

Scars of Nation: Surgical Penetration and the Ecuadorian State

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R E S U M E N

En Ecuador, las mujeres de clase media, y cada vez más las de clase obrera, pagan gustosamente por tener una cicatriz. Las cesáreas que se hacen en las clínicas privadas les deja una cicatriz que es la marca de aquellas mujeres que no están sujetas al uso indigno de los devaluados servicios de salud pública. No es afirmar la ciudadanía per se lo que estas mujeres buscan con estas cicatrices, ya que en Ecuador la ciudadanía es particularmente denigrada en el ámbito médico. Esta cicatriz es más bien el signo de la posibilidad de diferenciarse de las masas de mujeres gobernadas, quienes necesitan hacer demandas ciudadanas de servicios sociales de las instituciones del Estado. Las cicatrices, y los cuerpos que las portan, ejercen una relación racializada con la nación. Los cuerpos morenos pueden aguantar el parto vaginal dentro de la disciplina de las maternidades públicas. Cuando las mujeres pagan por cesáreas, las cicatrices privadas las hacen más blancas y valiosas para la nación. Después de todo, no le han quitado nada al Estado. [Ecuador, genero, salud, política, raza]

A B S T R A C T

In Ecuador, middle-class women, and increasingly more working-class women, eagerly pay to be scarred. Cesarean sections carried out in private clinics leave a lateral scar—the mark of women not subject to the indignities of devalued public medical services. It is not citizenship per se that these women are after with their scars, since in Ecuador, citizenship, especially in the medical realm, is denigrated. Instead, the scar is a sign of a woman's ability to remain distinct from the governed masses who need to make citizenship claims for social services on state institutions. Scars and the bodies that carry them enact a racialized relationship to the nation. Browner bodies can withstand vaginal birth within the disciplines of public maternity care. When women pay for

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cesarean sections, the private scars make them whiter and more worthy of the nation. After all, they have not taken anything from the state. [Ecuador, gender, health, politics, race]

FROM 2002 to 2005, prisoners across Ecuador staged a series of visceral protests. In 2002, 34 men crucified themselves in Guayaquil's largest penitentiary, *Penitenciaría del Litoral* (Garces 2010). Three years later, in the same prison, two women sewed their lips together with black thread to mark their hunger strikes, while others made banners written in their own blood (BBCNews 2005). These nationally publicized acts were a protest against the policy of preventative incarceration; they were also carried out to demand that the Ecuadorean Congress would authorize more resources to alleviate the subhuman conditions of the overflowing prisons, some of which had no electricity or running water. The prisoners used a corporeal and particularly Catholic idiom of suffering to publically demand better care and treatment from state institutions (Garces 2010). Despite their many kinds of protests to denounce their abject situation, including forms of self-mutilation, only the act of self-crucifixion generated a national sense of broader charitable goodwill, which altered their care and treatment at the hands of prison authorities.

This article describes another corporeal practice that constituted care relations between bodies and the state in Ecuador in the early 2000s, before Rafael Correa's postneoliberal call for a citizen's revolution, which promised to increase social welfare provisioning. This practice of cesarean sections carried out in private clinics marked the relation of the recipient's body to the nation through scars. These scars instantiated a very different set of relations than the relations made between the nation and the prisoners when they crucified themselves. The self-mutilated prisoners used their abject, bloodied, and cut bodies to publically demand more care from the state. Cesarean sections and their attendant scars did something else. Less audibly, and less visibly, this surgical cut indexed a woman's sociomaterial attempt to gather enough resources to seek and receive care in a private clinic, thus avoiding public medical facilities. The scar was a result of her ability to cultivate a corporeal state of worthiness within private care, precisely because she did not take resources from state institutions. This worthiness constituted corporeal class relations in Ecuador, inseparable from political and race relations. The scars received by these women, at least in the early 2000s, made them whiter.

My analysis of the political, corporeal relations mapped by cesarean section scars in Ecuador is inspired by social science scholarship on the relationship between the body and political status, which is influenced by the work of Michel Foucault, especially in respect to neoliberal economic transformations (Biehl 2005; Briggs and Mantini-Briggs 2003; Petryna 2002; Rose and Novas 2005). As

Foucault and other scholars have demonstrated, scientific medicine worked as such a powerful tool for governance in postenlightenment Europe precisely because medicine was deemed a solely “technical” means by which to manage “apolitical” biology, which embedded the biological body within increased regimes of surveillance (Foucault 1990; Gordon 1988). These scars also complicate this literature, which is primarily based on North American and European cases with a specific history of relations between citizens and the nation state.

While the crucifixions and the cesarean sections might have seemed like demands for and retreats from a retracting welfare state, they were also shaped using templates of charitable and paternalistic practices that stretch back to well before the late 19th century. This article, then, begins by tracing the particular historical configuration of political and economic status and bodily states in Ecuador. My analysis of the relationship of bodies to citizenship and the political economies of nations ends with an argument for the specificity of bodies themselves. The body, even the biological body, is specific, historical, and materially contingent in both Latin America and in North America. Instead of one, timeless universal biology we might think in terms of what Margaret Lock calls “local biologies” (Lock 1993). While social scientists located in North America and Western Europe must continue to press their case for malleable bodies with particular histories (Duden 1991; Haraway 1991), this is already how many Ecuadorians live the body. This malleability is especially acute with regard to race, which can be shifted between the poles of Indian and white, with whiteness the often-unquestioned goal (Weismantel 2001).

