby brother.

I observed similar trends in the institution for children in Plan 3000 where I spent a lot of time during both my stays in Santa Cruz. While older children often accompanied their younger siblings with them and were expected to take care of them, e.g. by comforting the little ones when they cried, it was only girls who brought very small infants under 2 years of age. Sometimes they even brought babies who could not walk[33] and so had to be carried all the time.[34] The girls would pass the baby between each other (although some boys also participated in baby care, especially when they were related to the baby), and sometimes to one

[33] The youngest baby was the seven-month-old niece of one of the older girls at Luz del Mundo. Small babies, however, were rarely brought to the institution. Children are not encouraged to bring them, and, given that the majority of babies are breastfed in Bolivia (rather than formula-fed), there are no facilities at LDM for feeding such infants if their mothers are absent.

[34] This was also due to the bad quality of streets in suburban Santa Cruz: they are often unpaved and filled with ruts and potholes. As a result, it is easier to carry a baby, in one's arms, an *aguayo*, or increasingly commonly, a baby-carrier. Additionally, it would be impossible to load a regular-sized baby pram on a *micro*, mini-bus.

of the adult volunteers as well. Hardly ever was the baby put down except to have its nappy changed, which the girls were also able to do very expertly, to the frequent accompaniment of mocking comments from the boys. *¡Qué asco!*, How gross! – they would exclaim at the smell of a soiled nappy, laughing with disgust while watching girls change the baby's nappy. Girls were much more likely to take care of babies and young children without prompting. Practices such as feeding, changing, or entertaining babies are encouraged in girls from a very young age, directing the process of caring for children towards the female domain.

Figure 20. Father with children, *Plan 3000*, 2013.

While most of the time childminding activities are performed by women, male Andean migrants in suburban Santa Cruz should not be deemed insensitive to their paternal opportunities. Although on the whole, in Santa Cruz, it is women who largely bear the responsibility for childrearing, these patterns have been slowly changing. Among the processes influencing these transformations there are economic pressures of living in the city – many women must work to

supplement their household's income and they are not always able to fit their employment around childcare, as a result of which some of the childminding responsibilities may fall on the spouse. In a related process, more and more women gain professional education and, subsequently, well-paid jobs, which also frequently requires delegating taking care of the children to other people, including the children's fathers. And finally, men in Santa Cruz may be taking on board some kind of idea of equality, propagated by feminist organisations in the city[35] and in popular media discussing lifestyle topics. While I met a number of male parents who looked after their children in a manner that was systematic and reliable, they still stood out the landscape of parental care in Santa Cruz.

Having children is important for couples in the Andes (see e.g. Canessa 1998: 234), but it is especially important from the point of view of women, because it demonstrates one of their core abilities as females. Sara Cooley phrases it in a radical way: to her, in the Andes, "[t]he woman's body is a mother's body" (2008: 140). The first successful delivery marks the transformation of a female individual not only into a mother, but also into a woman (see e.g. Finerman 1982). While many ethnographies of reproductive processes in the Andean zone emphasise the links between human fertility and agricultural production (see e.g. Harris 2000; Canessa 1998; Allen 1988), this parallel is not explicit in the context of Andean migrants to the city of Santa Cruz who have children. Thus, while producing offspring is still very important, contemporary migrants in Santa Cruz explain their significance in different ways, only some of which resemble the Andean model.

For Julia and Rodrigo, their first daughter sealed their marriage. They had been together for five years before Julia became pregnant. They had been advised to go to a church in the neighbouring district of Villa 1ero de Mayo, where masses were held in Quechua. Despite the fact that neither of them spoke Quechua, they prayed and a few months later Julia became pregnant. She

[35] *Mujeres Creando*, Women Creating, or *Casa de la Mujer*, Women's Shelter are examples of organisations in Bolivia promoting ideas of gender equality.

explained to me that she had been worried about being infertile, in which case she feared that Rodrigo would have divorced her.[36]

However, I also heard many stories in which gestation was a breaking point in a relationship. Some of the women who spoke to me described how telling their partner about pregnancy ended their relationship. Sometimes the separation was only temporary and the partner would come back after a few months, as illustrated in the story of Doña Dolores. At other times the break-up was permanent – Doña Paula, for example, first became pregnant at the age of fifteen and was left by the man who sired the baby. The man's parents took care of her during pregnancy and offered to raise the baby.[37] Similar instances of pregnancies influencing the trajectories of intimate relationships can be found in accounts presented in previous chapters. It can be argued that the asymmetry of pregnancy, where women assume the burden of bringing a child into the world, marks the beginning of an unequal distribution of duties towards the offspring. Although it is possible to notice changes in the way that parents share childcare in Santa Cruz, it is still women who undertake the majority of tasks, which also guarantees them a special social role.

There is another possible reading of asymmetrical parenthood, one which interprets the unequal distribution of parental responsibilities as women's privilege, rather than a hindrance. The prevalence of females among the primary caretakers of children is related to a pattern of leaving fertility decisions to women (McNamee 2009: 167; see also Paulson & Bailey 2003), which places women in the position of experts and decision-makers with respect to reproduction and childrearing. This position may be burdensome, but it also makes women important and irreplaceable, especially in the symbolic dimension

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[36] However, as I have shown through the story opening this section, subsequent pregnancies marked or initiated significant changes in their relationships. Nonetheless, according to Julia, childcare obligations were not the only factors contributing to tensions in their marriage at the time of my research.

[37] Doña Paula, not without doubt and hesitation, accepted the offer. She is still in touch with her first son, who runs a local supermarket in the city of Cochabamba.

of motherhood. The asymmetry of parental responsibilities forces women into a very specific role, leaving little space for men to participate as active caretakers. Perhaps it is also possible to look at women as active agents, who push men away (for instance, by treating them as incompetent child minders) rather than being coerced into the social role of a mother. While migrant women's options in terms of employment become significantly constricted by the demands of active motherhood, being the main caretaker also makes them the key person in their offspring's lives.[38] In turn, mothers in Santa Cruz often elevate the relationship with their children to one of the main purposes of their lives, thus reinforcing a pattern of women as true child carers. "*Yo vivo por mi hija*, I live for my daughter," Rosa told me a number of times. Once I dared ask: "And Roberto?" She replied: "I love him very much, he's very good to me. But I live for her."

Social network, loneliness, and motherhood

Loneliness seems to be a very common feature of motherhood, which does not mean that it is not dreaded or feared. Its ubiquity is sometimes even noticed by people too young to be parents themselves, as illustrated by the following story.

Lucía liked to speak her mind. She was clever and diligent, attentive to her little siblings' needs but without being overprotective. One day we were sitting on the patio in the shade of a small tree, hoping for the merciful breeze amidst the heat of the early afternoon when Lucía initiated a conversation about relationships. She asked if I were married or had a boyfriend. When I said that I was single, Lucía looked at me sternly and said: "*Nunca te cases*, don't ever get married. Men make women suffer. Sleep with them, get pregnant, and then kick

[38] It was clear to me that many of my friends in the field had had troubled relationships with their mothers, which they sometimes commented on, describing instances in which their mothers were stubborn, hypocritical, or even cruel. However, the fact that they were aware of their female parents' imperfections was not a factor in the general attitude of respect and relative obedience they had for them.

them out." At the time I thought that it was a truly terrifying thing to hear from a seven-year-old.

I told a number of people in Bolivia about the piece of advice I received from Lucía, and most of them were rather amused upon learning how old she was. The content of advice did not seem so strange to them, that is, until I mentioned her age – as if the only odd element of this situation was a disillusioned young girl. Lucía's parents, Esmeralda and Walter, fought a lot; apparently, her father was jealous of her mother. They were still living together but Esmeralda worked as a medical doctor in a faraway hospital and she was away for 14-15 hours at a time. Walter worked as an airport night guard and not only were his shifts longer than Esmeralda's, they also rarely overlapped with hers. But perhaps what Lucía told me was not just an abstracted version of how she wished the relationship of her parents to have unfolded. Maybe what the girl spoke of was an empowering acknowledgment of the potential of female agency. A decision to "kick them out" might indicate taking relationship matters into one's own hands, not waiting to be left by a man but pre-empting such a turn of events in a rather radical manner. It is possible that what she alluded to was something that was missing from the lives she was witnessing everyday in suburban Santa Cruz: women who do not suffer, fathers who help out. I do not want to suggest that Lucía was right in polarising gender roles and failing to recognise the importance of other persons in the process of bringing up children. After all, the girl herself and her two younger siblings were mostly taken care of by their two grandmothers, at least one of whom raised her own children without a male partner. But I think that Lucía pointed to some important aspects of social relationships, which also reverberated in narratives of women who spoke to me about their experience of *sobreparto*.

Figure 21. Lucía with her late grandmother, Doña Valentina, and her siblings, Walter and baby Andrea, *Plan 3000*, 2012.

The normative advice that Lucía offered suggested that women are better off on their own (i.e. without a male partner although not childless[39]). The corollary of such a relationship strategy is that a woman who wants to have children must also be ready to raise her offspring relying on herself and the social network, but not on the intimate partner. Even though Lucía does not speak of migration explicitly, she is a child of second generation migrants, which indirectly shaped her social experiences. Both her grandmothers, who took care of Lucía and her younger siblings daily, came to Santa Cruz from the Andes many decades ago. The elderly women, Doña Valentina and Doña Balbina, taught their grandchildren about the places they came from and introduced them to traditions from their places of origin (Oruro and Potosí, respectively) through foods, songs,

[39] For a discussion of the role of motherhood in negotiating gender relations in Bolivia see e.g. McNamee (2009) and Paulson & Bailey (2003). For a discussion of this dynamic in Ecuadorian Andes see Cooley (2008). Barlow & Chapin (2010) offer a cross-cultural overview of the practice of mothering.

and an occasional word or phrase in Quechua. The girl absorbed her grandmothers' experience, filtered by the time and generation gap. In the end, even the seven-year-old Lucía had some kind of idea of what it is like to be a migrant mother in Santa Cruz: it often meant, paradoxically, to be alone with children.[40]

Since the weaker social networks influenced by migration have an impact on people's well-being, it is possible to analyse the tensions between the expectations and the reality of social relationships for migrants with reference to health and illness (Grønseth & Oakley 2007: 4). Women who spoke to me about their experiences of *sobreparto* shaped their narratives about pain and illness in a way which revealed the relationship between bodily suffering and the most important aspects of their overall lived experience.[41] While *sobreparto* remained the focus of their accounts, the processes which accompanied it reverberated with significance. Migration may not have always been mentioned explicitly, unlike the state of feeling alone at crucial points in women's lives. Their weak social networks usually – and especially in the initial phase of migration – offered insufficient support. In other words, women frequently emphasised that they were not surrounded by many relatives or a close-knit community, although they rarely tried to explain the cause of such a status quo.

Because my research took a postpartum illness as its point of departure, it was inevitable that motherhood (in addition to pregnancy, childbirth, and puerperium) would play a significant role in the women's life stories. Loneliness was like a thread wrapping around the trajectories of women's lives, sometimes more loosely, sometimes so tightly that it made them ill.

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[40] I found it fascinating that she told me "*Duerme con ellos*," sleep with them – acknowledging that women have children with multiple partners, as if she recognised that the monogamous relationships are not as popular as the social ideal would have it (see earlier in this chapter; cf. Paulson 2003: 251).

[41] See e.g. Yarris (2011: 227); Kleinman, Das & Lock, (eds.) (1997); Kleinman (1997, 1995).

Illness narratives can play a significant role in pointing to disruptions in kinship relationships and larger social networks.[42] Many scholars suggest that the social conditions have an impact on people's health,[43] and they influence female population in a different way than the male one.[44] In particular, everyday modes of social suffering present in women through "embodied manifestation of distress" (Tapias 2006: 400).[45] In other words, rather than thinking of *sobreparto* as a "failure in the body", it is possible to see it as an embodiment of the experience of imperfect social relationships, manifested through the mindful social bodies of women who fall ill with it (Das & Das 2007: 69; see Chapter 4). Arthur Kleinman proposes to analyse health issues by means of the framework of social suffering, which removes the boundaries dividing health and societal problems (2010; see also Kleinman, Das & Lock, [eds.] 1997). In the case of *sobreparto* among the migrant women from the Andean zone to the lowland city of Santa Cruz, this particular postpartum illness can be seen as a convergence of multiple tensions into a state of distress of a mindful social body.

If social support is considered to be integral to the experience of illness (see e.g. Smith-Oka 2014: 107), the feeling of loneliness featuring in the narratives of migrant women in Santa Cruz is equally important. This loneliness indexes the quality of social relationships these women have at their disposal in the face of a precarious period in their reproductive lives. In the accounts I collected, women who were fortunate enough to recover did so with the help of others. Their narratives almost invariably include someone from the social network who dropped by to see the woman after childbirth and who offered the diagnosis of *sobreparto*. Sometimes those people would even care for the ill woman until she got better. Although loneliness made women take risks and fall ill with *sobreparto*

[42] See Chapter 3.

[43] See e.g. Collyer, (ed.) (2015); Phelan, Link & Tehranifar (2010); Biehl, Good & Kleinman, (eds.) (2007); Das, Kleinman & Lock, (eds.) (2001); Farmer (1996, 2004).

[44] See e.g. Smith-Oka (2012, 2014); Mendenhall (2012); Yarris (2011); Spangler (2011); Fleuriet (2007); Rock (2003); Green (1999); Farmer, Connors & Simmons (1996); Scheper-Hughes (1992).

[45] See also Smith-Oka (2014); Yarris (2011); Spangler (2011); Fleuriet (2007); Rock (2003).

as a result, this event was also an opportunity to verify their support system. In many cases, an illness proved that there are people in social network to be relied upon. However, it does not mean that these women expected such a turn of events or that their evaluation of their postpartum situation was irrational. On the contrary, I argue that there were good reasons for these women to feel lonely: the social cues they were receiving prior to the illness from the members of their social network were suggesting to those women that they were, in fact, alone. What is more, they really were alone – that is, until they became sick and someone, a friend, a neighbour, a relative, came to visit and help, which changed the social dynamic.

Migrant mothers who spoke to me about their experiences of *sobreparto* articulated a very peculiar tension: they felt lonely even though they had just had a baby. A change would be heralded by members of their social networks, people who re-establish their relationships with these women by engaging in their situations in an active way, by visiting them, diagnosing them, spending time with them. It seems that loneliness did not necessarily describe physical solitude for these migrant mothers. Loneliness denoted a moment of particularly weak embeddedness in their social networks. The lack of a strong social network was dangerous at the time of childbirth because it could lead to risky behaviours, which could result in *sobreparto*. Yet, loneliness was also transitory – as the phrase *estaba solita* suggested, with the verb *estar*, denoting an impermanent "to be" state. Perhaps then, in a subversive way, the extreme, precarious loneliness, a moment of uncertainty is there to remind people about the ideal of good living, being surrounded by people who care for each other.

Conclusion

The goal of this thesis was to show how it is possible to look at *sobreparto* as much more than a postpartum bodily dysfunction. Using a traditionally Andean postnatal condition among Andean migrants in the lowland Bolivian city of Santa Cruz de la Sierra as a point of departure, I argued that focus on the occurrence of this illness in an atypical setting opens up new dimensions for analysis. In addition to exposing particular transformations of the traditional understandings of health, illness, and the body, the study of *sobreparto* in a lowland city also enables analysis of issues such as the quality of social networks, neoliberalism and modernity, and gender issues. Migration and weak social networks, the feeling of loneliness and lack of support, as well as womanhood and motherhood are crucial dimensions of reproduction, which both intersect with, and are fuelled by, these processes. Even though female reproduction is seemingly (although not exclusively) about procreation, it is significant that this process is fraught with perils, such as postpartum illnesses. *Sobreparto*, therefore, can be used as a lens through which it is possible to observe the interplay of social and political macro- and micro-processes in people's lives at the time of reproduction.