My analysis concentrates on the constitution of race, especially whiteness, through the “crucial economic and moral significance of care relations, in which life chances are forged” (Biehl and Eskerod 2007:110). In Ecuador, the collective goal of *blancamiento* (whitening) is reinscribed within private gynecological care, even though race in the Andes is not often spoken about through the idiom of whitening, but through cultivation practices of education, clothing, language, and occupation (Pitt-Rivers 1973; Wade 1993; Cadena 1995; Colloredo-Mansfeld 1998). By extending these cultivation practices to include medical care as another means to mark and transform race, I am making a more general point about the malleability of material reality. This link brings the Andean race literature together with science technology studies working to provincialize North American tendencies to mark a divide between nature and culture, as well as North American assumptions about the universality and fixity of biological processes (Haraway 1991; Latour 1993; Mol 2002; Lock and Nguyen 2010).

In Ecuador, medical care makes race. Public health services in Ecuador, as in much of the Andes, were developed to manage and intervene upon poor and indigenous subject populations, especially supposedly hyperfertile indigenous women (Clark 1998; Ewig 2010). At least until Correa’s administration, which began in

2007, public health care was experienced as inferior care. Care received in private clinics was superior, and signaled a female patient's ability to be cared for outside of the state's purview. Although these care relations were carried out in private clinics, they participated in Ecuador's longstanding state project of whitening the nation (Larson 2004). In other words, these private scars produced in unregulated medical clinics furthered a national project. The fact that the scars were private, hidden under clothing, only seen by their bearer, or possibly a few intimates (family members, including children), paralleled the consumptive medical relations that were sought outside public surveillance. Private scars mark a private set of personal relationships that while furthering paternalistic relations also participate in the neoliberal privatization of the political into the domestic sphere.¹ Through scarification, the body is transformed into a different political, economic, and racial state, testifying to its bearer's past experience of being cut and marked within the intimate relations of private medical care (Seremetakis 1994).

I came to the cesarean section scar by accident, through an interest in in vitro fertilization (IVF), another invasive female gynecological procedure, which in Ecuador is practiced solely in private clinics. Throughout intervals from 1998 to 2007, I conducted ethnographic research and observation in nine of Ecuador's private IVF clinics and in patients' homes, in the capital, Quito, and Guayaquil, the country's largest and most commercial city. Throughout this research, especially in a year of intensive fieldwork in 2002–2003, I observed female infertility patients, their male partners, IVF practitioners, the mostly male physicians, mostly female laboratory biologists, and staff and gamete donors at IVF clinics. I conducted over 130 formal open-ended interviews with IVF patients, practitioners, and gamete donors, as well as local Catholic priests, lawyers, bio-ethicists, and public health officials (see Roberts 2007, 2009, 2012). I followed patients into their homes while they recovered and rested after the IVF process, and in subsequent years visited several of these women again. During these encounters the cesarean section was a ubiquitous topic of discussion, connected to larger concerns participants had about the inadequacies of public health care and their efforts to be cared for in private. Also, ubiquitous was their linkage of infertility to the dysfunctional, civilized bodies of whiter women contrasted with the healthier, "primitive" bodies of Indian and black women.

The middle-class women I encountered in Ecuador, both inside and outside the clinics, had almost all undergone some sort of private, invasive surgery (e.g., laparoscopy, or fibroid removal), or had had intensive hormonal treatments for female functioning gone awry. When these women did become pregnant, the quantity of interventions necessary to prevent the failure of the whiter female body seemed to grow exponentially, priming these women for their inevitable and anticipated cesarean section at the end of pregnancy. In IVF clinics, nearly all the women I met undergoing IVF assumed that if they became pregnant they

would give birth via cesarean section. This was unsurprising, given that as a region Latin America has some of the highest cesarean section rates in the world, largely taking place in private hospitals and clinics. I met no patient who became pregnant through IVF who had a vaginal birth.

Within this history of devalued public health care in Ecuador, the cure for reproductive dysfunction lay in private gynecological care. The appeal of private care was linked to the mystique of the modern, but also central to its appeal was the quality and quantity of investment in a patient's care, in the form of money raised and spent, and postpartum bed rest surrounded by a caring staff or relatives. These relations resonate with nonbureaucratic relations, like those found on haciendas, but they are not "premodern." What is described here is a "complicated paternalism" with historical resonances that are constantly replayed through political and economic transformation (Biehl and Eskerod 2007:157). In millennial Ecuador, both in vitro fertilization and cesarean section exemplified desirable care relations and forms of governance that marked patients not as governed proletariat patients, mistreated in public medical facilities, but as privileged intimates of their physicians. Of the two procedures, however, only cesareans left a scar that manifested the bearer's privileged relation to the nation.