This research treated narratives of individual reproductive trajectories as a pretext for looking at the processes of migration, the biomedicalisation of childbirth, and transformations in the notions of motherhood and womanhood among migrant women who migrate from the Andean zone to the city of Santa Cruz. In this context, reproduction is crucial not just because it is linked to important social phenomena, such as motherhood, which is then related to pregnancy, childbirth, and possible postpartum illness; neither is its importance limited to its use demonstrating the couple's ability to produce (by reproducing) (see e.g. Canessa 1998; Harris 2000). The significance of reproduction stems

from its indispensability for the continuation of social life but also from the potential dangers embedded in it, including death as the result of a postpartum illness (Murphy-Lawless 1998). The potency of reproduction lies in its power to make and unmake lives as well as in its ability to bring people together to help each other out at times underpinned by uncertainties related to the future. *Sobreparto* is a condition that both reflects and embodies these insecurities surrounding reproduction.

This thesis focused on the phenomenon of *sobreparto* as captured in women's narratives about this particular illness. This approach allowed the location of *sobreparto* within a wider frame of life trajectories, exposing motifs beyond the temporarily dysfunctional body (see Mattingly & Garro 2001; Garro 1992; Kleinman 1992). I argued that it is possible to use narratives of *sobreparto* as a springboard for a study of dimensions of life such as motherhood, migration, social networks, as well as emotions. Simultaneously, in addition to revealing more general themes, these narratives sometimes allowed the women themselves to make sense of their lives. By trying to explain what happened to them through their accounts of *sobreparto*, women articulated their personal understanding of these events (Good 1992; Becker 1997). While arriving at an explanation cannot undo what has already occurred, it offers the possibility of accepting the past and moving on (Mattingly & Garro 2001). These individual stories of frequently difficult and challenging lives, punctuated by pregnancies, touch upon phenomena beyond the idiosyncrasies of particular life trajectories, such as modernity or understandings of gender. *Sobreparto* exposes these issues and sheds light on their intricate complexity in the context of Andean migrants in the lowland city of Santa Cruz.

I looked at *sobreparto* from a number of different analytical perspectives, which contribute to the understanding of this postpartum condition. At the level of the body, *sobreparto* can be viewed as a serious disturbance of bodily equilibrium (see e.g. Loza & Álvarez 2011; Larme & Leatherman 2003; Bradby &

Murphy-Lawless 2002). According to Andean understandings, the postpartum body is susceptible to all kinds of dangerous influences, which is why a woman who has just given birth requires appropriate care (e.g. Loza & Álvarez 2011). *Sobreparto* marks a failure to receive such care and constitutes a reminder of its importance during the puerperium, when the body is at its most vulnerable. On the social level, *sobreparto* points to the fundamental character of the social network in people's lives (ibid.). Members of one's social network, from relatives to neighbours, enable the woman who has just given birth to take care of herself, to avoid risky behaviour, thus letting her know that she is not on her own with the newborn baby. While motherhood remains a central aspect of womanhood, it is also characterised by inherent hardships and dangers. Whether manifesting itself as an illness or the feeling of being alone, suffering is frequently perceived to be an inescapable aspect of being a mother (Bourque & Warren 1981). In this sense, *sobreparto* constitutes one of the potential risks of womanhood, further emphasised by the fact that its occurrence is inextricably related with acts of reproduction.

Through close analysis of ethnographic accounts of *sobreparto*, it was possible to see the tensions between the ill body, the troubled mind, and imperfect social relationships. Building on the seminal work of Margaret Lock and Nancy Scheper-Hughes on the mindful body (1987) and supplementing it with theories emphasising the social character of bodily experience (Boellstorff & Lindquist 2004), I used the term "mindful social body" to capture the two crucial dimensions recurring in the stories of postpartum illness I collected. In the Andes, the puerperal body is considered to be open (see e.g. Loza & Álvarez 2011), and thus vulnerable to all kinds of influences. This understanding is present among Andean migrant women in Santa Cruz, although not often explicitly articulated. In fact, the openness of the body was expressed through narratives about failures to ensure that the body is protected during the postnatal period. However, these failures were often attributed to insufficient support on

the part of one's social network, which also caused negative emotions, including feeling alone.

Thus, I argue that confining the understanding of *sobreparto* to the realm of health and illness significantly restricts the scope of its possible implications. On the other hand, recognising emotions and social relationships in the analysis of a phenomenon that is often classified as an illness enables the inclusion of wider and more complex sets of meanings into the interpretation. *Sobreparto* may be an illness, but it is not simply an illness of the body. Central to this understanding is consideration of somatic states as expressions beyond physiology (Tapias 2006, 2015). If strong emotions can cause bodily distress, then it is also possible to look at illnesses as expressions of emotions – perhaps even too complex to be articulated with words. In such an understanding, *sobreparto* can be read as an intense expression of an extremely complex set of feelings and circumstances.

Furthermore, *sobreparto* can also be viewed through an even wider lens, as a phenomenon located within neoliberal Bolivian politics (cf. Smith-Oka 2014; Tapias 2015). Looking at a traditionally Andean illness in the context of a lowland city reveals tensions in contemporary Bolivian healthcare policies. While it is undeniable that increased access to biomedical treatments have brought many positive changes to Bolivian citizens, such as a considerable decrease in both maternal and infant mortality rates (see Chapter 2), these transformations were often implemented in a manner which relied on rejecting local medical traditions (see Albó 2004; Zalles Asin 2006). In the case of childbirth, for instance, Bolivian women have been encouraged to give birth in hospitals (Galindo Soza 2010). As a result of this shift, midwives have become marginal in the processes of pregnancy and childbirth (Paz Ballivián 2010). In the city of Santa Cruz these changes have advanced so far that midwives are almost impossible to find. In this context, it is even more significant that Andean migrant women continue to talk about and fall ill with *sobreparto*. This illness escapes biomedical categorisation, undermining the dominance of scientific medicine in the context of Santa Cruz. However, since biomedicine is one of the manifestations of transformations

towards modernity in Bolivia, *sobreparto* can be read as a rejection or defiance of government-defined "civilisation". By remaining outside of the dominant medical model, this postpartum condition offers an alternative way of thinking about health, illness, and socialty.

The choice of a large, modern, lowland city as a research area also determined themes that emerged alongside illness narratives. One of these motifs concerned expectations of intimate and kinship relationships (cf. Paulson 2007). To migrants from the Andes, Santa Cruz offers the unprecedented freedom that comes with being anonymous. Simultaneously, women, especially from rural areas in the Andean zone, are faced with a high level of machismo, which makes women's lives more difficult in other respects (Peña Claros & Boschetti 2008). While the government, media, and religious institutions promote a model of stable heterosexual relationships, being part of such a couple remains unachievable for many (ibid.). As a result, many migrant women feel dissatisfied with the quality of their intimate relationships, complaining of husbands or partners who do not help, and of being left alone with childrearing duties. As for kinship relationships, the act of migration puts migrants, male and female alike, in the position of restructuring their social networks anew, which can be even more difficult in urban areas where people must devote more time to remunerated work and commuting (cf. Windmark 2003). In the case of women who have children, these necessities are even more constraining, as women seek to reconcile childcare and work (García & de Oliveira 1997; Windmark 2003). Despite these hardships, relatively few migrants choose to return to where they came from. Instead, they often accept imperfect social relationships as a part of the lot of womanhood, in addition to loneliness.

In talking about their experiences of *sobreparto* from the past, women often discussed the expectations they had of their intimate relationships. Even though women accept that they are expected to be able to take care of their offspring on their own, they also recognise the hardships that come with it. Andean migrants in Santa Cruz are also exposed, at least to some extent, to discourses promoting

other ways of sharing parental duties, which can also cause frustrations, especially in the face of the high level of machismo prevailing in this lowland city. At the same time, women often treat men as incompetent childminders, reinforcing the patterns of single-parent childcare. Additionally, their narratives often expressed a paradoxical tension between having children and being alone.

Although never the main thread of the story, loneliness or feeling alone, frequently featured in women's narratives. I argued that the foregrounding of loneliness in the analysis revealed it as an existential condition, normalised through the hardships of life. Recognising the role of feeling alone in individual stories of *sobreparto* showed its place in the unfolding of the events that led to this postpartum illness. While I do not want to suggest that loneliness is the sole cause for *sobreparto*, I believe that including it in the analysis uncovers new dimensions of this phenomenon. Placing the spotlight on the usually unnoticed existential condition of loneliness exposes the critical role of the social network and expectations of intimate relationships in everyday existence. These phenomena in turn direct us towards understandings of womanhood and motherhood, reproduction and biomedicalisation, and, more generally, the effects of neoliberalism among migrant Andean women in Santa Cruz.

Studying *sobreparto* outside of the Andean zone revealed considerable transformations in certain aspects of this phenomenon. For instance, some of the postpartum proscriptions gained contemporary features in the city of Santa Cruz: there were migrant women who explained that the binding of the abdomen helps restore the pre-pregnancy figure. My informants' knowledge about this illness was often fragmented and based mainly on their own experience. Furthermore, the descriptions of aetiology and cure that they provided differed from one another, sometimes quite significantly. A number of recipes for medicinal infusions to treat *sobreparto* involved plants only found in the lowlands, demonstrating points of fusion between highland and lowland medical systems. Despite these transformations, *sobreparto* in Santa Cruz remains a dangerous

postpartum condition occurring via women's mindful social bodies (cf. Scheper-Hughes & Lock 1987; Boellstorff & Lindquist 2004) at times of "failed sociality" (Tapias 2006: 402).

This research does not pretend to present a comprehensive aetiology of *sobreparto* among Andean migrants in Santa Cruz, precisely because I argued that this condition falls beyond the realms of health and illness. However, the way that *sobreparto* is recognised, talked about, and treated, points to its being considered some kind of a medical condition. Simultaneously, the fact that it does not have a biomedical equivalent is significant outside of cultural medical relativism. As explained in Chapter 2, Andean migrants in Santa Cruz were unanimous in claiming that the anti-inflammatory pills that biomedical doctors prescribe in cases of *sobreparto* do not work. They also said that this condition requires a specific non-biomedical intervention; namely, being cared for by members of one's social network, drinking herbal infusions, and having one's body massaged with fat. While it is clear that *sobreparto* is located within a medical tradition involving an understanding of the body that differs from its biomedical model, it is even more important that Andean migrants in Santa Cruz continue to consider biomedical interventions or categories as unable to provide a cure or an explanation.

There are other limitations to my research. Due to the fact that I relied on narratives as a source of detailed ethnographic data, my sample was relatively limited. I strived to establish relationships of trust with all my informants, which translated into focusing on the same group of approximately fifteen women, with whom I had multiple conversations, including recorded interviews. Because *sobreparto* does not have an unambiguous counterpart in biomedicine and because women in Santa Cruz usually receive help from members of their social network, obtaining reliable statistical data would require census-like canvassing, which I was unable to conduct on my own. As a result, it is not possible to offer a statistical analysis of *sobreparto*'s incidence in Santa Cruz, beyond a general

statement that most women above the age of 30 seemed to know what it is, while this knowledge was not as widespread among the younger population.

There has been only one study of *sobreparto* in an urban area in highland Bolivia. The El Alto study, led by Carmen Beatríz Loza and Walter Álvarez (2011), offered a comprehensive analysis of the inadequacy of biomedical strategies for addressing Andean understanding of pregnancy and childbirth. In particular, they criticised Bolivian health policies, which were modelled on biomedical recommendations for pregnancy and childbirth, for minimising the importance of the postpartum period. For Andean women living in El Alto, however, the puerperium remained not only an important but a potentially dangerous period. Since there have been no previous studies of *sobreparto* in the city of Santa Cruz de la Sierra, it remains impossible to trace precisely the modifications that the understandings of *sobreparto* have undergone. Additionally, the population of Santa Cruz also includes indigenous people from other areas of Bolivia, whose customs and concepts, including those of illnesses, have also entered the everyday understandings of the inhabitants of this multiethnic city. It is possible that had the sample been larger, there would be even less consistency between explanations as Santa Cruz is influenced by medical traditions from Eastern Bolivia as well – in addition to the currently dominant biomedicine.

Under the aegis of "intercultural health," Bolivia has adopted a legal framework for recognising traditional medical systems as equal to biomedicine, with appropriate government structures, such as the Vice-Ministry of Traditional Medicine and Interculturality created in 2006. While the recommendations appear well-intentioned, their implementation often lies in the hands of biomedical doctors, mostly trained in a paradigm which does not take medical pluralism for granted. What complicates the situation further is the frequent incompatibility or untranslatability of the categories through which illnesses are considered, such as describing bodily symptoms by talking about emotions. In the case of *sobreparto*, the lack of a biomedical cure is one of the defining features of this condition,

illustrating the complexity of trying to frame this phenomenon within intercultural health policies. At the same time, as an increasing number of women in Bolivia give birth in hospitals, there are even more reasons to insist that medical personnel be respectful of non-biomedical understandings of health and illness, as well as of events such as labour (beyond simply conforming to the basic legal requirements). In addition to more general recommendations for attending hospital childbirth, including appropriate heating and allowing women in labour to drink herbal infusions, the prevention of *sobreparto* would require making sure that the woman is not on her own once she leaves the hospital. As more women choose to give birth in hospitals in Bolivia, home births and traditional midwives who attend them have become less common. It is rather unlikely that biomedical doctors in Bolivia will suddenly begin to invite traditional midwives to deliver babies in hospitals. However, there may be a structural solution which, on the one hand, would recognise the phenomenon of *sobreparto* as belonging outside biomedicine, and on the other hand, could reinvigorate traditional midwifery as a profession by emphasising postnatal care. A traditional birth attendant could pay a series of visits to a woman who has recently given birth in her own household, acknowledging the potential dangers of the postpartum period but also ensuring that the mother and the baby receive appropriate care. Such a structural solution marries health and social policies, which is why it could be effective in the case of *sobreparto*, an illness which is not just a bodily dysfunction, but a social affliction.

Through stories of *sobreparto*, women articulated their vulnerabilities during the postpartum period. By speaking about changes in their bodies brought about by pregnancy and episodes of *sobreparto*, they revealed their emotions concerning aspects of life that were important to them, such as ideas of womanhood, motherhood, and expectations about the quality of their social networks. That said, the meanings of *sobreparto* discussed in this thesis include aspects of these women's lives that they did not explore beyond their particular situations – such as migration, economic situations, and government policies concerning the

modernisation and biomedicalisation of everyday life in Bolivia. Analysis of *sobreparto* enables consideration of people's lives on different levels but also helps to show how the processes occurring at each of those levels are mutually interdependent and deeply intertwined. The lowland city of Santa Cruz offers a unique setting for scrutinising these transformations through the lens of a traditionally Andean postpartum illness.

Appendix I

Migrants to the city of Santa Cruz de la Sierra by department of origin (INE 2012). Only persons above the age of 15 were included in the census, thus, the results are likely to be underestimates.

SANTA CRUZ DE LA SIERRA				
Department of origin	**Current domicile**			
	Santa Cruz de la Sierra	Elsewhere in Bolivia	Abroad	**Total**
Chuquisaca	55,107	1,252	96	56,455
La Paz	65,433	1,750	113	67,296
Cochabamba	72,225	1,945	201	74,371
Oruro	21,732	573	53	22,358
Potosí	33,494	839	61	34,394
Tarija	16,154	553	25	16,732
Santa Cruz	55,296	1,579	68	56,943
Beni	40,812	1,184	81	42,077
Pando	1,136	54	-	1,190
Total	**361,389**	**9,729**	**698**	**371,816**
N/A	1,082,723			

Appendix II

Ethnic self-identification in the 2012 census for the city of Santa Cruz de la Sierra (INE 2012).