In the Cut

In Quito, I often stay with Marta in her multigenerational compound. Marta has five adult children and six grandchildren. All of her children were born vaginally; all of her grandchildren were born through cesarean section. One evening in 2002, one of Marta's sons, Esteben, and his wife Keti were over for their nightly visit. We spent the evening talking about Keti's upcoming cesarean section. I asked Keti why her doctor said she needed a cesarean. Keti explained that her doctor had told her that her pelvis was not correctly shaped: "He said I'd get to seven centimeters. And my labor will stop. I will never get to ten". Then, almost blithely, she added, "Its all *plata* (money). They just want to charge more." Esteben nodded, explaining how the doctor did not think Keti would progress, and would not want to wait long. "He wants it to take ten minutes. Money and time. Money and time."

We started to speculate about how much money Keti's doctor made per month. Esteben estimated that he made at least US\$4,000. Marta estimated US\$20,000. I added that it must be a lot since every middle-class woman I had met in Ecuador had had a cesarean section. Esteben agreed, but Marta protested. She reminded us that Maria, her long-term *empleada* (domestic servant), had told us the day before about her daughter Rosa's birth at the public maternity hospital. She did not have a cesarean section. Esteben turned to Marta, exhorting her excitedly, "Mama! Mama! Middle class! Middle class!" Marta demurred. As the daughter of a migrant from the rural and indigenous highlands, Rosa was certainly not middle

class. Ketí remembered that a friend had had a vaginal birth by accident. She was waiting to be prepped for her “medically necessary” cesarean, in fact was “begging for one,” but the baby was born before they could begin the surgery. She was the only friend or relative that any of them could think of who had had a vaginal birth, and it was by accident. Esteben added, “This is the custom here, caesareans.” Then he explained, rather offhandedly, what I came to hear repeatedly in Ecuador—that women can only undergo two cesarean sections: “Their uterus might burst with another.” Cesarean section, then, serves as a form of birth limitation, noteworthy in a nation where tubal ligation has never been as ubiquitous as elsewhere in Latin America.

A short time later Ketí and I were having our dinner of coffee and rolls in the kitchen. Esteben barreled into the room followed by Marta. They had been arguing in the living room. Esteben was in a rage about one of the family dogs: “My mother is so generous she is giving the dog for surgery.” Marta had told her niece, Esteban’s cousin, that she could operate on the male dog, Tulo. The niece was in veterinarian school and the surgery would allow her to pass her graduation exam. When I asked what the surgery was for, Esteben repeated “For nothing! For nothing! Just to do it in front of the doctors!” To which Marta responded that the surgery was to “sterilize Tulo,” making Esteben explode all over again: “I feel bad for the dog. Bad for the dog! How he will suffer!” Marta countered that Cuca, the female dog, was pregnant again. “She is old and the puppies she has keep getting smaller and smaller. She shouldn’t have any more puppies.” Esteben was indignant. He asked his mother, “Is this a *casa social*?” (a social house, implying open boundaries, a brothel). “Here! Have my father! Have my brother-in-law! Do surgery on them! My mother is so generous!” Marta seemed nonplussed by her son’s outburst: “Why should I have to pay for what I could get for free.” Nearly spitting in anger, Esteben asked her, “What would have happened if Esteben Sr., [his father], had a vasectomy?” Marta and Ketí both turned away from Esteben. Apparently they were done with the conversation, so I asked them about female sterilization versus vasectomy. They both thought this was a funny question. Laughing, they agreed that in Ecuador men do not get vasectomies. Even though Marta had heard that “it’s much safer for men than women.”

A few days later I asked Marta about the surgery and she told me that Esteben had called his cousin’s father and convinced him to forbid his daughter from using Tulo for the surgery—a frustrating aftermath to the evening. My room was up on the roof terrace, next to the dogs, and each consecutive litter of Cuca’s puppies was smaller and more piteous. I was chagrined that Esteben had prevailed over his mother, who lived with and cared for the dogs. For once it had seemed that a male body was targeted for intervention out of concern for a female body.

After reading my notes from that night, I realized how we had stayed on topic the whole evening, even though we changed sexes and species. In this case sex

mattered more than species. We moved from the discussion of Keti's inevitable and uncontroversial surgical invasion, which reinforced her status as a middle-class mother, responsibly opening herself to the doctor's modern agenda ("money and time, money and time"), which guaranteed the health of her child, to a debate about the surgical violation of a male dog that would prevent his ability to further impregnate Cuca. For Esteben, it seemed that his mother's pimping of Tulo to further his younger female cousin's professional ambitions placed the masculinity of all males, including his father's, under siege. By calling his mother's home a *casa social*, Esteben implied its borders were open to the promiscuous and indiscriminate invasion of a surgical knife that targeted the sanctity of the male body of any species. He was unconcerned about Keti's surgery, which ultimately limited her fertility rather than his. Keti and Cuca were the proper surgical subjects—female.

While Keti and Marta did not share in the perception of the dog's threatened masculinity, they, like Esteben, did share in the notion of class- or race-based motherhood achieved through cesarean section, which was necessary for the failed bodies of middle-class women, but not for men. As this account of Keti's cesarean and Tulo's narrowly escaped sterilization illustrates, in Ecuador, middle-class women's bodies are penetrated and controlled through operations and drugs, while men's bodies must remain capable of producing a large family, outside the iron cage of rational family planning and fertility control, given that bodily invasion is frequently coded as emasculating (Gutmann 2003; Cohen 2004). Elite men's bodies remain potent while cesarean section disciplines and limits elite women to two children.