SANTA CRUZ DE LA SIERRA			
Declared ethnic self-identification **A**: Nations or majority groups **B**: Nations or minority groups recognised by law of the Electoral System **C**: Other types of declarations	**Cases**	**Cases %**	**Total %**
A - Aymara	26,541	17.68	17.68
A - Quechua	57,038	37.99	55.66
B - Afroboliviano	4,098	2.73	58.39
B - Araona	31	0.02	58.41
B - Ayoreo	546	0.36	58.77
B - Baure	262	0.17	58.95
B - Canichana	50	0.03	58.98
B - Cavineño	50	0.03	59.02
B - Cayubaba	36	0.02	59.04
B - Chacobo	79	0.05	59.09
B - Chiquitano	20,701	13.79	72.88
B - Bésiro	8	0.01	72.88
B - Uru Chipayas	24	0.02	72.90
B - Esse Ejja	40	0.03	72.93
B - Guarasugwe	9	0.01	72.93
B - Guarayo	3,552	2.37	75.30
B - Guarani	14,367	9.57	84.87
B - Itonoma	3,331	2.22	87.08
B - Joaquiniano	122	0.08	87.16
B - Kallawaya	23	0.02	87.18
B - Leco	254	0.17	87.35
B - Machineri	2	0.00	87.35
B - Maropa	30	0.02	87.37
B - Reyesano	15	0.01	87.38
B - Mojeño	3,574	2.38	89.76

B - Ignaciano	9	0.01	89.77
B - Javeriano	1	0.00	89.77
B - Trinitario	245	0.16	89.93
B - Moré	23	0.02	89.95
B - Mosetén	33	0.02	89.97
B - Movima	1,113	0.74	90.71
B - Murato	5	0.00	90.71
B - Urus	92	0.06	90.77
B - Pacahuara	22	0.01	90.79
B - Sirionó	70	0.05	90.83
B - Tacana	189	0.13	90.96
B - Tapiete	8	0.01	90.97
B - Tsimane Chiman	430	0.29	91.25
B - Weenayek	61	0.04	91.29
B - Yaminahua	1	0.00	91.29
B - Yuki	29	0.02	91.31
B - Yuracaré	87	0.06	91.37
B - Yuracaré-Mojeño	78	0.05	91.42
C - Andamarca	3	0.00	91.43
C - Aroma	36	0.02	91.45
C - Ayllu Jukumani	1	0.00	91.45
C - Ayllu Kacachaca	1	0.00	91.45
C - Ayllu Porco	2	0.00	91.45
C - Ayllu Yura	10	0.01	91.46
C - Belen	1	0.00	91.46
C - Calcha	4	0.00	91.46
C - Challapata	13	0.01	91.47
C - Chaqui	3	0.00	91.47
C - Charagua	135	0.09	91.56
C - Chayanta	34	0.02	91.58
C - Chichas	211	0.14	91.73
C - Chiriguano	169	0.11	91.84
C - Choquecota	2	0.00	91.84
C - Chullpas	1	0.00	91.84
C - Condo	1	0.00	91.84
C - Corque	3	0.00	91.84
C - Curahuara de Carangas	10	0.01	91.85
C - Huachacalla	5	0.00	91.85
C - Huari	20	0.01	91.87
C - Huaylla Marka	2	0.00	91.87
C - Jach'a Pacajaqui	13	0.01	91.88
C - Jacha Carangas	10	0.01	91.88
C - Lagunillas	14	0.01	91.89

C - Larecaja	4	0.00	91.89
C - Lipez	1	0.00	91.90
C - Mataco	18	0.01	91.91
C - Mojocoya	4	0.00	91.91
C - Monkox	25	0.02	91.93
C - Moro Moro	11	0.01	91.93
C - Orinoca	11	0.01	91.94
C - Pampa Aullagas	1	0.00	91.94
C - Pojos	16	0.01	91.95
C - Pojpo	1	0.00	91.95
C - Poroma	2	0.00	91.95
C - Pucara	17	0.01	91.97
C - Qhapaq Uma Suyu	1	0.00	91.97
C - Qhara Qhara	4	0.00	91.97
C - Qollas	806	0.54	92.51
C - Quila Quila	10	0.01	92.51
C - Sabaya	3	0.00	92.51
C - Salinas	11	0.01	92.52
C - San Juan	6	0.00	92.53
C - Suyu Charcas	7	0.00	92.53
C - Suyu Sura	3	0.00	92.53
C - Tinquipaya	5	0.00	92.54
C - Tobas	2	0.00	92.54
C - Totora Marka	21	0.01	92.55
C - Turco	3	0.00	92.55
C - Ucumasi	1	0.00	92.55
C - Urmiri de Quillacas	3	0.00	92.56
C - Yampara	136	0.09	92.65
C - Yapacaní	39	0.03	92.67
C - Originario	602	0.40	93.07
C - Intercultural	3	0.00	93.08
C – Campesino (peasant)	7,461	4.97	98.04
C – Indígena (indigenous)	2,553	1.70	99.74
C – Indígena u originario no especificado (unspecified indigenous or original)	384	0.26	100.00
Total	**150,158**	**100.00**	**100.00**
N/A	1,292,238		

Appendix III

***SOBREPARTO* – ETHNOGRAPHIC CASE STUDIES**													
	Name	**Area**	**Causes**			**Symptoms**	**Moment of occurrence & duration**	**Long-term consequences**	**Treatment**	**Anthropological interpretations**	**Related illnesses**	**Additional remarks**	**Source**
			Local aetiology	**Biomedical categories**	**Relationship with the number of offspring**								
1	*sobreparto*	Peru		Postpartum complications: vaginitis, cervicitis, salpingitis. (p. 46)		Specific of vaginitis, cervicitis, salpingitis. (p. 46)	Period immediately following childbirth. (p. 46)		A strand of hair of the ill woman, three eyelashes and three eyebrow hairs, finger and toe-nail trimmings are burnt and the woman should drink the ashes with wine or a "*wayra*" infusion. (p. 46) Rubbing the ill woman with a rabbit, which is then killed. Five coca leaves are attached to the dead rabbit, which is then thrown into a river or on the road. (p. 46)		Postpartum haemorrhage	Biomedical symptoms – traditional cure.	Frisancho Pineda (1973)
2	*sobreparto*, *mal parto*	Chile	Washing oneself, getting one's feet wet (e.g. by walking barefoot), feeling depressed. (p. 218-222)	Retained placenta, haemorrhage, puerperium, puerperal infection. (p. 218-222)					Easily preventable. (p. 222)		*entuerto* (pains after the placenta has been expelled); *mal de madre, la madre* (abdominal pains caused by the feeling of a solid object moving up in the abdomen)	Dismissive attitude of the author, mixing local and biomedical aetiologies.	Plath (1981)
3	*desmando*	Peru	Not taking care of oneself during childbirth, not using *faja* after childbirth and not staying in bed for a sufficient amount of time after childbirth. (p. 33)		Probability of illness increases with pregnancies after the first bout of *desmando*. (p. 34)	The woman feels pain in the tail bone and her whole body feels *descompuesto*, unsettled, upset, out of sorts. Cramps. (p. 33)			Rubbing the body with alcohol in which rosemary and *charero*[i] soaked. Cramps are treated with curly pepper soaked in alcohol. Soon after the symptoms of *desmando* occur, the body needs to be rubbed with all kinds of fat, mainly from llama, vicuña, cow's knee and all kinds of suet, boiled with rosemary, mint, green celery, Peruvian ragweed (*Ambrosia peruviana*). After the woman's coccyx has been rubbed with fat, her abdomen should be wrapped with a cloth. (p. 34)		*warmi madre*	In cases where the women suffered from *desmando* before, the treatment should be repeated after each new childbirth, but not more often than necessary. (p. 34)	Lira (1985)

***SOBREPARTO* – ETHNOGRAPHIC CASE STUDIES**													
	Name	**Area**	**Causes**			**Symptoms**	**Moment of occurrence & duration**	**Long-term consequences**	**Treatment**	**Anthropological interpretations**	**Related illnesses**	**Additional remarks**	**Source**
			Local aetiology	**Biomedical categories**	**Relationship with the number of offspring**								
4	Postpartum illness	Bolivia	Contact with "cold" elements during childbirth and postpartum period. (p. 10) Failure to bind or cover the head after childbirth, gaining excessive body fat during pregnancy. (p. 28) Fright cause by air entering the woman's body. (p. 28-29, 56, 63) Cold air entering the body. (p. 28, 58) Consuming "cold" foods: spicy foods, onions, chichi (corn beer), potatoes, lamb, plantains. (p. 27)			Pain in the entire body, shivers (*escalorfrío*). (p. 27-28)	Postpartum period is the time when the woman is the most vulnerable. It may last from one week to two months.	Possibly fatal.	Binding the abdomen with *faja* to prevent the *magre*, an organ formed behind the navel during pregnancy, from moving up and asphyxiating the woman. (p. 28) Mixing the nail trimmings with the woman's hair, skunk and fox meat, which mixture is burnt and its smoke is inhaled by the woman. She also has to drink an infusion of these ashes. (p. 28, 58) Remaining in semi-seated position, with bound abdomen and the head, avoiding exposure to sun and heat. Cleaning oneself with rosemary infusion.. Consuming "hot" foods, e.g. meat broths with oregano; and drinks, e.g. cinnamon water, anise tea, chocolate. (p. 58-59)		*sobreparto*, *recaída*, *pasmo*, *suspension de la sangre* (Sp. lit. suspension of the blood), *arrebateo*, rise of the *magre*	Childbirth is referred to as "illness" despite the fact that pregnancy is treated like a normal process. (p. 10, 21)	Gonzales et al. (1991)
5	*sobreparto*	Cuyo Cuyo, Peru	Insufficient bed rest after birth, exposure to heat or cold due to going back to work too soon after labour (i.e. soon after the immediate postpartum period). Cold air entering a sweaty warm body of a woman through a vulnerable opening. (p. 147)		There exists a link between high number of offspring and weak health, hence proneness to sobreparto.	Chronic weakness, malaise. Itchy rash, numbness, tingling in hands and feet, headaches, sensitivity to heat and cold. Headaches, swollen gums. (p. 147)	Can occur at any time after giving birth if the woman exposes herself to temperature extremes or works too hard. (p. 147)	Incurable chronic condition.		State of health (including reproductive health) is interpreted through the prism of local economy – hard life weakens health – this is why differences between various conditions are of secondary importance to their function of relieving woman's burden. (p. 147)	*madre onqoy*[xi] *sopla*	*Sobreparto* is a general category of female illness. Women may claim this affliction if they feel overwhelmed with their workloads. The author interprets *sobreparto* as a possibility of resistance for women. (p. 155, 157)	Larme (1993)
6	*debilidad*	Southern Peruvian Highlands	Overall feeling of physical weakness and general malaise resulting from insufficient rest and improper care after giving birth. (p. 270-271)				Occurs soon after childbirth and lasts a week or two. Some informants reported feeling the effects 30 years later. (p. 275-276)	Possible chronic effects.				Luerssen emphasises that illness affects the ability to perform domestic and subsistence tasks of both the sick and the caregivers, unsettling the work balance in the household. (p. 275-276)	Luerssen (1993)

***SOBREPARTO* – ETHNOGRAPHIC CASE STUDIES**													
	Name	**Area**	**Causes**			**Symptoms**	**Moment of occurrence & duration**	**Long-term consequences**	**Treatment**	**Anthropological interpretations**	**Related illnesses**	**Additional remarks**	**Source**
			Local aetiology	**Biomedical categories**	**Relationship with the number of offspring**								
7	*sobreparto*	El Alto, Bolivia	Cold soups served in hospitals (as opposed to hot broths eaten at home), Touching water, not protecting oneself from the cold, not enough rest following labour.. (p. 161)			Coldness in the body, cold shivers (*escalorfrío*). (p. 161)		Pain in the feet, in the bones of the hands, bone pain later in life. (p. 161)					Dibbits (1994)
8	*sobreparto*	Cuyo Cuyo, Peru	Females are considered inherently *débil*, weak, and they are believed to continue to lose strength through multiple childbirths. Being weak makes one prone to falling ill with sobreparto. (p. 1005, 1012-13)							Larme suggests that the inherent bodily weakness of females in Cuyo Cuyo is further reinforced by denying women tasks which produce sweat, which has cleansing qualities. (p. 1005, 1012-13)		Reproductive illnesses are empowering for the women of Cuyo Cuyo. (p. 1005, 1012-13)	Larme (1998)
9	*sobreparto*	Nuñoa, Peru			Link between a high number of offspring and weak health, resulting in proneness to sobreparto. (p. 1039)	Chronic weakness, malaise. (p. 1039)				Health depending on economic position, heavy workloads and fertility. (p. 1039)		Sobreparto is a general category of female illness.	Leatherman (1998)
10	*recaída*	Laraos, Peru	Air, cold, sun, which dry the woman's breast milk. (p. 149-153)			Swollen face, hands, deformation of the hands (e.g. curled up fingers, like in arthritis). (p. 149-153)	Following childbirth, lasts between 2 weeks and 2 months. (p. 149-153)		The woman must spend the first half of her illness at bed rest, the second half – inside the house. She must follow dietary restrictions. (p. 149-153)		Movement of organs in the abdomen, which may be prevented by tying a flannel cloth or large towel around the abdomen. (p. 149-153)		Lestage (1999)
11	*debilidad*	Northern Peruvian Andes	The result of the embodiment of life's accumulated hardships. (p. 309)	Reproductive stress. (p. 309)	Link between a high number of offspring and weak health, causing susceptibility to sobreparto. (p. 309)						*madre onqoy*	Men and children are not immune to *debilidad* – the importance is given to the family as a health unit. (p. 309-310)	Oths (1999)

***SOBREPARTO* – ETHNOGRAPHIC CASE STUDIES**													
	Name	**Area**	**Causes**			**Symptoms**	**Moment of occurrence & duration**	**Long-term consequences**	**Treatment**	**Anthropological interpretations**	**Related illnesses**	**Additional remarks**	**Source**
			Local aetiology	**Biomedical categories**	**Relationship with the number of offspring**								
12	*sobreparto, kutipa*	Peru, 9 different Andean departments	Childbirth difficulties, being weak after having already given birth to many children, not taking care of oneself during and after childbirth. Exposure to excessive light, cold, heat, certain foods during childbirth, physical abuse. (p. 95-96)		Occurs with the 3rd or 4th childbirth and following ones. Large number of offspring causes sobreparto. (p. 95, 100)	Pains, sometimes stronger than labour pains, burning and/or itching sensation (*quemazón*), shivers (*escalorfrío*), headache. (p. 95)	Puerperium: on or after the 3rd day after childbirth. It can last for two months until one year, sometimes turns chronic (some women reported feeling the effects for 5 to 6 years). (p. 95-96)	Chronic pain, death. (p. 96)			*arrebato, recaída, entuerto*		Yon Leau (2000)
13	*Recaída* (=*sobreparto*, puerperal fever)	Andean Bolivia	Exposure to cold air and drafts. (p. 43, 45)						Protecting the woman from cold air and drafts, serving nutritious food and an infusion of a tuft of hair and nail trimmings of the woman who has given birth (alternatively, a mixture of herbs and other ingredients, such as skunk meat). (p. 43, 45)		haemorrhage uterine illnesses		Arnold & Murphhy-Lawless (2001)
14	*recaída* (=*sobreparto*, puerperal fever)	Aymara communities, Bolivia	Childbirth causes the position of the uterus to become temporarily unfixed. The womb may move up and result in the woman's asphyxiation. (p. 88) Getting up too early after labour, touching water, not wearing warm socks, remaining seated (especially in the sun) after labour. (p. 89-90)			Excessive bleeding (although certain amount of bleeding is expected). Hot hands, feeling like a sieve (Sp. *se sienten como un cedazo*), with holes, in the hands, fingers, and the entire body. (p. 89)	Occurs two or three days after childbirth and lasts for two weeks. (p. 89)		Sobreparto can be cured with herb infusions, some informants mentioned *manteo* (Aym. *thalthapt'ïta*). (p. 89-90) Mutton and chicken broths should be served, prolonged illness is treated with infusions of herbs or parts of plants, such as twigs of fig trees. (p. 88) Consuming "hot" foods and avoiding prohibited foods, such as *ají* (spicy condiment), papaya, noodles, rice, sometimes even potatoes, which can cause stomachache. Rice has an ambivalent status: it is a desired ingredient of broths, but it should not be consumed on its own. (p. 88-89) Abdominal massages and/or infusions of various plants are given to reposition the uterus. (p. 91)				Arnold & De Dios Yapita et al. (2002)