It would have been unlikely that Marta and Keti would have linked their sexed fate to that of a dog, however, since most middle-class urban Ecuadorian women found comparisons with animals odious, and redolent of association with Indians, who birth "naturally" without surgery. This association also emerged in my observations in gynecological clinics. Linda, a laboratory biologist at a private full-service gynecological clinic in Quito, convinced the director to allow her to watch a woman attempt a "*parto normal*," a vaginal birth, a rare event there. For Linda, who had had children via cesarean section, the experience was horrifying and traumatic, like "watching torture." The woman screamed explosively and acted like "an, animal, like a savage wild woman, like an *auca*" (which is less than human, a jungle dweller). In the end, the woman had a cesarean section anyway. Linda asked me rhetorically, "What was the point?" By attempting a *parto normal* this woman became animal, savage, tied to darkness, Indianness, and blackness. It is poor urban women, Indians, rural campesinas, or black women, who are portrayed as able to give birth vaginally, in public hospitals or outside hospitals altogether, sometimes in the fields where they labor. This distinction between kinds of birth is codified in advertisements like those at Quito's most well-respected and expensive private hospital, the Hospital Metropolitano, which, in the early 2000s, advertised

both “traditional births and cesareans”; in effect, it was an offer of a choice between an Indian or a white birth.

Ecuador’s Economy of Corporeal Care

Much has changed in the region with the invigoration of the left in Brazil, Bolivia, and Venezuela in the early 2000s, and then in Ecuador with the election of Rafael Correa in 2007. I have not conducted field research since the year he took office to see firsthand how his administration has affected public and private medical care and the relations between the two. From scholarly and press accounts it seems that at least some social welfare funds are reaching their intended destinations and there has been a measurable increase in the use of public institutions (Olson 2009). Correa has also attempted to “modernize” state institutions by dismantling long-standing paternalistic benefits, such as bonuses and Christmas presents to the police force, whose attempted rebellion in October 2010 was a protest to defend their privileged status in relation to the state. These changes have taken place in the context of Correa’s alarming use of strong-arm attempts to shut down political participation and the independent press. Correa argues there is no need for social movements separate from, and in opposition to, the state. Through his formation of a “citizen’s revolution,” he argues that previously disenfranchised groups have been included and now receive the necessary recognition and care as “Ecuadorians,” not as privileged populations. Correa contrasts his form of governance to the “long, sad neoliberal night” that came before his ascension to the presidency (Torre 2011:28).

Correa’s battle against both neoliberalism and paternalism epitomizes the complicated nature of political economic relations in Ecuador before Correa, which many scholars characterized only as neoliberal. Neoliberalism tends to be a label for an antistatist, promarket ideology, which seeks to limit the scope and activity of state governance and state responsibility for social programs. Neoliberalism has also been linked to new forms of subjectivity that posit individuals as self-reliant, educated, entrepreneurial consumers who need very little from state institutions (Gill 2000; Ong 2006). In the 1980s and 1990s, neoliberal economic policy became a force to contend with throughout Latin America. A consensus around the adoption of neoliberal economic models took hold quickly among many Andean state planners and economists, including those in Ecuador (Conaghan et al. 1990; Portes and Hoffman 2003). Policies in Ecuador and other Andean nations included austerity measures, the fall of trade barriers, increased NGO responsibility for social programs, and intensified calls for citizen participation and responsibility for their own social welfare (Paley 2001; Valdivia 2003; Wilson 2008).

But the exclusive use of neoliberalism to explain social welfare provisioning, or the lack of it in Ecuador before Correa, misrecognized the local reality of a nation

that had “never had the resources of a Keynesian welfare state” (Sharma and Gupta 2006). State-funded welfare programs emerged in the late 19th century and early 20th century in Europe and Latin America as a means to mitigate the economic and social dislocations of industrialization, serving a more expansive and inclusive role than the charitable religious organizations that came before them (Segura-Ubiergo 2007). The retrenchment of state welfare was obvious then, in the United Kingdom and the United States, as well as in Latin American nations like Mexico, Chile, and Costa Rica, where relatively robust forms of state-funded health care and social security were dismantled under the banner of neoliberal, structural adjustment (Mesa-Lago 2008). In the majority of Latin American nations, however, including Ecuador, social welfare programs barely got off the ground before developed-world economic advisors began campaigning for their termination in order to alleviate debt (Castro and Singer 2004; Biehl 2005; Zulawski 2007).

For a short time, with the Ecuadorian oil boom in the late 1970s and early 1980s, when state coffers were temporarily flush, it looked like the promise and dream of a welfare state might finally be born. Indeed, a new and progressive set of guaranteed rights to health care for all citizens was passed during this time (Gerlach 2003). But these promised rights were never delivered. With the oil bust in the 1980s, education and health services continued to remain underfunded. Even while market ideology debates began to inform social policy, state institutions had not “rolled back” their social service provisioning: they had never provided them in the first place (Segura-Ubiergo 2007). Additionally, the Ecuadorians who sought private medical care did not become individualized, self-educated consumers/patients, and they bore little resemblance to Indians or prisoners who attempted to negotiate care and recognition from the state, as well as from private and philanthropic institutions like NGOs. In fact, private gynecological patients’ efforts could be understood as produced as a form of opposition to those kinds of public demands for state care.

In Ecuador, separations or privatizations of elites from state institutions and services are not only indicative of recent neoliberal economic reform but continued a precedent of ostensible separation set in motion at the birth of the nation state, in which elites formed the state but wrote themselves out of its governance (Guerrero 1997, 2003; Krupa 2010). Dominated Indian subject populations, whose lives were administered on private haciendas, became the governed. In the early 2000s, the middle and upper classes continued to maintain their historic distance from state governance by living in gated communities, hiring private security forces, and traveling in private cars, along with sending their children to private schools and paying out of pocket for health care. This co-constitution of the public and private administration of populations provides a framework for understanding my ethnographic material concerning private gynecological interventions in Ecuador.

In millennial Ecuador, when Indians demanded recognition and inclusion by the state, especially with the 1998 uprising, citizenship became even more devalued.

The hierarchal private domain beckoned, where patients were cared for neither as citizens, nor as subjugated Indians or peons in return for labor, but as favored family members, especially daughters. Patients could call doctors and other staff at all times of the day or night and receive in-depth attention. In the clinics patients called physicians “mi papa científico” and physicians called patients “mi hija” (my daughter). These women did not want citizenship or recognition from the state. Their bodies, which were cared for outside the state, registered their privileged relation to the nation. To pay for private care, such as cesarean sections, women and their families sought loans from friends and family, in a form of hierarchical paternalistic care instead of state welfare.²

Private Patients

Ana became pregnant through an IVF cycle in a private clinic in Guayaquil, Ecuador. Unlike every other woman I met in Ecuador’s IVF clinics, she thought that maybe she would try to have a parto normal, a vaginal birth, for her IVF baby. But none of her friends had had normal births, and, ultimately, Ana was convinced to have a cesarean section by her mother, who warned her she would not be able to withstand the pain, and by her doctor, who explained that a normal birth was too risky for such a precious and expensive IVF baby. So, in addition to the expense of IVF she saved even more money to have her baby in a private clinic where cesarean sections are guaranteed. Six years later Ana had another baby, this time without IVF, but with another cesarean section—the scar made fresh again. She explained that when she tells her IVF son, Isaac, his origin story she points to the scar under her clothes and says, “This is where they removed you.” Then Isaac would ask, “When I was with you in your belly?” Then pointing to her scar again, she tells him, “I suffered a lot to get you in there. We waited a long time wanting to have a baby and the doctor put you there.”

Ana made her cesarean section scar perform a double duty—standing for her surgical birth and for IVF—what it took to get Isaac into her belly, as well as out. This story, told to an IVF child, was similar to the stories other parents told their IVF babies (as well as relatives), about the struggle to make them. One woman told me she had all her IVF receipts saved so that she could show them to her child one day in order to demonstrate how much she had wanted him. Ana’s scar served as another kind of receipt, written on her body. She could point to it under her shirt when she wanted Isaac to hear about her efforts and suffering, and the resources she mobilized for both the IVF cycle and the cesarean section, which allowed her both to conceive him and avoid a public hospital.

Most urban Ecuadorian women are well aware of the radical differences between public and private birth. The cesarean section rate in private clinics is almost 90 percent while it is less than 20 percent in public hospitals and clinics, and as

low as 8 percent in rural areas. While the overall rate is lower than some other Latin American nations, like Brazil, Venezuela, Chile, and Argentina (Althabe et al. 2004), it is still considered a very high level of surgical intervention overall. Obtaining the scar can cost anywhere from US\$300 to US\$1,500, making it something that nearly everyone can at least aspire to afford. Like Ketí, the vast majority of middle-class women I spoke with did not know a single woman of their generation who had had a parto normal, except their *empleadas*. The scar of surgical invasion conferred their difference from their browner, poorer *empleadas* who could become pregnant and give birth so easily, and who used public medical care.³

Women across classes, inside and outside of infertility clinics, shared tales of the horrors that would await them and their babies if they gave birth in a public hospital. Consuelo, the poorest IVF patient I encountered during the research, told me she was terrified of giving birth in Guayaquil's public maternity hospital. While pregnant with IVF twins in 2003, she had begged her husband, Jorge:

Please don't put me in there. I don't want to go, for all the things you hear sometimes. Those babies are born dead. I was traumatized by this. We made all the effort and I was put in the semipensionada.

In order to attract more patients, the public maternity hospital had divided itself into three different service classes. It was still possible to have a low or no cost birth, but patients could also opt for a *pensionado* (full-service), or *semipensionado* (half-service) birth. She and Jorge saved and went into debt for the semipensionado, which automatically included a cesarean section. In Ecuador, women with means assumed they would never step foot in a public medical facility to give birth, while women with less resources, like Consuelo, made concerted efforts to avoid them.