***SOBREPARTO* – ETHNOGRAPHIC CASE STUDIES**													
	Name	**Area**	**Causes**			**Symptoms**	**Moment of occurrence & duration**	**Long-term consequences**	**Treatment**	**Anthropological interpretations**	**Related illnesses**	**Additional remarks**	**Source**
			Local aetiology	**Biomedical categories**	**Relationship with the number of offspring**								
15	*sobreparto*	Andean Bolivia	Childbirth opens the body, making it vulnerable to illness or evil spirits. The greatest risk occurs in the period between the birth of the baby and the expulsion of the placenta. Falling asleep too soon after the labour. Exposure to cold, insufficient nutrition with hot foods and broths, touching cold water, prolonged sitting or squatting, which may cause the blood to coagulate. Allowing blood to clot excessively. (p. 60-62) **Living alone.** (p. 47)					Death through asphyxiation if the expulsion of placenta is delayed – the retained placenta moves up and asphyxiates the woman. (p. 43-6)	Drinking infusion of *chhijchipa*, a herb of the marigold family, with roasted pig's foot (possibly hoof). (p. 47) Manteo, a practice involving throwing a woman (usually in labour) up in the air using a blanket. This practice is frequently employed to reposition the foetus for delivery (or just to make the pregnant woman more comfortable), however, Bradby & Murphy-Lawless suggest that it is also used a number of weeks following childbirth to reposition the woman's internal organs. (p. 47)	Women's illnesses during the postpartum are not solely of reproductive character. (p. 2) Sobreparto, despite an explanatory model involving non-biological agents, is equalled to "infection" on many occasions. (p. 304, 320-1, 344, 346, 355) Despite recognising cultural differences in medical systems, for instance, by explicitly mentioning the fact that traditional birth attendants and biomedical health practitioners both consider each other's procedures "dirty". (p. 125, 144) It is worth noting that the researchers observed "a general increase in anxiety around birth in urban, as opposed to rural areas." (p. 145)	Uterine prolapse	Pregnancy and childbirth perceived as normal life events rather than medical conditions requiring medical intervention. Contemporary model of pregnancy and childbirth in the Andes is composed of various traditions, local as well as colonial and biomedical medical systems. (p. 4) Hospital childbirth is not listed among causes of sobreparto.	Bradby & Murphy-Lawless (2002)
16	*sobreparto*	Southern Peruvian Andes	Used to refer to a postpartum infection, often co-occurring with a pain in the lower abdomen, sometimes fever. Also used to describe a group of symptoms including "weakness, general malaise, headaches, and body aches – chronic complaints that persisted years after the last birth." (p. 198-199) Chronic reproductive illnesses related to social discord in the community. (p. 201)		Incidence increases with subsequent pregnancies. (p. 200)		Often occurred many years after the last childbirth. (p. 192)	Possibly chronic consequences.	It is possible to prevent it by feeding the woman nutritious meals cooked from local food and removing a part of her workload. (p. 199) The woman should avoid activities considered especially "hot" or "cold", e.g. cooking, doing the laundry.	The author suggest that *sobreparto* 'embodies women's experience of their lives and work." (p. 192) They also argue that sobreparto may be a source of women's empowerment, because it removes some of the workload from women and forces men to take women seriously by taking care of them. (p. 205)	*Madre*, *sopla* (sometimes used interchangeably with *sobreparto*)	*Sobreparto* was the most common reproduction-related issue in that area. (p. 198)	Larme & Leatherman (2003)

***SOBREPARTO* – ETHNOGRAPHIC CASE STUDIES**													
	Name	**Area**	**Causes**			**Symptoms**	**Moment of occurrence & duration**	**Long-term consequences**	**Treatment**	**Anthropological interpretations**	**Related illnesses**	**Additional remarks**	**Source**
			Local aetiology	**Biomedical categories**	**Relationship with the number of offspring**								
17	*sobreparto* (=*recayra*, *recaída*)	La Paz and El Alto, Bolivia	Emotional state of a woman giving birth in hospital. (p. 59) During pregnancy, avoiding gestures related with weaving, maintenance of bodily equilibrium, caring about the relationships with the forces of nature which can affect both the baby and the mother, not going to the cemetery. (p. 112-13) Exposure to cold air, which enters the body. (p. 166) Expose to low temperature by touching the cold metal on the birthing table, not changing hygienic rowels frequently enough, lack of appropriate blankets, exposed feet (without warm socks), C-section exposing them to the cold. (p. 170) Causes of sobreparto – statistics: Hospital – 33%; cold – 26 %; touching water – 14%; curses – 11%; sun – 6%; dirt – 3%; unknown – 7%. (p. 170)	Infection as a result of childbirth, excessive bleeding, postpartum haemorrhage, bladder, kidney, nipple or mammary gland infections, problems with lactating or depression (called *pena* or *tristeza*). (p. 60)	Indirect relationship: some women experience sobreparto a number of times during their lives, due to previous abortions, miscarriages or childbirths, since these occasions are strongly related to changes of temperature, especially in biomedical facilities. (p. 170)	Escalorfrío (shivers and chills), sweating, pain in the bones, general feebleness, expulsing clots of blood, pieces of the placenta, foetid and/or overabundant discharge (interpreted by biomedicine as endometriosis). (p. 166)	Sobreparto can occur from the day of childbirth to more than a year after and can last from less than 24 hours to years, becoming a chronic illness. (p. 171)	Death. (p. 94) Chronic illness. (p. 171)	The most common remedies involve chijchipa, hair and nail trimmings, pig's hoofs, fox meat, laika pichitanka broth. (p. 176)	The authors suggest that the postpartum period mirrors what happened to the woman during the pregnancy and childbirth. (p. 76) *Sobreparto* is understood as a turning point in a woman's sexual and reproductive life. (p. 94) The authors criticise reducing *sobreparto* to a haemorrhage or puerperal infection/sepsis. (p. 156-160)	*Sobreparto* is understood as belonging to a range of postpartum conditions, including delayed puerperium (*puerperio alejado*) and delayed post-puerperium (*post-puerperio alejado*). (p. 189)	The authors suggest that women seek this condition, which results in the sick women being reprimanded. Simultaneously, it is recognised that sometimes women do not have the possibility of taking care of themselves in a way that could ensure preventing sobreparto. (p. 170, 214)	Loza & Álvarez (2011)

[i] *Charero* remains an unidentified plant. Lira (1985) does not offer alternative names. Girault classifies it as a plant endemic to the Ayacucho region of Peru (1984: 29). Other sources suggest that it does not possess a Latin name (cf. Torres 2001: 92). Scarpa & Aimi (1985: 209) list *charero* with other unidentified plants used to treat altitude sickness and hypoxia.

[ii] *Madre onqoy* (Qu. womb sickness), also referred to as *madre*, was reported by 80% of the informants in Larme's study (1993). They described symptoms concerned with the lower back, the digestive tract, the urinary tract, and reproductive organs of women (as well as this area of the body) (ibid.: 143-144). Curiously, in Cuyo Cuyo *madre* has an equivalent for men, *riñón* (Sp. kidney), which, analogously, refers to "the lower back, digestive tract, urinary tract, and reproductive organs of men"; this term is used to describe this area as well. Both *madre* and *riñón* are thought to result from organ displacement caused by hard work, prolonged vibrations (such as a journey in a truck) or physical trauma, such as childbirth in the case of females (ibid. 143-144, 147). Larme summarises: "[these illnesses] are suffered only by married individuals, and they become more frequent as an individual ages. The cumulative effects of a life of hard physical work can eventually lead to permanent damage and weakness in men's and women's bodies, and therefore to chronic *riñón* and *madre*" (ibid.: 144). That these conditions do not occur out of wedlock may be interpreted as their correlation: if virtually all individuals eventually marry, and the conditions are caused by general loss of strength and vitality, it is then inevitable that they are only found in married individuals.

Appendix IV

Civil status (INE 2012).

SANTA CRUZ DE LA SIERRA			
Civil status	**Number of people**	**%**	**Total %**
Single	444,359	43,85	43,85
Married	290,990	28,72	72,57
Cohabitant/common-law partner	208,086	20,54	93,11
Separated	21,525	2,12	95,23
Divorced	18,366	1,81	97,05
Widowed	29,937	2,95	100
Total	**1,013,263**	**100**	**100**
N/A:	429,133		

Relationship with the head of household (INE 2012).

SANTA CRUZ DE LA SIERRA			
Relationship with the household head	**Gender**		
	Female	**Male**	**Total**
Head	121,844	236,349	358,193
Spouse, cohabitant, common-law-partner	164,367	21,976	186,343
Child	272,503	287,094	559,597
Daughter- or son-in-law	13,202	11,660	24,862
Niece or nephew	41,437	44,312	85,749
Sibling or sibling-in-law	21,748	24,277	46,025
Parent or parent-in-law	16,369	8,185	24,554
Other relative	37,958	40,361	78,319
Household employee	7,966	2,452	10,418
Other non-relative	18,187	20,117	38,304
Co-tenant	11,615	18,417	30,032
Total	727,196	715,200	1,442,396

Appendix V

Economic activity of Bolivian population (INE 2012). Data show declared primary economic activity.

BOLIVIA			
Economic activity (1 possible answer) – population over the age of 7	**Gender**		
	Female	**Male**	**Total**
A: Agriculture, animal husbandry, forestry and fishing	24.13	28.74	26.81
B: Mining and quarry exploitation	0.44	2.72	1.76
C: Manufacturing industry	7.9	9.61	8.89
D: Provision of electricity, gas, steam, and air conditioning	0.03	0.17	0.12
E: Provision of water, residual water removal, waste and contamination management	0.07	0.12	0.1
F: Construction	0.89	13.21	8.05
G: Small and large-scale commerce, vehicle repairs	24.58	11.2	16.81
H: Transport and storage	0.68	9.46	5.78
I: Provision of accommodation and food services	7.76	1.62	4.19
J: Information and communication	0.88	1.17	1.05
K: Financial and insurance services	0.81	0.63	0.71
L: Real estate	0.1	0.1	0.1
M: Professional, scientific and technical services	2.05	2.53	2.33
N: Administrative and support services	2.39	1.28	1.75
O: Public administration, defence and social security planning	1.75	2.72	2.31
P: Education	5.98	3.07	4.29
Q: Health and social support services	4.09	1.29	2.46
R: Art, entertainment, and recreation services	0.29	0.77	0.57
S: Other services	1.93	1.28	1.55

Economic activity (1 possible answer) – population over the age of 7	**Gender**		
	Female	**Male**	**Total**
T: Activities in private households as employers, activities involving undifferentiated production of goods and services for private and commercial use	3.81	0.13	1.67
U: Foreign organisations and authorities	0.02	0.01	0.02
V: Unspecified	4.25	3.33	3.72
W: Incomplete description	5.19	4.83	4.98
Total	100	100	100
N/A:	5,340,133		

Economic activity of Santa Cruz de la Sierra population (INE 2012). Data show declared primary economic activity.

SANTA CRUZ DE LA SIERRA			
Economic activity (1 possible answer) – population over the age of 7	**Gender**		
	Female	**Male**	**Total**
A: Agriculture, animal husbandry, forestry and fishing	0.93	2.86	2.04
B: Mining and quarry exploitation	0.51	1.32	0.98
C: Manufacturing industry	8.77	13.5	11.5
D: Provision of electricity, gas, steam, and air conditioning	0.05	0.25	0.17
E: Provision of water, residual water removal, waste and contamination management	0.13	0.24	0.19
F: Construction	0.78	16.7	9.95
G: Small and large-scale commerce, vehicle repairs	29.89	18.78	23.49
H: Transport and storage	0.91	12.05	7.33
I: Provision of accommodation and food services	10.86	2.98	6.32
J: Information and communication	1.24	1.83	1.58
K: Financial and insurance services	1.39	1.06	1.2
L: Real estate	0.29	0.3	0.3

Economic activity (1 possible answer) – population over the age of 7	**Gender**		
	Female	**Male**	**Total**
M: Professional, scientific and technical services	3.41	3.98	3.74
N: Administrative and support services	4.58	2.69	3.49
P: Education	5.88	2.23	3.77
Q: Health and social support services	5.77	1.58	3.35
R: Art, entertainment, and recreation services	0.48	1.1	0.84
S: Other services	3.15	2.03	2.51
T: Activities in private households as employers, activities involving undifferentiated production of goods and services for private and commercial use	6.64	0.19	2.92
U: Foreign organisations and authorities	0.01	0.01	0.01
V: Unspecified	3.56	2.93	3.2
W: Incomplete description	9.32	8.88	9.07
Total	100	100	100
N/A:	748,780		

Ethics approval

25 April 2012

Karolina Kuberska
Department of Social Anthropology

Ethics Reference No: *Please quote this ref on all correspondence*	**SA8544**
Project Title:	**The meanings of sobreparto. Postpartum illnesses and embodiment of emotions**
Researchers Name(s):	**Karolina Kuberska**
Supervisor(s):	**Professor Tristan Platt**

Thank you for submitting your application which was considered at the <name> School Ethics Committee meeting on the 27/02/2012. The following documents were reviewed:

Ethical Application Form **27/02/2012**

The University Teaching and Research Ethics Committee (UTREC) approves this study from an ethical point of view. Please note that where approval is given by a School Ethics Committee that committee is part of UTREC and is delegated to act for UTREC.

Approval is given for three years. Projects, which have not commenced within two years of original approval, must be re-submitted to your School Ethics Committee.

You must inform your School Ethics Committee when the research has been completed. If you are unable to complete your research within the 3 three year validation period, you will be required to write to your School Ethics Committee and to UTREC (where approval was given by UTREC) to request an extension or you will need to re-apply.

Any serious adverse events or significant change which occurs in connection with this study and/or which may alter its ethical consideration, must be reported immediately to the School Ethics Committee, and an Ethical Amendment Form submitted where appropriate.

Approval is given on the understanding that the 'Guidelines for Ethical Research Practice' (http://www.st-andrews.ac.uk/media/UTRECguidelines%20Feb%2008.pdf) are adhered to.

Yours sincerely

Convenor of the School Ethics Committee OR Convener of UTREC

Ccs

Supervisor
School Ethics Committee

References

Abercrombie, Thomas A. 1998. *Pathways of memory and power: Ethnography and history among an Andean people*. Madison: University of Wisconsin Press.

Abu-Lughod, Lila & Catherine A. Lutz. 1990. "Introduction: Emotion, discourse, and the politics of everyday life", in: Catherine A. Lutz & Lila Abu-Lughod, (eds.), *Language and the politics of emotion*, Cambridge: Cambridge University Press, pp. 1-23.

Abu-Lughod, Lila. 1986. *Veiled sentiments. Honor and poetry in a Bedouin society*. Berkeley: University of California Press.

Abu-Lughod, Lila. 1988. "Fieldwork of a dutiful daughter", in: Soraya Altorki & Camillia Fawzi El-Solh, (eds.), *Arab women in the field: Studying your own society*. New York: Syracuse University Press, pp. 139-162.

Ahearn, Laura M. 2009. *Invitations to love: Literacy, love letters, and social change in Nepal.* Ann Arbor: University of Michigan Press.

Alba, Juan José. 1989. "La tirisia. Una nueva interpretación psicoanalítica", *Búsqueda*, 1(1): 31-54.

Albó C., Xavier. 2004. "Interculturalidad y salud", in: Gerardo Fernándes Juárez, (ed.), *Salud e interculturalidad en America Latina. Perspectivas antropológicas*, Quito: Abya-Yala, pp. 65-74.

Albó C., Xavier. 2013. "Preguntas étnico-lingüísticas del censo. Hay dudas sobre la comparabiliddad de los datos de autopertenencia en los censos de 2001 y 2012", *La Razón*, 08/12/2013, http://www.la-razon.com/opinion/columnistas/Preguntas-etnico-linguisticas-censo_0_1957004393.html, accessed on 03/07/2014.

Allen, Catherine J. 1982. "Body and soul in Quechua thought", *Journal of Latin American Lore*, 8(2): 179-196.

Allen, Catherine J. 1988. *The hold life has: Coca and cultural identity in an Andean community*. Washington: Smithsonian Institution Press.

Allen, Victoria M., Colleen M. O'Connell & Thomas F. Baskett. 2005. "Maternal and perinatal morbidity of caesarean delivery at full cervical dilatation compared with caesarean delivery in the first stage of labour", *BJOG: An International Journal of Obstetrics & Gynaecology*, 112(7): 986-990.