This privatization of the public maternity hospital took place in the early 2000s, when Ecuador had some of the leading indicators of poor health in Latin America (Crandall et al. 2005); only 2 percent of Ecuador's annual budget was allocated for public health, with only Haiti spending less (Vos et al. 2004). The WHO estimated that in 2002, 64 percent of all health spending in Ecuador came from private sources, indicative of Ecuadorians' antipathy toward and lack of faith in public health services. Of those expenditures, 88.4 percent came directly out of pocket from individual and family household incomes. The WHO also found that 42.5 percent of the poor, and 37 percent the poorest of the poor, turned to the costly private sector rather than use free or low cost public services (WHO 2005). Like many nations in Latin America, the constitution and various laws guaranteed health as a right of its citizens but this meant very little in practice—and indignities abounded. Patients were treated abysmally, there were few supplies, buildings were crumbling, and iatrogenic infection was commonplace.

At the time of this research, private medicine was unregulated and flourishing in Ecuador, with ubiquitous advertisements for every sort of medical specialty at all

price ranges blanketing the cityscapes. The most expensive private clinics had the latest technologies and services, but even the more moderately priced and cheapest clinics provided a level of personalized patient care impossible to find in the realm of public health. In Ecuador, private gynecological clinics proliferated along with infertility centers, plastic surgery, weight loss centers, and medi-spas, although very few “natural” birth centers existed. Keti, Ana, and Conseulo’s cesarean section scars made in private clinics were indications of the spread of neoliberal economic policies into Ecuador’s (pre-Correa) expanding private health sector. But many of the underlying economic, relational, and physiological logics that shaped the provisioning of private medicine in Ecuador were not new.

The directors of Ecuador’s private medical clinics were in many ways similar to agrarian *hacendados* who have always been able to circumvent the law because they were its makers. Historically, physicians came from elite families and also became state authorities and elected officials. Like *hacendados*, elite physicians held positions in state institutions, which allowed them to shield their clinical domains from state oversight.⁴ Private medical practitioners in Ecuador operated with virtually no oversight from state institutions. There was no Ecuadorian school of medicine that could issue and revoke licenses to practice. Doctors could think of no instance of ever being scrutinized by state institutions for more than sanitation compliance. The functionaries I interviewed at the Ministry of Health confirmed this. The documents patients and practitioners signed were not legally binding: physicians’ clinical practices were not scrutinized by insurance companies because patients paid out of pocket, and because they did not carry malpractice insurance. Clinic directors were not accountable to any larger formal institution.

Deborah Poole argues that in the Andes, sites of interface, where state institutions demand payment or distributes services, exist where poor and indigenous citizen subjects were made to learn the “gap between membership and belonging” (Poole 2004). The multitudes were disciplined to the inequities of standing in line for unequal resources while the connected jumped ahead or were ushered to back rooms, or did not require these services at all. Indigenous people, or prisoners who protested for state recognition, or patients who stood in line in public hospitals assumed the position of the masses, whose only recourse was to state resources. Through the 1990s and early 2000s groups such as indigenous people and prisoners made increasing demands on the state, for recognition and self-determination as well as for resources and care, at the same time that elites and middle classes intensified their retreat from state services in the realms of education, security, and health.⁵

In Ecuador, seemingly prosaic tasks, such as paying utility bills, replacing a lost driver’s license, registering for public education, using public medical care, and even entering public swimming pools, represented an absurdly large drain on the temporal and emotional resources of the poorer economic sector. These people

could not avoid these requirements—they did not have employees to stand in line for them, and could not afford *tramitadores* (paid paperwork processors)—and neither did they have the resources to avoid them. For those who needed public services, mostly the urban poor and working class, the state was an especially potent bureaucratic force in their everyday lives, which disciplined them to know their devalued status. Simultaneously, “the state” became ever more materialized through these exercises in power (Sharma and Gupta 2006). Those who did not have to interact with the state in Ecuador were elite by definition, and could make their own forms of freedom outside of the law. The inferior nature of public medical services also instantiates the state. The dailyness of its circumvention is similar to what Sharma and Gupta describe in terms of how “proceduralism” (the routine repetitive practices of rule following and its violation) is central to the way the state is imagined, encountered, and reexamined by the population (Sharma and Gupta 2006).

Both the state and whiteness/darkness are enacted through the term *viveza criolla* (cunning whiteness/innate cunning), which conveys how the ability to pass around or above the law is white. The term has a historically complex meaning. While creole has come to mean “mixed” in the colonial period, criollos were persons born in the colonies but of Spanish descent, and so they were white. At its most basic, the term *viveza criolla* means cunning at another’s expense, putting one over on someone else, flouting the rules and the law. The term’s link to criollo, or whiteness, illuminates the powerful relations of inequality that this usually entails.⁶ Those who can get the upper hand are white. Cunning whiteness makes it possible to jump the line at the bank, or at the state utility company, or to get one’s driver’s license without the usual difficulties. These acts and resources demonstrate “white” ability to disregard the rules of both state and private institutions. In Ecuador at this time, status was not derived from one’s ability to make public demands upon state institutions, since social welfare programs were seen as inferior to private health care, education, and security. It was the poor who used public services, and indigenous groups who formed social movements to make political demands on the state, not the middle classes or elites who could maneuver around them.⁷