Allen, Victoria M., Colleen M. O'Connell & Thomas F. Baskett. 2006. "Maternal morbidity associated with cesarean delivery without labour compared with induction of labour at term", *Obstetrics & Gynaecology*, 108(2): 286-294.

Allen, Victoria M., Colleen M. O'Connell, Robert M. Liston & Thomas F. Baskett. 2003. "Maternal morbidity associated with caesarean delivery without labour compared with spontaneous onset of labour at term", *Obstetrics & Gynaecology*, 102(3): 477-82.

Arnold, Denise Y. & Jo Murphy-Lawless et al. 2001. *Hacia un modelo social del parto: Debates obstétricos interculturales en el altiplano boliviano*. La Paz: ILCA.

Arnold, Denise Y. & Juan de Dios Yapita et al. 2002. *Las wawas del Inka: Hacia la salud materna intercultural en algunas comunidades andinas*. La Paz: ILCA.

Atkinson, Paul & Martyn Hammersley. 2007. *Ethnography: Principles in practice* (3rd ed.). London: Routledge.

Balladelli, Pier Paolo. 1988. *Entre lo mágico y lo natural*. Quito: Abya-Yala.

Barlow, Kathleen & Bambi L. Chapin. 2010. "The practice of mothering: An introduction", *Ethos*, 38(4): 324-338.

Barry, Christine. 2009. "Response to Amy Pollard's paper 'Field of screams: difficulty and anthropological fieldwork'", *Anthropology Matters*, 11(2): 1-3.

Bastia, Tanja. 2011. "Migration as protest? Negotiating gender, class, and ethnicity in urban Bolivia", *Environment and Planning A*, 43(7): 1514-1529.

Bastien, Joseph W. 1978. *Mountain of the condor. Metaphor and ritual in an Andean ayllu*. St Paul: West Publishing Co.

Bastien, Joseph W. 1985. "Qollahuaya-Andean body concepts: A topographical-hydraulic model of physiology", *American Anthropologist*, 87(3): 595-611.

Bastien, Joseph W. 1987. *Healers of the Andes: Kallawaya herbalists and their medicinal plants*. Salt Lake City: University of Utah Press.

Bastien, Joseph W. 1988. *Cultural perceptions of neonatal tetanus and programming implications, Bolivia*. Arlington, VA: The Resources for Child Health Project.

Bastien, Joseph W. 1994. "Collaboration of doctors and nurses with ethnomedical practitioners", *World Health Forum*, 15: 133-137.

Bastien, Joseph W. 2003. "Sucking blood or snatching fat: Chagas' disease in Bolivia", in: Joan D. Koss-Chioino, Thomas Leatherman, Christine Greenway, (eds.), *Medical pluralism in the Andes*, New York: Routledge, pp. 166-187.

Basu, Alaka Malwade. 2006. "The emotions and reproductive health", *Population and Development Review*, 32(1): 107-121.

Bateman, Avalene. 1994. "Healthwatch: Postpartum depression", *Agenda*, 22: 57-61.

Bazzaco, Edoardo. 2008. "Dínamica demográfica, flujos migratorios y proceso de urbanización en el departamento de Santa Cruz, Bolivia. Un estudio de caso", in: José Luis Luzón & Márcia Cardim, (eds.), *Problemas socials y regionales en America Latina. Estudios de casos*, Barcelona: Universitat de Barcelona, pp. 71-100.

Beatty, Andrew. 2005. "Emotions in the field: What are we talking about?", *Journal of the Royal Anthropological Institute*, 11(1): 17-37.

Bechara, Antoine, Hanna Damasio & Antonio R. Damasio. 2000. "Emotion, decision making and the orbitofrontal cortex", *Cerebral Cortex*, 10(3): 295-307.

Becker, Gay. 1997. *Disrupted lives: How people create meaning in a chaotic world*. Berkeley: University of California Press.

Behar, Ruth & Deborah A. Gordon, (eds.). 1995. *Women writing culture*. Berkeley: University of California Press.

Behar, Ruth. 1997. *The vulnerable observer: Anthropology that breaks your heart*. Boston: Beacon Press.

Belliard, Juan Carlos & Johnny Ramírez-Johnson. 2005. "Medical pluralism in the life of a Mexican immigrant woman", *Hispanic Journal of Behavioral Sciences*, 27(3): 267-285.

Bendelow, Gillian & Simon J. Williams, (eds.). 2005 [1998]. *Emotions in social life. Critical themes and contemporary issues*. London: Routledge.

Benería, Lourdes. 2008. "The crisis of care, international migration, and public policy", *Feminist Economics*, 14(3): 1-21.

Bergholdt, Anders. 1999. *Cambas y collas. Un estudio sobre identidad cultural en Santa Cruz de la Sierra, Bolivia*. Occasional Papers No. 3. Aarhus: Centro de Estudios Latinoamericanos, Universidad de Aarhus.

Biehl, João, Byron J. Good & Arthur Kleinman, (eds.). 2007. *Subjectivity: Ethnographic investigations*. Berkeley: University of California Press.

Blanes, José. 2007. "Bolivia: Las áreas metropolitanas en perspectivas de desarrollo regional", *Villalibre*, 1: 23-44.

Blaxter, Mildred. 1990. *Health and lifestyles*. London: Routledge.

Bloch, Maurice. 1991. "Language, anthropology, and cognitive science", *Man, N.S.*, 26(2): 183-198.

Boellstorff, Tom & Johan Lindquist. 2004. "Bodies of emotion: Rethinking culture and emotion through Southeast Asia", *Ethnos*, 69(4): 437-444.

Bolin, Inge. 2006. *Growing up in a culture of respect. Child rearing in highland Peru*. Austin: University of Texas Press.

Bound Alberti, Fay. 2009. "Heartfelt emotions", *Lancet*, 374(9700): 1502-1502.

Bound Alberti, Fay. 2012 [2010]. *Matters of the heart. History, medicine, and emotion*. Oxford: Oxford University Press.

Bourque, Susan C. & Kay Barbara Warren. 1981. *Women of the Andes: Patriarchy and social change in two Peruvian towns*. Ann Arbor: University of Michigan Press.

Bradby, Barbara & Jo Murphy-Lawless. 2002. *Reducing maternal mortality and morbidity in Bolivia: Appropriate birth practices in the formal and informal sectors of perinalatal care*. La Paz: ILCA.

Bradby, Barbara. 1999. "Will I return or not?: Migrant women in Bolivia negotiate hospital birth", *Women's Studies International Forum*, 22(3): 287-301.

Bradby, Barbara. 2002. "Local knowledge in health: The case of Andean midwifery", in: Henry Stobart & Rosaleen Howard, (eds.), *Knowledge and learning in the*

Andes: Ethnographic perspectives, Liverpool: Liverpool University Press, pp. 166-193.

Brettell, Caroline & James Hollifield, (eds.). 2008. *Migration theory: Talking across disciplines*. New York: Routledge.

Browner, Carole H. & Carolyn F. Sargent. 1996. "Anthropology and studies of human reproduction", in: Carolyn F. Sargent & Thomas M. Johnson, (eds.), *Medical anthropology: Contemporary theory and method*, London: Praeger, pp. 219-234.

Browner, Carole H. 1989. "Women, household, and health in Latin America", *Social Science & Medicine*, 28(5): 461-473.

Browner, Carole H. 2001. "Situating women's reproductive activities", *American Anthropologist*, 102(4): 773-788.

Buijs, Gina. 1993. "Introduction", in: Gina Bujis, (ed.), *Migrant Women: Crossing Boundaries and changing identities*, Oxford: Berg, pp. 1-19.

Bussmann, Rainer W. & Ashley Glenn. 2010. "Medicinal plants used in Northern Peru for reproductive problems and female health", *Journal of Ethnobiology & Ethnomedicine*, 6(30): 1-12.

Cadden, Joan. 1993. *Meanings of sex difference in the Middle Ages: Medicine, science, and culture*. Cambridge: Cambridge University Press.

Campos, Roberto, Luca Citarella & Alessia Zangari, (eds.). 2010. *Yachay tinkuy. Salud e interculturalidad en Bolivia y América Latina*. La Paz: PROHISABA/ Cooperación Italiana/Editorial Gente Común.

Candela, Gemma. 2013. "La Paz pierde población y El Alto la supera; Santa Cruz crece más", *La Razón*, 07/08/2013, http://www.la-razon.com/sociedad /La_Paz-poblacion-El_Alto-Santa_Cruz_0_1883211728.html, accessed on 24/04/2014.

Canessa, Andrew. 1998. "Procreation, personhood and ethnic difference in Highland Bolivia", *Ethnos*, 63(2): 227-247.

Canessa, Andrew. 2000. "Fear and loathing on the *kharisiri* trail: Alteritiy and identity in the Andes", *Journal of the Royal Anthropological Institute*, 6(4): 705-720.

Canessa, Andrew. 2005. *Natives making nation: Gender, indigeneity and the state in the Andes*. Tucson: University of Arizona Press.

Canessa, Andrew. 2006. "'Todos somos indígenas': Towards a new language of national political identity", *Bulletin of Latin American Research*, 25(2): 241-263.

Canessa, Andrew. 2007. "Who is indigenous? Self-identification, indigeneity, and claims to justice in contemporary Bolivia", *Urban Anthropology*, 36(3): 14-48.

Canessa, Andrew. 2008. "The past is not another country: Exploring indigenous histories in Bolivia", *History and Anthropology*, 19(4): 353-369.

Canessa, Andrew. 2009. "El indio desde adentro, el indio desde afuera: Ciudadanía, raza y sexo en una comunidad boliviana", *La Manzana de la Discordia*, 5(2): 5-20.

Canessa, Andrew. 2012. "New Indigenous Citizenship in Bolivia: Challenging the Liberal Model of the State and its Subjects", *Latin American and Caribbean Ethnic Studies*, 7(2): 201-221.

Caprara, Andrea. 2010. "La relación médico-paciente: Un enfoque cultural", in: Roberto Campos, Luca Citarella & Alessia Zangari, (eds.), *Yachay tinkuy. Salud e interculturalidad en Bolivia y América Latina*. La Paz: PROHISABA/Cooperación Italiana/Editorial Gente Común, pp. 201-212.

Cartwright, Elizabeth. 2007. "Bodily remembering: Memory, place, and understanding Latino folk illnesses among the Amuzgos Indians of Oaxaca, Mexico", *Culture, Medicine & Psychiatry*, 31(4): 527-545.

Casanovas, Roberto, Silvia Escobar de Pabón & Enrique Ormachea. 1989. *Migración y empleo en la ciudad de Santa Cruz*. La Paz: Proyecto Migraciones y Empleo Rural y Urbano/OIT/FNUAP.

Castellón Quiroga, Iván. 1997. *Abril es tiempo de kharisiris: Campesinos y médicos en comunidades andino-quechuas*. Cochabamba: Editorial Serrano.

Castles, Stephen & Mark Miller. 2009. *The age of migration: International population movements in the modern world*. New York: Guilford.

Cavender, Anthony P. & Manuel Albán. 2009. "The use of magical plants by *curanderos* in the Ecuador highlands", *Journal of Ethnobiology & Ethnomedicine*, 5(3): 1-9.

Chirino, Fabiana et al. 2010. *Huellas migratorias. Duelo y religión en las familias de migrantes del Plan Tres Mil de la ciudad de Santa Cruz*. La Paz: Fundación PIEB.

Clifford, James & George E. Marcus, (eds.). 1986. *Writing culture: The poetics and politics of ethnography*. Berkeley: University of California Press.

Clifford, James. 1986. "Introduction: Partial truths", in: James Clifford & George E. Marcus, (eds.), *Writing culture: The poetics and politics of ethnography*, Berkeley: University of California Press, pp. 1-29.

Clifford, James. 1997. *Routes: Travel and translation in the late twentieth century*. Cambridge: Harvard University Press.

Collyer, Fran (ed.). 2015. *The Palgrave handbook of social theory in health, illness and medicine*. Basingstoke: Palgrave Macmillan.

Combès, Isabelle. 2006. "Cuando el nombre no hace al indio", in: Isabelle Combès, (ed.), *Definiciones étnicas, organización social y estrategias políticas en el Chaco y la Chiquitania*, Santa Cruz: IFEA/SNV/El País, pp. 19-23.

Condori, Iván. 2013. "Santa Cruz sube a Bs 2 el pasaje del transporte", *La Razón*, 19/04/2013, http://www.la-razon.com/index.php?_url=/ciudades/Santa-Cruz-Bs-pasaje-transporte_0_1817818235.html, accessed on 01/06/2015.

Conrad, Peter. 2007. *The medicalization of society: On the transformations of human conditions into treatable diseases*. Baltimore: The Johns Hopkins University Press.

Cook, Joanna. 2010. "Ascetic Practice and Participant Observation, or, the Gift of Doubt in Field Experience", in: James Davies & Dimitrina Spencer, (eds.), *Emotions in the field. The psychology and anthropology of fieldwork experience*, Stanford: Stanford University Press, pp. 239-265.

Cooley, Sara. 2008. "Bringing body to bear in the Andes: Ethnicity, gender, and health in Highland Ecuador", *Michigan Discussions in Anthropology*, 17(1): 132-160.

Crain, Mary M. 1996. "The Gendering of ethnicity in the Ecuadorian Andes: Native women's self-fashioning in the urban marketplace", in: Marit Melhuus & Kristi Anne Stølen, (eds.), *Machos, mistresses, Madonnas. Contesting the power of Latin American gender imagery*, London: Verso, pp. 134-158.

Crandon-Malamud, Libbet. 1991. *From the fat of our souls: Social change, political process and medical pluralism in Bolivia*. Berkeley: University of California Press.

Crapanzano, Vincent. 1985. *Tuhami: Portrait of a Moroccan*. Chicago: University of Chicago Press.

Crapanzano, Vincent. 2010. "'At the Heart of the Discipline.' Critical Reflections on Fieldwork", in: James Davies & Dimitrina Spencer, (eds.), *Emotions in the field. The psychology and anthropology of fieldwork experience*, Stanford: Stanford University Press, pp. 55-78.

Crist, Raymond E. 1946. "Bolivia – Land of contrasts", *American Journal of Economics and Sociology, Inc.*, 5(3): 297-325.

Csordas, Thomas J. 1993. "Somatic modes of attention", *Cultural Anthropology*, 8(2): 135-156.

Csordas, Thomas J. 1994. "Introduction: The body as representation and being in the world", in: Thomas J. Csordas, (ed.), *Embodiment and experience: The existential ground of culture and self*, Cambridge: Cambridge University Press, pp. 1-24.

Cuaresma Sánchez, Carlos Ricardo (ed.). 2005. *Diccionario quechua-español-quechua*. Cuzco: Gobierno Regional Cusco.

Cueto, Marcos & Steven Palmer. 2015. *Medicine and public health in Latin America*. New York: Cambridge University Press.

Curran, Sara R., 2006. "Research Ethics are Essential: Ethical Considerations for Research in Cross-Cultural Settings", in: Ellen Perecman & Sara R. Curran, (eds.), *A Handbook for Social Science Field Research: Essays & Bibliographic Sources on Research Design and Methods*, Thousand Oaks: SAGE Publications, pp. 197-217.

Cusk, Rachel. 2008. *A life's work: On becoming a mother*. London: Faber and Faber.

Damasio, Antonio R. 1994. *Descartes' error: Emotion, reason and the human brain*. New York: Putnam.

Das, Veena & Ranendra K. Das. 2007. "How the body speaks: Illness and the lifeworld among the urban poor", in: João Biehl, Byron J. Good & Arthur Kleinman, (eds.), *Subjectivity: Ethnographic investigations*, Berkeley: University of California Press, pp. 66-97.

Das, Veena, Arthur Kleinman & Margaret M. Lock, (eds.). 2001. *Remaking a world: violence, social suffering, and recovery*. Berkeley: University of California Press.

Davies, James. 2010. "Introduction. Emotions in the Field", in: James Davies & Dimitrina Spencer, (eds.), *Emotions in the field. The psychology and anthropology of fieldwork experience*, Stanford: Stanford University Press, pp. 1-31.

Davis, Dona L. & Setha M. Low. 1989. "Preface", in: Dona L. Davis & Setha M. Low, (eds.), *Gender, health, and illness: The case of nerves*, New York: Hemisphere Publishing, pp. xi–xv.

De Jong Gierveld, Jenny, Theo van Tilburg & Pearl A. Dykstra. 2006. "Loneliness and social isolation," in: Valentina L. Vangelisti & Daniel Perlman, (eds.), *The Cambridge handbook of personal relationships*, Cambridge: Cambridge University Press, pp. 485-499.

Delamont, Sara. 2009. "Familiar screams: A brief comment on 'Field of screams'", *Anthropology Matters*, 11(2): 1-2.

Department for Environment, Food & Rural Affairs. 2014. "Rural Urban Classification", 01/05/2014, https://www.gov.uk/government/collections/rural-urban-definition, accessed on 24/07/2014.

Devereux, George. 1967. *From anxiety to method in the behaviour sciences*. The Hague: Mouton.

Dibbits, Ineke. 1994. *Lo que puede el sentimiento. La temática de la salud a partir de un trabajo con mujeres de El Alto Sur*. La Paz: TAHIPAMU.

Dibbits, Ineke. 2003. *Uno de dos: El involucramiento de los hombres en la atención de la salud perinatal, revelaciones desde Santa Rosa y Rosas Pampa, el Alto, Bolivia*. La Paz: TAHIPAMU.

Durham, Deborah. 2011. "Disgust and the anthropological imagination", *Ethnos*, 76(2): 131-156.

Dykstra, Pearl A. 1990. *Next of non-kin. The importance of primary relationships for older adults' well-being*. Amsterdam/Lisse: Swets & Zeitlinger.

El Deber. 2012. "Superá el miedo al ginecólogo", 25/07/2012, http://www.eldeber.com.bo/supera-el-miedo-al-ginecologo/120724213726, accessed on 11/03/2014.

Escandell, Xavier & Maria Tapias. 2010. "Transnational lives, travelling emotions, and idioms of distress among Bolivian migrants in Spain", *Journal of Ethnic & Migration Studies*, 36(3): 407-423.

Faier, Leiba. 2011. "Theorising the intimacies of migration: Commentary on emotional formations of transnational worlds", *International Migration*, 49(6): 107-112.

Farmer, Paul, Margaret Connors & Janie Simmons. 1996. *Women, poverty and AIDS: sex, drugs, and structural violence*. Monroe, ME: Common Courage Press.

Farmer, Paul. 1996. "On suffering and structural violence: A view from below", *Daedalus*, 125(1): 261-283.

Farmer, Paul. 2004. "An anthropology of structural violence", *Current Anthropology*, 45(3): 305-317.

Fassin, Didier. 2007. *When bodies remember: Experiences and politics of AIDS in South Africa*, transl. by A. Jacobs & G. Varro. Berkeley: University of California Press.

Fernández Juárez, Gerardo. 1999. *Médicos y yatiris. Salud e interculturalidad en el Altiplano aymara*. La Paz: Ministerio de Salud y Previsión Social/CIPCA y ESA/OPS-OMS.

Figes, Kate. 2008 [1998]. *Life after birth*. London: Virago.

Finerman, Ruthbeth. 1982. "Pregnancy and childbirth in Saraguro: Implications for health care delivery in southern Ecuador", *Medical Anthropology*, 6(4): 269-276.

Finerman, Ruthbeth. 1989. "The burden of responsibility: Duty, depression, and *nervios* in Andean Ecuador", *Health Care for Women International*, 10 (2-3):141-157.

Finkler, Kaja. 1994. *Women in pain: Gender and morbidity in Mexico*. Philadelphia: University of Pennsylvania Press.

Fleuriet, K. Jill. 2007. "Articulating distress on multiple levels: Illnesses, history, and culture among the Kumiai of Baja California, Mexico", *Mexican Studies/Estudios Mexicanos*, 23(1): 155-180.

Foss, Laurence & Kenneth Rothenberg. 1987. *The second medical revolution: From biomedicine to infomedicine*. Boston: Shambhala.

Foster, George M. 1994. *Hippocrates' Latin American legacy: Humoral medicine in the New World*. Langhorne: Gordon and Breach.

Frank, Arthur. 2005 [1995]. "The body's problems with illness", in: Mariam Fraser & Monica Greco, (eds.), *The body: A reader*, London: Routledge, pp. 318-323.

Frankel, Stephen. 1986. *The Huli response to illness*. Cambridge: Cambridge University Press.

Fray, Kathy. 2005. *Oh baby: Birth, babies & motherhood uncensored*. Auckland: Random House.

Freund, Peter E. S. 1990. "The expressive body: A common ground for the sociology of emotions and health and illness", *Sociology of Health & Illness*, 12(4): 452-477.

Frisancho Pineda, David. 1973. *Medicina indígena y popular*. Lima: Librería Editorial Juan Mejía Baca.

Galindo Soza, Mario. 2010. *El progreso invisible. El Seguro Universal Materno Infantil*. La Paz: Fundación Milenio.

Gálvez Murillo, Albert de la. 2009. "Atención obstétrica y complicaciones del embarazo y parto en Bolivia", *Cuadernos del Hospital de Clínicas*, 54(2): 100-107.

García, Brígida & Orlandina de Oliveira. 1997. "Motherhood and extradomestic work in urban Mexico", *Bulletin of Latin American Research*, 16(3): 367-384.

Garro, Linda C. 1992. "Chronic illness and the construction on narratives", in: Mary-Jo DelVecchio Good, Paul E. Brodwin, Byron J. Good & Arthur

Kleinman, (eds.), *Pain as human experience: An anthropological perspective*, Berkeley: University of California Press, pp. 100-137.

Garro, Linda C. 2001. "The remembered past in a culturally meaningful life: Remembering as cultural, social, and cognitive process", in: Carmella C. Moore & Holly F. Matthews, (eds.), *The psychology of cultural experience*, Cambridge: Cambridge University Press, pp. 105-147.

Gaskin, Ina May. 2011. *Birth matters: A midwife's manifesta*. London: Pinter & Martin Ltd.

Geertz, Clifford. 1990. *Works and lives: The anthropologist as author*. Stanford: Stanford University Press.

Geertz, Clifford. 2001. *Available light. Anthropological reflections on philosophical topics*. Princeton: Princeton University Press.

Gélis, Jacques. 1991. *History of childbirth: Fertility, pregnancy and birth in early modern Europe*, transl. by R. Morris. Cambridge: Polity.

Gibbons, Luz et al. 2010. "The global numbers and the costs of additionally needed and unnecessary caesarean sections performed per year: Overuse as a barrier to universal coverage", *World Health Report*, Background paper, 30. Geneva: WHO.

Girault, Louis. 1984. *Kallawaya. Guérriseurs itinérants des Andes. Recherches sur les pratique médicinales et magiques*. Paris: ORSTOM.

Goffman, Erving. 1989. "On Fieldwork", *Journal of Contemporary Ethnography*, 18(2): 123-132.

Goffman, Erving. 1990 [1959]. *The presentation of self in everyday life*. London: Penguin Books.

Gonzales S. Fernando et al. 1991. "Qualitative research on knowledge, attitudes, and practices related to women's reproductive health", Working paper no. 9. Prepared by Centro de Investigación Análisis y Estudios Socioeconómicos and MotherCare Project, Cochabamba, Bolivia.

Good, Byron J. 1992. "The body in pain: The making of a world of chronic pain", in: Mary-Jo DelVecchio Good, Paul E. Brodwin, Byron J. Good & Arthur Kleinman, (eds.), *Pain as human experience: An anthropological perspective*, Berkeley: University of California Press, pp. 29-48.

Green, Linda. 1994. "Fear as a way of life", *Cultural Anthropology*, 9(2): 227-256.

Green, Linda. 1998. "Lived lives and social suffering: Problems and concerns in medical anthropology", *Medical Anthropology Quarterly*, 12(1): 3-7.

Green, Linda. 1999. *Fear as a way of life. Mayan widows in rural Guatemala*. New York: Columbia University Press.

Greenway, Christine. 1998a. "Hungry earth and vengeful stars: Soul loss and identity in the Peruvian Andes", *Social Science &Medicine*, 47(8): 993-1004.

Greenway, Christine. 1998b. "Objectified selves: An analysis of medicines in Andean sacrificial healing", *Medical Anthropology Quarterly*, 12(2): 147-167.

Grønseth, Anne Sigfrid & Robin Oakley. 2007. "Introduction: Ethnographic humanism – migrant experiences in the quest for well-being", *Anthropology in Action*, 14(1-2): 1-11.

Grosz, E. 1994. *Volatile bodies: Toward a corporeal feminism*. Bloomington and Indianapolis: Indiana University Press.

Harkness, Sara. 1987. "The cultural mediation of postpartum depression", *Medical Anthropology Quarterly*, 1(2): 194-209.

Harris, Olivia. 1978. "Complementarity and conflict: An Andean view of women and men", in: Jean La Fontaine, (ed.), *Sex and age as principles of social differentiation*. ASA Monograph 17. London: Academic Press, pp. 21-40.

Harris, Olivia. 2000. *To make earth bear fruit: Essays on fertility, work and gender in highland Bolivia*. London: Institute of Latin American Studies.

Hashimoto, K. et al. 2013: "Isolated low-normal amniotic fluid volume in the early third trimester: association with adverse perinatal outcomes", *Journal of Perinatal Medicine*, 41(4): 349–353.

Hatzfeld, Jean. 2006. *Life laid bare: The survivors in Rwanda speak*, transl. by L. Coverdale. New York: Other Press.

Hatzfeld, Jean. 2008. *Into the quick of life: The Rwandan genocide – the survivors speak*, transl. by G. Feehily. London: Serpent's Tail.

Hatzfeld, Jean. 2009. *The strategy of antelopes: Living in Rwanda after the genocide*, transl. by L. Coverdale. London: Serpent's Tail.

Heelas, Paul. 2007. "Emotion talk across cultures", in: Helena Wulff, (ed.), *The emotions: A cultural reader*, Oxford: Berg, pp. 31-36.

Henderson, Andrew, Gloria Galeano & Rodrigo Bernal. 1995. *Field guide to the palms of the Americas*. Princeton: Princeton University Press.

Herzfeld, Michael. 1996. "Embarrassment as pride: Narrative resourcefulness and strategies of normativity among Cretan animal-thieves", in: Charles L. Briggs, (ed.), *Disorderly discourse: narrative, conflict, and inequality*, New York: Oxford University Press, pp. 72-94.

Hobbs, Dick. 2011. "Ethnography – Hidden worlds", in: Dick Hobbs, (ed.), *Ethnography in context*, London: SAGE Publications, pp. 2-12.

Hochschild, Arlie Russell. 2005 [1998]. "The sociology of emotion as a way of seeing", in: Gillian Bendelow & Simon J. Williams, (eds.), *Emotions in social life. Critical themes and contemporary issues*, London: Routledge, pp. 3-15.

Hoffman, Eva. 2008. *Lost in translation: A life in a new language*. London: Vintage Books

Hogan, Margaret C. et al. 2010. "Maternal mortality for 181 countries, 1980-2008: A systematic analysis of progress towards Millennium Development Goal 5", *Lancet*, 375(9726): 1609-1623.

Hogan, Michael C., (ed.). 2014. "Prosopis alba. South American Mestique", http://eol.org/pages/695196/names/common_names, accessed on 07/10/2014.

Hrdy, Sarah Blaffer. 1999. *Mother nature: Natural selection and the female of the species*. London: Chatto & Windus.

Hrdy, Sarah Blaffer. 2005. "On why it takes a village: Cooperative breeders, infant needs, and the future", in: Robert L. Burgess & Kevin MacDonald, (eds.), *Evolutionary perspectives on human development*, Thousand Oaks: SAGE Publications, Inc., pp. 167-189.

Hrdy, Sarah Blaffer. 2008. "Cooperative breeding and the paradox of facultative fathering", in: Robert S. Bridges, (ed.), *Neurobiology of the parental brain*, Burlington, MA: Academic, pp. 407-416.

Hrdy, Sarah Blaffer. 2009. *Mothers and others: The evolutionary origins of mutual understanding*. Cambridge, MA: Harvard University Press.

Hudić, Igor et al. 2012. "The Misgav-Ladach method of Cesarean section: A step forward in operative technique in obstetrics", *Archives of Gynecology & Obstetrics*, 286(5): 1141-1146.

Hume, Lynne & Jane Mulcock, (eds.). 2004. *Anthropologists in the field: Cases in participant observation*. New York: Columbia University Press.

Hymes, Dell (ed.). 1972. *Reinventing anthropology*. New York: Random House.

INE, UDAPE & DFID. 2005. *Departamento de Santa Cruz. Estadísticas e indicadores sociodemográficos, productivos y financieros por departamento*. La Paz: INE.

INE. 1992. *Bolivia: Censo nacional de la población y vivienda 1992*. La Paz: Instituto Nacional de Estadística.

INE. 2001. *Bolivia: Censo nacional de la población y vivienda 2001*. La Paz: Instituto Nacional de Estadística.

INE. 2003. *Características demográficas de la población en Bolivia*. La Paz: Instituto Nacional de Estadística.

INE. 2008. *Encuesta nacional de la demografía y salud*. La Paz: Instituto Nacional de Estadística.

INE. 2012. *Censo de población y vivienda 2012*. La Paz: Instituto Nacional de Estadística.

INE. 2014. "Salario minimo nacional," http://www.ine.gob.bo/indice/general.aspx?codigo=41201, accessed on 21/03/2015.

INE. 2015. "La remuneración de las trabajadoras del hogar guarda relación con el salario mínimo nacional y registra aumentos significativos", INE press release, 12/02/2015, http://www.ine.gob.bo/pdf/boletin/NP_2015_14.pdf, accessed on 05/06/2015.

Inhorn, Marcia C. 2006. „Defining women's health: A dozen messages from more than 150 ethnographies", *Medical Anthropology Quarterly*, 20(3): 345-378.

Irving, Andrew. 2005. "Life made strange: An essay on the re-inhabitation of bodies and landscapes", in: Wendy James & David Mills, (eds.), *The qualities of time: Anthropological approaches*, Oxford: Berg, pp. 317-329.

Jacinto, Valter, (ed.). 2014. "Dysphania ambrosioides. Wormseed", http://eol.org/pages/587524/names, accessed on 07/10/2014.

Jackson, Michael. 2010. "No from anxiety to method in anthropological fieldwork", in: James Davies & Dimitrina Spencer, (eds.), *Emotions in the field. The psychology and anthropology of fieldwork experience*, Stanford: Stanford University Press, pp. 35-54.

Jenkins, Janis H. & Martha Valiente. 1994. "Bodily transactions of the passions: *El calor* among Salvadoran women refugees", in: Thomas J. Csordas, (ed.), *Embodiment and experience: The existential ground of culture and self*, Cambridge: Cambridge University Press, pp. 163-182.

Jordan, Brigitte. 1993. *Birth in four cultures. A crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States*. Revised and expanded by Robbie Davis-Floyd. Prospect Heights, IL: Waveland Press, Inc.

Justiniano, M. Joaquín & Todd S. Frederiksen. 1998. *Tarara amarilla. Centrolobium microchaete. Papilionoideae*. Santa Cruz: Proyecto de Manejo Forestal Sostenible (BOLFOR).

Kearney, Michael. 1986. "From the invisible hand to visible feet: Anthropological studies of migration and development", *Annual Review of Anthropology*, 15: 331-361.

King, Helen. 1998. *Hippocrates' woman: Reading the female body in ancient Greece*. London: Routledge.

Kirmayer, Laurence J. & Allan Young. 1998. "Culture and somatisation: Clinical, epidemiological, and ethnographic perspectives", *Psychosomatic Medicine*, 60: 420-430.

Kirmayer, Laurence J. 1992. "The body's insistence on meaning: Metaphor as presentation and representation in illness experience", *Medical Anthropology Quarterly*, 6(4): 323-346.