The devalued nature of state services in millennial Ecuador complicates the anthropological analytic categories of “bio-sociality” and “biological citizenship,” which describe educated activist patient groups cohered around a problematic biological status, as they interact with formal institutions such as state ministries, or pharmaceutical firms, to advocate for recognition and resources (Petryna 2002; Rabinow 1996; Rapp 1999). Both terms, while useful in describing the relations that occur between state actors and citizens in nations with relatively robust welfare institutions, have less analytical purchase in locations like Ecuador, or in India where, Veena Das argues, most collectivities lack “the social capital for dealing with biological conditions” (Das 2001, 2).⁸ Ecuador’s colonial history and international

status as a chronically unstable democracy, with a weak civil society, produced a very different experience of the social and of citizenship (Gerlach 2003; Whitten 2003). Thus, in Ecuador in the early 2000s there were few activist patient groups who advocated for themselves as liberal subjects in relation to a state. Those who wanted public recognition were more abject, such as the prisoners in the Guayaquil prisons. Cesarean section scars, hidden under clothing, mapped a more distant relation to the state and a closer relation to the nation.

Cesarean sections scars in Ecuador further complicate the analytic terms of biosociality and bio-citizenship, because these concepts trace how biotechnological advances, including genomics, have generated new understandings of the biological as shaped by the social. Biosociality and biological citizenship make less sense when applied to Ecuador, in regard to *the biological* itself. As I map out in the next section, in Ecuador, the biological has not historically signified a domain separate from culture, nor the determinism common to North America and Europe. Biology in Ecuador and throughout much of the Andes and Latin America has tended to be less essential than malleable. Thus, one of biosociality's two most salient characteristics, the emergence of nature as "artificial" and the ability to be "remade through technique" (Rabinow 1996:99)—is not necessarily new to the Andes, where the body can be cultivated and racially transformed.

Racial Cultivation

While we waited for the spermatozoa to spin in the centrifuge in the laboratory, Linda, the biologist traumatized by witnessing the "savage" vaginal birth, showed me an infinitesimal amount of fat on her abdomen. She planned to have it removed that weekend via liposuction by one of the traveling Argentine plastic surgeons ubiquitous in Quito after the 2001 Argentine economic crash. Linda was going to pay dearly to have her fat sucked out by a stranger, a surgeon from one of South America's whitest nations, a scenario that would be potentially horrific for highland Indian women in Ecuador who fear the *pishtaco*, the white stranger who sucks fat. The *pishtaco* is an Andean bogeyman, a spectral figure, usually urban, rich, and white. He roams rural areas with a knife hidden under his coat waiting to cut the fat out of Indians who cross his path, weakening them to the point of death. The story of his cut is told by Andean Indians as a way to distinguish themselves from those who engage in the impersonal capitalistic exchanges of mestizos and whites. It makes them more Indian (Canessa 2000).

The plastic surgeon is a dashing figure, usually urban, rich, and white. He roams cities with a scalpel, waiting to cut the fat out of the whiter and mestiza women who pay to lie down before him. The story of his cut is told by mestizas as a way to distinguish themselves from those who engage in degrading, impersonal, bureaucratic exchanges of public medicine. The *pishtaco* cuts out fat, a valued

substance in the rural Andes, used to animate collective reciprocity. The surgeon cuts out fat, a substance reviled by urban women in the Andes for its link to rural corporality. These cuts race and sex those they penetrate: to be cut into is female. It is who or what does the cutting that races the invaded woman. A white pishtaco's unwelcome invasion into a rural woman's body with a fat-stealing knife produces an Indian woman (Weismantel 2001). A white physician's expensive surgical cut produces a whiter urban woman, a woman subject to the knife of a private clinic where she is ministered to personally, remaining unsubjected to the degradations of public medical institutions.

As cutters, the pishtaco and the surgeon are related figures with a history. In Europe, surgery was a problematic practice throughout the 18th century during the shift from spiritual corporeality to an avowedly secular embodiment where bodies became a series of operable, separate parts (Doyle and Roen 2008). Nineteenth-century surgeons in Europe and North America also had a difficult time disassociating themselves from the unsavory practices of cutting into bodies, many of them illicitly snatched from their graves. This history resonates with highland Indian fears of pishtacos, as they do across the globe, where the poor and the marginalized live with a well-founded anxiety about losing themselves or their parts to the appetites of the global market in kidneys, corneas, and other tissues (Cohen 2004; Scheper-Hughes 2005). Ecuadorian, mestizo urbanites, however, are not necessarily concerned with the breach of dignified, bodily integrity that surgery and pishtacos have been understood to entail. Paying to have a surgeon cut into one's body positively transforms a woman into a more desirable, whiter state of being.

For most North Americans the proposition that someone could become whiter is nonsensical. Race in North America tends to be understood as materially embodied, inherent to a person—essential, biological, interior, and fixed, despite the fact that scholars have shown how race is constructed and performed (Hartigan 2010). This determinism contributes to the continued pernicious understanding, and sometimes justification, of unequal life conditions and inequalities. Raza in the Andes also tends to be materially embodied; however, this materiality is malleable (Cadena 2000; Leinaweaver 2008; Orlove 1998; Smith 1996). Race can be changed through changes in body and comportment. While raza is more pliant than in North America, it is also used in pernicious designations of difference and justifications of inequality. Both versions of race thinking are products of historical processes, although many scholars of Latin America and the Andes persist in implicitly portraying North American race, with its claim to depth and fixity, as closer to a universal, ontological truth (Wade 1993). Much of this literature distinguishes between North American race, as produced through understandings of lineage/biology, and Latin American and Andean raza, as produced through appearance and social relations, without noting the historical contingency of the bioscientific concept of race as well.⁹

The materiality of *raza* in Ecuador involves a constellation of factors that include employment, locale, dress, class, levels of “decencia,” and sexual conduct (Cadena 2000). From the early republican period onward, education was one of the main strategies for making national citizens out of Indians: “By definition Indians were seen as ignorant, because it was assumed that Indians who were educated would automatically become mestizos” (Clark 1998:230).