Kitayama, Shinobo & Hazel Rose Markus. 1994. *Emotion and culture*. Washington, D.C.: American Psychological Association.

Kleinman, Arthur & Byron J. Good, (eds.). 1985. *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*. Berkeley: University of California Press.

Kleinman, Arthur & Joan Kleinman. 2007. [1985]. "Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meanings of pain", in: Margaret Lock & Judith Farquhar, (eds.), *Beyond the body proper. Reading the anthropology of material life*, Durham: Duke University Press, pp. 468-474.

Kleinman, Arthur, Veena Das & Margaret M. Lock, (eds.). 1997. *Social suffering*. Berkeley: University of California Press.

Kleinman, Arthur. 1992. "Pain and resistance: The delegitimation and relegitimation of local worlds", in: Mary-Jo DelVecchio Good, Paul E. Brodwin, Byron J. Good & Arthur Kleinman, (eds.), *Pain as human experience: An anthropological perspective*, Berkeley: University of California Press, pp. 169-197.

Kleinman, Arthur. 1995. *Writing at the margin: discourse between anthropology and medicine*. Berkeley: University of California Press.

Kleinman, Arthur. 1997. "'Everything that really matters': Social suffering, subjectivity, and the remaking of human experience in a disordering world", *The Harvard Theological Review*, 90(3): 315-335.

Kleinman, Arthur. 2006. *What really matters. Living a moral life amidst uncertainty and danger*. New York: Oxford University Press.

Kleinman, Arthur. 2010. "Four social theories for global health", *The Lancet*, 375(9720): 1518-1519.

Koss-Chioino, Joan D., Thomas Leatherman & Christine Greenway, (eds.). 2003. *Medical pluralism in the Andes*. New York: Routledge.

Kothari Uma. 2008. "Global peddlers and local networks: Migrant cosmopolitanisms", *Environment and Planning D: Society and Space*, 26(3): 500-516.

Kwast, Barbara E. 1980. "Comments", in: Hugh Philpott, (ed.), *Maternity services in the developing world.* Proceedings of the Seventh Study Group of the Royal College of Obstetricians and Gynaecologists, p. 251.

Laderman, Carol. 1994. "The embodiment of symbols and the acculturation of the anthropologist", in: Thomas J. Csordas, (ed.), *Embodiment and experience: The existential ground of culture and self*, Cambridge: Cambridge University Press, pp. 183-197.

Lakoff, George & Mark Johnson. 1980. *Metaphors we live by*. Chicago: University of Chicago Press.

Larme, Anne C. & Thomas Leatherman. 2003. "Why *sobreparto*? Women's work, health and reproduction in two districts of southern Peru", in: Joan D. Koss-Chioino, Thomas Leatherman, Christine Greenway, (eds.), *Medical pluralism in the Andes,* New York: Routledge, pp. 191-208.

Larme, Anne C. 1993. "Work, reproduction, and health in two Andean communities (Department of Puno, Peru)," Working Paper No. 5. Production, storage, and exchange project, University of North Carolina Department of Anthropology, Chapel Hill, NC.

Larme, Anne C. 1998. "Environment, vulnerability and gender in Andean ethnomedicine", *Social Science & Medicine*, 47(8): 1005-1015.

Leatherman, Thomas. 1998. "Changing biocultural perspectives on health in the Andes," *Social Science & Medicine*, 47(8): 1031-1041.

Leite, Guilherme K. C. et al. 2009. "Scar endometrioma following obstetric surgical incisions: retrospective study on 33 cases and review of the literature", *São Paulo Medical Journal*, 127(5): 270-277.

Lestage, Françoise. 1999. *La naissance et la petite enfance dans les Andes péruviennes: Pratiques, rites, répresentations*. Paris: L'Harmattan.

Levy, Robert Isaac. 1973. *Tahitians: Mind and experience in the Society Islands*. Chicago: University of Chicago Press.

Lira, Jorge A. 1985. *Medicina andina. Farmacopoea y ritual*. Cusco: Centro de Estudios Rurales Andinos.

Lopez Pila, Esther. 2014. "'We don't lie and cheat like the *Collas* do.' Highland-lowland regionalist tensions and indigenous identity politics in Amazonian Bolivia", *Critique of Anthropology*, 34(4): 429-449.

Low, Setha M. 1994. "Embodied metaphors: Nerves as a lived experience", in: Thomas J. Csordas, (ed.), *Embodiment and experience: The existential ground of culture and self*, Cambridge: Cambridge University Press, pp. 139-162.

Loza, Carmen Beatríz & Wálter Álvarez. 2011. *Sobreparto de la mujer indígena, saberes y prácticas para reducir la muerte materna*. La Paz: INBOMETRAKA.

Loza, Carmen Beatríz, (ed.). 2012. *Las compañeras en el alumbrar. Despejando la penumbra en el arte obstetrico. Bolivia 1837-2012*. La Paz: UNFPA.

Loza, Carmen Beatríz. 2008. *El laberinto de la curación. Itinerarios terapéuticos en las ciudades de La Paz y El Alto*. La Paz: ISEAT.

Loza, Carmen Beatríz. 2013. "¿La disminuión de la mortalidad materna es un simple problema técnico de adecuación cultural?", *Historia, Ciências, Saúde-Manguinhos*, 20(3): 1082-1085.

Lucca Droxkler, Manuel de & Jaime Zalles Asin. 1996. *Ñana mya ñanderëta rupigua. Plantas medicinales de nuestro territorio. Tomo 1: Enfermedades más importantes del Chaco*. La Paz: Editorial Salamandra.

Luerssen, J. Susan. 1993. "Illness and household reproduction in a highly monetized rural economy: A case from the Southern Peruvian Highlands", *Journal of Anthropological Research*, 49(3): 255-281.

Lugo, Alejandro & Bill Maurer, (eds.). 2000. *Gender matters: Rereading Michelle Z. Rosaldo*. Ann Arbor: University of Michigan Press.

Luhrmann, Tanya. 2010. "What Counts as Data?", in: James Davies & Dimitrina Spencer, (eds.), *Emotions in the field. The psychology and anthropology of fieldwork experience*, Stanford: Stanford University Press, pp. 212-238.

Lutz, Catherine A. & Geoffrey M. White. 1986. "The anthropology of emotions", *Annual Review of Anthropology*, 15: 405-436.

Lutz, Catherine A. 1986. "Emotion, thought, and estrangement: Emotion as a cultural category", *Cultural Anthropology*, 1(3): 287-309.

Lutz, Catherine A. 1988. *Unnatural emotions: Everyday sentiments on a Micronesian atoll and their challenge to Western theory*. Chicago: University of Chicago Press.

Lyon, Margot L. & J. M. Barbalet. 1994. "Society's body: Emotion and the 'somatization' of social theory", in: Thomas J. Csordas, (ed.), *Embodiment and experience: The existential ground of culture and self*, Cambridge: Cambridge University Press, pp. 48-66.

Lyon, Margot L. 2005 [1998]. "The limitations of cultural constructionism in the study of emotion", in: Gillian Bendelow & Simon J. Williams, (eds.), *Emotions in social life. Critical themes and contemporary issues*, London: Routledge, pp. 39-59.

Macía, Manuel J., Emilia García & Prem Jai Vidaurre. 2005. "An ethnobotanical survey of medicinal plants commercialized in the markets of La Paz and El Alto, Bolivia", *Journal of Ethnopharmacology*, 97: 337–350.

MacKenzie, Ian Z. 1993. "The unripe cervix and its management for labour induction", *Annals of the Academy of Medicine, Singapore*, 22(2): 151-157.

MacLean Stearman, Allyn. 1989. *Camba and Kolla. Migration and development in Santa Cruz, Bolivia*. Orlando: University of Central Florida Press.

MacLean Stearman, Allyn. 2011 [1976]. *Highland migrant in lowland Bolivia: Regional migration and the department of Santa Cruz*. Public domain reprint. Charleston, SC: Nabu Press.

Magann, Everett F. et al. 1999. "Does an amniotic fluid index of ≤ 5 cm necessitate delivery in high-risk pregnancies? A case-control study", *American Journal of Obstetrics & Gynecology*, 180(6/1): 1354-1359.

Manzoni, Mauricio. 2005. "Santa Cruz de la Sierra, una ciudad que busca su espacio", *Ciudades*, 9: 135-60.

Martin, Laura. 2001 [1987]. *The woman in the body. A cultural analysis of reproduction*. Boston: Beacon Press.

Mathez-Stiefel, Sarah-Lan, Ina Vandebroek & Stephan Rist. 2012. "Can Andean medicine coexist with biomedical healthcare? A comparison of two rural communities in Peru and Bolivia", *Journal of Ethnobiology & Ethnomedicine*, 8(26): 1-14.

Mattingly, Cheryl & Linda C. Garro. 2001. "Narrative as construct and construction", in: Cheryl Mattingly & Linda C. Garro, (eds.), *Narrative and the cultural construction of illness and healing*, Berkeley: University of California Press, pp. 1-49.

Maupin, Jonathan Nathaniel. 2008. "Remaking the Guatemalan midwife: Health care reform and midwifery training programs in highland Guatemala", *Medical Anthropology*, 27(4): 353-382.

Mauss, Marcel. 2007 [1935]. "Techniques of the body", in: Margaret Lock & Judith Farquhar, (eds.), *Beyond the body proper. Reading the anthropology of material life*, Durham: Duke University Press, pp. 50-68.

McNamee, Catherine B. 2009. "Wanted and unwanted fertility in Bolivia: Does ethnicity matter?", *International Perspectives on Sexual and Reproductive Health*, 35(4): 166-175.

Mendenhall, Laura. 2012. *Syndemic Suffering: Social Distress, Depression, and Diabetes Among Mexican Immigrant Women*. Walnut Creek, California: Left Coast Press.

Merleau-Ponty, Maurice. 1962 [1945]. *Phenomenology of perception*, transl. by C. Smith, London: Routledge & Kegan Paul.

Miles, Ann & Thomas Leatherman. 2003. "Perspectives on medical anthropology in the Andes", in: Joan D. Koss-Chioino, Thomas Leatherman & Christine Greenway, (eds.), *Medical pluralism in the Andes,* New York: Routledge, pp. 3-15.

Milton, Kay. 2007. "Emotion (or life, the universe, everything)", in: Helena Wulff, (ed.), *The emotions: A cultural reader*, Oxford: Berg, pp. 61-76.

Minaglia, Steven, Daniel R. Mishell & Charles A. Ballard. 2007. 'Incisional endometriomas after Cesarean section: A case series", *The Journal of Reproductive Medicine*, 52(7): 630-634.

Ministerio de Economía y Finanzas Públicas. 2012. "El Salario Mínimo Nacional sube a Bs 1.000 para la gestión 2012," http://www.economiayfinanzas .gob.bo/index.php?opcion=pdf&id=2397, accessed on 24/07/2014.

Ministerio de Salud y Deportes. 2006a. *Libro marco legal: Seguro Universal Materno Infantil*. La Paz: Ministerio de Salud y Deportes.

Ministerio de Salud y Deportes. 2006b. *Protocolos de de atención materna y neonatal culturalmente adecuados*. La Paz: Ministerio de Salud y Deportes/Organización Panamericana de Salud – Organización Mundial de Salud/Causananchispaj.

Ministerio de Salud y Deportes. 2007. *Articulación de parteras tradicionales al sistema de salud*. La Paz: Ministerio de Salud y Deportes.

Ministerio de Salud y Deportes. 2011. *Reglamento de asignaciones familiares – R.M. 1068*. La Paz: Ministerio de Salud y Deportes.

Molina B. Ramiro & Xavier Albó C. 2006. *Gama étnica y lingüística de la población boliviana*. La Paz: PNUD.

Molinié Fioravanti, Antoinette. 1991. "Sebo bueno, indio muerto: La estructura de una creencia andina", *Bulletin de l'Institut d'Études Andines*, 20(1): 79-92.

Moloney, Anastasia. 2010. "Difficulties hit Bolivia's programme for pregnant women", *Lancet*, 375(9730): 1955.

Morgan, Lynn. 1997. "Imagining the unborn in the Ecuadoran Andes", *Feminist Studies*, 23(2): 322-350.

Murphy-Lawless, Jo. 1998. *Reading birth and death. A history of obstetric thinking*. Cork: Cork University Press.

Nabhan, Ashraf F. 2008. "Long-term outcomes of two different surgical techniques for caesarean", *BJOG: An International Journal of Gynaecology & Obstetrics*, 100(1): 69-75.

Nichter, Mark 1981. "Idioms of distress: Alternatives in the expression of psychosocial distress: A case study from South India", *Culture, Medicine & Psychiatry*, 5(4): 379-408.

Nichter, Mark. 2010. "Idioms of distress revisited", *Culture, Medicine & Psychiatry*, 34(2):401-416.

Nordstrom, Carolyn & Antonius C. G. M. Robben, (eds.). 1995. *Fieldwork under fire: Contemporary studies of violence and survival*. Berkeley: University of California Press.

Okely, Judith. 2009. "Response to Amy Pollard", *Anthropology Matters*, 11(2): 1-4.

Olujic, Maria B. 1998. "Embodiment of terror: Gendered violence in peacetime and wartime in Croatia and Bosnia-Herzegovina", *Medical Anthropology Quarterly*, 12(2): 31-50.

Opinión. 2012. "Censo en Bolivia se inició en 1831", 18/11/2012, http://www.opinion.com.bo/opinion/informe_especial/2012/1118/suplementos.php?id=4094, accessed on 23/04/2013.

Oths, Kathryn S. 1999. "Debilidad: A biocultural assessment of an embodied Andean illness," *Medical Anthropology Quarterly*, 13(3): 286-315.

Pandolfi, Mariella. 2007 [1991]. "Memory within the body: Women's narrative and identity in a Southern Italian village", in: Margaret Lock & Judith Farquhar, (eds.), *Beyond the body proper. Reading the anthropology of material life*, Durham: Duke University Press, pp. 451-458.

Paulson, Susan & Patricia Bailey. 2003. "Culturally constructed relationships shape sexual and reproductive health in Bolivia", *Culture, Health & Sexuality*, 5(6): 483-498.

Paulson, Susan. 2007. "Modern families of modern development cede to alternative bonds in Bolivia's social movements", *Urban Anthropology and Studies of Cultural Systems and World Economic Development*, 36(6): 239-280.

Paz Ballivián, Marcos, (ed.). 2011. *El rol de las parteras tradicionales en el sistema único de salud*. La Paz: UNFPA.

Pedersen, Duncan & Veronica Baruffati. 1989. "Healers, deities, saints and doctors: Elements for the analysis of medical systems", *Social Science & Medicine*, 29(4): 487-496.

Peña Claros, Claudia & Alejandra Boschetti. 2008. *Oriente. Desafiar el mito camba-colla interculturalidad, poder y resistencia en el Oriente boliviano*. La Paz: UNIR.

Peña Claros, Claudia & Nelson Jordán Bazán. 2006. *Ser cruceño en octubre. Una aproximación al proceso de construcción de la identidad cruceña a partir de la crisis de octubre de 2003*. La Paz: Fundación PIEB.

Peña Hasbún, Paula, Rodrigo Barahona Lara, Luis Enrique Rivero Coimbra & Daniela Gaya Ábrego. 2009. *La permanente construcción de lo cruceño. Un estudio sobre la identidad en Santa Cruz de la Sierra*. Santa Cruz de la Sierra: UAGRM/CEDURE/PIEB.

Pennebaker, James W., (ed.). 1995. *Emotions, disclosure, and health*. Washington, D.C.: American Psychological Association.

Pérez, Wilma. 2013. "Cuatro de cada 10 embarazos en el país son recibidos por cesárea," *La Razón*, 07/04/2013, http://www.la-razon.com/index.php?_url=/sociedad/embarazos-pais-recibidos-cesarea_0_1810019072.html, accessed on 19/09/2014.

Phelan, Jo C., Bruce G. Link & Parisa Tehranifar. 2010. "Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications", *Journal of Health and Social Behavior*, 51(1, suppl.): 28-40.

Plath, Oreste. 1981. *Folclor médico chileno: Antropología y salud*. Santiago de Chile: Editorial Grijalbo.

Platt, Tristan. 1986. "Mirrors and maize: The concept of *yanantin* among the Macha of Bolivia", in: John V. Murra, Nathan Wachtel & Jacques Revel, (eds.),

Anthropological history of Andean politics, Cambridge: Cambridge University Press, pp. 228-259.

Platt, Tristan. 1997. "The sound of light: Emergent communication through Quechua shamanic dialogue", in: Rosaleen Howard-Malverde, (ed.), *Creating context in Andean cultures*, New York: Oxford University Press, pp. 196-226.

Platt, Tristan. 2002. "El feto agresivo: Parto, formación de la persona y mitohistoria en los Andes", *Estudios Atacameños*, 22: 127-155.

Platt, Tristan. 2013. "Care and carelessness in rural Bolivia: Silence and emotion in Quechua childbirth testimonies", *Bulletin de l'Institut Français d'Études Andines*, 42(3): 333-351.

PNUD. 2007. *Objetivos de desarollo del milenio. Santa Cruz. Situación actual, evaluación y perspectivas*. La Paz: PNUD.

Pollard, Amy. 2009. "Field of screams: difficulty and anthropological fieldwork", *Anthropology Matters*, 11(2): 1-24.

Pratt, Geraldine & Brenda Yeoh. 2003. "Transnational (Counter)Topographies", *Gender, Place & Culture*, 10(2): 159-166.

Pribilsky, Jason. 2001. "Nervios and 'modern childhood.' Migration and shifting contexts of child life in the Ecuadorian Andes", *Childhood*, 8(2): 251-273.

Psacharopoulous, George. 1993. "Ethnicity, education, and earnings in Bolivia and Guatemala", *Comparative Education Review*, 37(1): 9-20.

Quesada, James. 1998. "Suffering child: An embodiment of war and its aftermath in post-Sandinista Nicaragua", *Medical Anthropology Quarterly*, 12(2): 51-73.

Rabinow, Paul. 1978. *Reflexions on fieldwork in Morocco*. Berkeley: University of California Press.

Ramírez Hita, Susana. 2005. *Donde el viento llega cansado: Sistemas y prácticas de salud en la ciudad de Potosí*. La Paz: Cooperación Italiana.

Rebhun, Linda. 1993. "Nerves and emotional play in Northeast Brazil", *Medical Anthropology Quarterly*, 7(2): 131-151.

Rebhun, Linda. 1994. "Swallowing frogs: Anger and illness in Northeast Brazil", *Medical Anthropology Quarterly*, 8(4): 360-382.

Rebhun, Linda. 1999. *The heart is unknown country: Love in the changing economy of Northeast Brazil*. Stanford: Stanford University Press.

Rémillard, Ulysse et al. 2012. *El cusi. Attalea speciosa. Perspectivas para el desarollo económico local*. Santa Cruz: FCBC.

Rivière, Gilles. 1991. "Lik'ichiri y kharisiri… A propósito de las representaciones del 'otro' en la sociedad Aymara", *Bulletin de l'Institut d'Études Andines*, 20(1): 23-40.

Robillard, Chantal. 2010. "Honourable señoras, liminal campesinas and the shameful other: Re-defining feminities in Bolivia", *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 12(5): 529-542.

Rock, Melanie. 2003. "Sweet blood and social suffering: Rethinking cause-effect relationships in diabetes, distress, and duress", *Medical Anthropology*, 22(2): 131-174.

Ros Izquierdo, José & Isabelle Combès et al. 2003. *Los indígenas olvidados. Los guaraní-chiriguanos urbanos y peri-urbanos en Santa Cruz de la Sierra*. La Paz: Fundación PIEB.

Ros Izquierdo, José. 2004. "Los indígenas olvidados", *Comunicar*, 22: 109-114.

Rosaldo, Michelle Z. 1980. *Knowledge and passion: Ilongot notions of self and social life*. Cambridge: Cambridge University Press.

Rosaldo, Michelle Z. 1984. "Toward an anthropology of self and feeling", in: Richard A Shweder & Robert A. LeVine, (eds.), *Culture theory: Essays on mind, self, and emotion*, Cambridge: Cambridge University Press, pp. 137-157.

Rosaldo, Renato. 1989. *Culture & truth: The remaking of social analysis*. Boston: Beacon Press.

Rublack, Ulinka. 2002. "Fluxes: The early modern body and the emotions", transl. by P. Selwyn, *History Workshop Journal*, 53: 1-16.

Ruby, Jay, (ed.). 1982. *A crack in the mirror: Reflexive perspectives in anthropology*. Philadelphia: University of Pennsylvania Press.

Sanabria Fernández, Hernando. 1986. "Datos para una historia de la cultura en el Departamento de Santa Cruz", in: Francisco Prado & Guadalupe Abrego, (eds.), *Los cruceños y la cultura*, Santa Cruz de la Sierra: Cooperativa Cruceña de la Cultura, pp. 60-121.

Sanabria Fernández, Hernando. 2008. *El habla popular de Santa Cruz*. Santa Cruz de la Sierra: Editorial La Hoguera.

Sandoval, Dunia. 2008. "Condiciones laborales en Santa Cruz", *Periódico Digital PIEB*, 30/04/2008, http://www.pieb.com.bo/sipieb_imprimir.php?idn=2610, accessed on 05/06/2015.

Scarpa, Antonio & Antonio Aimi. 1985. "An ethnomedical study of *soroche* (i.e. altitude sickness) in the Andean Plateaus of Peru," in: Schröder, Ekkehard (ed.), *Ethnobotanik–Ethnobotany. Beiträge und Nachträge zur 5. Internationalen Fachkonferenz Ethnomedizin in Freiburg, 30.11.–3.12.1980*, Springer Fachmedien Wiesbaden GmbH, pp. 209-226.

Scheper Hughes, Nancy & Margaret M. Lock. 1987. "The mindful body: A prolegomenon to future work in medical anthropology", *Medical Anthropology Quarterly*, 1(1): 6-41.

Scheper-Hughes, Nancy & Carolyn Sargent, (eds.). 1998. *Small wars: The cultural politics of childhood*. Berkeley: University of California Press.

Scheper-Hughes, Nancy. 1992. *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.

Scholte, Bob. 1972. "Toward a reflexive and critical anthropology", in: Dell Hymes, (ed.), *Reinventing anthropology*, New York: Random House, pp. 430-458.

Sikkink, Lynn. 2001. "Home sweet market stand: Work, gender and getting ahead among Bolivian traditional medicine vendors", *Anthropology of Work Review*, 22(3): 1-6.

Sikkink, Lynn. 2010. *New cures, old medicines: Women and the commercialization of traditional medicine in Bolivia*. Belmont: Wadsworth/Cencage Learning.

Silverstein, Merrill & Xuan Chen. 1996. "Too much of a good thing? Intergenerational social support and the psychological well-being of older persons", *Journal of Marriage and Family*, 58(4): 970-982.

Silverton, Louise. 1993. *The art and science of midwifery*. New York: Prentice Hall.

Sistema de las Naciones Unidas en Bolivia & UDAPE. 2011. *El camino hacia el desarollo en Santa Cruz*. La Paz: SNUS & UDAPE.

Skultans, Vieda. 1998. *The testimony of lives: Narrative and memory in post-Soviet Latvia*. London: Routledge.

Smith-Oka, Vania. 2009. "Unintended consequences; Exploring the tensions between development programs and indigenous women in Mexico in the context of reproductive health", *Social Science & Medicine*, 68(11): 2069-2077.

Smith-Oka, Vania. 2012. "An analysis of two indigenous reproductive health illnesses in a Nahua community in Veracruz, Mexico", *Journal of Ethnobiology and Ethnomedicine*, 8(33): 1-10.

Smith-Oka, Vania. 2014. "Fallen uterus: Social suffering, bodily vigor, and socials support among women in rural Mexico", *Medical Anthropology Quarterly*, 28(1): 105-121.

Spangler, Sydney A. 2011. "'To open oneself is a poor woman's trouble': Embodied inequality and childbirth in south-central Tanzania", *Medical Anthropology Quarterly*, 25(4): 479-498.

Stacey, Judith. 1988. "Can there be a feminist ethnography?" *Women's Studies International Forum*, 11(1): 21-27.

Stefanoni, Pablo. 2013. "¿Por qué 'disminuyó' la población indígena?", *Página siete*, http://www.rebelion.org/noticias/2013/8/172152.pdf, accessed on 01/07/2014.

Stoller, Paul. 1984 "Sound in Songhay cultural experience", *American Ethnologist*, 11(3): 559-570.

Strathern, Andrew J. 2010 [1996]. *Body thoughts*. Ann Arbor: The University of Michigan Press.

Strong, Thomas. 2000. *Expecting trouble. The myth of prenatal care in America*. New York: University Press.

Suárez, María Matilde. 1974. "Etiology, hunger, and folk diseased in the Venezuelan Andes", *Journal of Anthropological Research*, 30(1): 41-54.

Symonds, E. Malcolm & Ian M. Symonds. 2004. *Essential obstetrics and gynaecology*. Edinburgh: Churchill Livingstone.

Tapias, Maria & Xavier Escandell. 2011. "Not in the eyes of the beholder: Envy among Bolivian migrants in Spain", *International Migration*, 49(6): 74-94.

Tapias, Maria. 2006. "Emotions and the intergenerational embodiment of social suffering in rural Bolivia", *Medical Anthropology Quarterly*, 20(3): 399-415.

Tapias, Maria. 2015. *Embodied protests: Emotions and women's health in Bolivia*. Urbana: University of Illinois Press.

Taussig, Michael. 1987. *Shamanism, colonialism, and the wild man: A study in terror and healing*. Chicago: University of Chicago Press.

Tedlock, Barbara. 1991. "From participant observation to the observation of participation: The emergence of narrative ethnography", *Journal of Anthropological Research*, 47(1): 69-94.

Teresi, Dick. 1994. "How to get a man pregnant", *New York Times*, 27/11/1994, http://www.nytimes.com/1994/11/27/magazine/how-to-get-a-man-pregnant.html, accessed on 25/07/2014.

Tiefer, Leonore. 1994. "The medicalisation of impotence: Normalising phallocentrism", *Gender & Society*, 8(3): 363-377.

Toro, Edgar. 2014. "Acuerdo permite subir el salario mínimo de Bs 1.200 a Bs 1.440", *La Razón*, 22/04/2014, http://www.la-razon.com/index.php?_url=/economia/Aumento-acuerdo-permite-salario-minimo_0_2038596165.html, accessed on 21/03/2015.

Torres, Juan. 2001. *Estrategia y plan de acción de la biodiversidad para el departamento de Ayacucho como base de su desarrollo sostenible*. Lima: Comunidad Andina Banco Interamericano de Desarrollo.

Tousignant, Michel. 1984. "*Pena* in the Ecuadorian Sierra: A psychoanthropological analysis of sadness", *Culture, Medicine and Psychiatry*, 8(4): 381-398.

Tousignant, Michel. 1989. "Sadness, depression and social reciprocity in Higland Ecuador", *Social Science & Medicine*, 28(9): 899-904.

Tremayne, Soraya. 2001. "Introduction", in: Soraya Tremayne, (ed.), *Managing reproductive life: Cross-cultural themes in fertility and sexuality,* New York: Berghahn Books, pp. 1-24.

UDAPE. 2004. *Caracterización de la exclusión de la salud en Bolivia*. La Paz: UDAPE.

UNFPA & FCI/Bolivia. 2011. *Mujeres indígenas: Salud y derechos*. La Paz: UNFPA/AECID.

United Nations. 2003. *The United Nations demographic yearbook*. New York: United Nations.

Vertovec, Steven, (ed.). 2010. *Anthropology of migration and multiculturalism: New directions*. London: Routledge.

Vilar, Roberto & Carlos Samaniego. 1981. *Sistema de contratación y migración laboral en Santa Cruz, Bolivia*. La Paz: Proyecto Migraciones y Empleo Rural y Urbano.

Wachtel, Nathan. 1994. *Gods and vampires: Return to Chipaya*, transl. by C. Volk. Chicago: University of Chicago Press.

Wądołowska, Anna. 2010. "Pluralizm medyczny a zdrowie reprodukcyjne kobiet w Regionie Indian Purépecha w Meksyku", in: Danuta Penkala-Gawęcka,

(ed.), *Nie czas chorować? Zdrowie, choroba i leczenie w perspektywie antropologii medycznej*, Poznań: Biblioteka Talgate, pp. 51-66.

Waldmann, Adrián. 2008. *El hábitus camba. Estudio etnográfico sobre Santa Cruz de la Sierra*. Santa Cruz de la Sierra: Editorial El País.

Watson, David & James W. Pennebaker. 1991. "Situational, dispositional, and genetic bases of symptom reporting", in: J. A. Skelton & Robert T. Croyle, (eds.), *Mental representations in health and illness*, New York: Springer-Verlag, pp. 60-84.

Weber, Katinka. 2012. "Chiquitano and the multiple meanings of being indigenous in Bolivia", *Bulletin of Latin American Research*, 32(2): 194-209.

WHO, UNICEF, United Nations Population Fund & The World Bank. 2014. *Trends in maternal mortality: 1990 to 2013*. Geneva: WHO.

WHO. 2006a. "Mortality country fact sheet 2006: Bolivia", http://www.who.int/whosis/mort/profiles/mort_amro_bol_bolivia.pdf, accessed on 13/12/2011.

WHO. 2006b. *Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice*. Geneva: WHO.

WHO. 2010a. *International statistical classification of diseases and related health problems, tenth revision. Vol. 1: Tabular list. Vol. 2: Instruction manual*. Geneva: WHO.

WHO. 2010b. *Monitoring Emergency Obstetric Care: A Handbook*, *vol. 30*, http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf?ua=1, accessed on 21/03/2015.

WHO. 2014. *Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division*, http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1, accessed on 25/04/2015.

WHO. 2015. "Maternal, newborn, child and adolescent health: Maternal and perinatal health", http://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/, accessed on 04/04/2015.

WHO/UNICEF. 1990. "Revised 1990 estimates of maternal mortality: A new approach by WHO and UNICEF", http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.11.pdf, accessed on 13/12/2011.

Widmark, Charlotta. 2003. *To make do in the city: Social identities and cultural transformations among urban Aymara speakers in La Paz*. Uppsala: Uppsala University Press.

Wikipedia contributors. 2015. "Santa Cruz de la Sierra", *Wikipedia, The Free Encyclopedia*, http://es.wikipedia.org/w/index.php?title=Santa_Cruz_de_la_Sierra&oldid=81263569, accessed on 10/04/2015.

Williams, Simon & Gillian Bendelow. 2002 [1998]. *The lived body. Sociological themes, embodied issues*. London: Routledge.

Williams, Simon. 2001. *Emotion and social theory*. London: SAGE Publications.

Wing, Deborah A. 2011. "Cervical ripening and induction of labor in women with a prior cesarean delivery", *UpToDate Inc.*, http://www.uptodate.com/

contents/cervical-ripening-and-induction-of-labor-in-women-with-a-prior-cesarean-delivery, accessed on 17/07/2015.

Wolf, Naomi. 2002. *Misconceptions: Truth, lies and the unexpected on the journey to motherhood*. London: Vintage.

Wulff, Helena. 2007. "Introduction. The cultural study of mood and meaning", in: Helena Wulff, (ed.), *The emotions: A cultural reader*, Oxford: Berg, pp. 1-16.

Yarris, Kristin Elizabeth. 2011. "The pain of 'thinking too much': *Dolor de cerebro* and the embodiment of social hardship among Nicaraguan women", *Ethos*, 39(2): 226-248.

Yon Leau, Carmen. 2000. *Hablan las mujeres andinas: Preferencias reproductivas y anticoncepción*. Lima: Movimiento Manuela Ramos.

Zalles Asin, Jaime. 2006. "Bolivia, un ejemplo de mutua exclusión cultural en salud con dramáticas consecuencias. Un desafío que no puede esperar", in: Gerardo Fernándes Juárez, (ed.), *Salud e interculturalidad en América Latina. Antropología de la salud y crítica cultural*, Quito: Abya-Yala, pp. 389-404.