Raza is often rooted in metabolic processes. For instance, instead of genetic codes, ingesting certain foods, such as barley versus white bread, constitutes *raza* (Weismantel 1995). Commentators on race in the Andes have noted that a person’s *raza* can be temporally and relationally defined, especially given that many people migrate within and without Ecuador and must live within several racial realities, which are economic realities as well. A woman can be an Indian when in the city trading with urbanites, and a mestiza in her home village when trading with kin who have never left (Weismantel 2001). Within one family, children can be of a different *raza*. There can be a more favored lighter child and a less favored *moreno* (dark-skinned) child, depending on their skin color.

The shape-shifting powers of *raza* prevailed across class, even for early–20th century elite eugenicists who emphasized Lamarckian over brute Darwinian models of inheritance (Stepan 1991). These reformers promoted a soft eugenics formed through demographic realities of the Indian majority. They focused on the cultivation and puericulture of children after they were born instead of the preventative act of keeping blood lines pure (Cadena 2000). Differences between these groups of eugenicists meant that at several points Latin American eugenics congresses voted to ignore North American and European eugenic mandates, because of the rigidity of their racial thinking (Stepan 1991). The Latin American congresses favored a more constructivist miscegenation that rejected the “totalitarian [biological] determinism” of the north in favor of “optimistic ideas,” such as favoring racial improvement through education” (Cadena 2000:18).

Raza entangles what in North America is understood as class relations. The claim here that assisted reproduction assists whiteness might appear to lose focus on the class relations involved in the ways women and their supporters access medical care. However, disentangling class and *raza* would do damage to an ethnographic understanding of care relations in Ecuador. Identifying the kinds of food ingested or care received as social markers of class, misses the way that *raza* is produced within economic relations. Private gynecological care cultivates female whiteness, which is simultaneously a political, economic, and physiological state.

Class involves labor relations, which, in Ecuador have been racially and regionally differentiated. Highland, as opposed to lowland labor was embedded in the paternalism of the hacienda. Constitutive race relations among Spanish and Indian, then later, Indian, mestizo, and white women and men determined workers’ roles in the labor hierarchy—class, race, and sex enfolded (Silverblatt 2004).

Reproductive labor relations are also classed and raced, although women have been the main and sometimes only targets of reproductive interventions (Morgan and Roberts 2012). Reproductive labor is raced as well as sexed, especially with respect to the kinds of children that women will produce. In the case of private gynecological care, women can become whiter reproducers, not only through education or professional advancement, but through being cared for as a whiter woman. This whiteness is modern to an extent, but is also an engagement in patriarchal, paternalist relations that allow women to be cared for more tenderly, like privileged daughters, rather than as public medical patients.

Raza in the Andes also has a deeply rooted religious valence. The conquistadores considered themselves as Christians—rather than Spaniards—conquering and converting heathens. At the time, *casta*, signifying a level of blood purity, was a legal, economic, and religious, as opposed to biological designation. Postconquest, the categories of Indian, Negro, Spaniard, and Jew were charted by the Inquisition through degrees of proximity to the blood purity of Christianity (Pitt-Rivers 1973). These categories eventually became the basis for *raza*, connected to biological race, which kept Christianity embedded in Andean practices of nationality and race (Silverblatt 2004). Indeed, a survey conducted in the early 1980s found that more than race, class, or nationality, Ecuadorians, at least in the Northern Sierra, identified as *cristianos* (Catholics) first. Religious identity was employed as the sign of a true person (Stutzman 1981).

In Ecuador, the experience of the material body, or what we might think of as the biological body, is not unitary. It is plastic and, more so than in North America, has been understood from indigenous groups to elites and politicians as cultivatable. In the postindependence Andes, elites struggled to make singular nations out of plurality, where the vast majority of their residents spoke disparate indigenous languages, participated in communal claims to land, and at first had little inclination to mold themselves as citizens of a nation whose leaders were participants in the coercive labor extraction of Indians. Creole elites saw these issues of radical difference, also known as the “Indian Problem,” as roadblocks to their civilizing, modernizing, and whitening project (Larson 2004).

This sense of a racial problem and a project to fix it continued. In 1972, the Ecuadorian president General Rodríguez Lara proclaimed, “there is no more Indian problem. We all *become* white when we accept the goals of national culture” (Stutzman 1981), is a declaration that the project to *become* white, that racial change within adulthood, is possible. Becoming whiter is different from racial passing as lived in the southern United States, which implies hiding one’s real interior race. A common saying in Ecuador—“money whitens”—is not a joke about misrecognition, where people are mistakenly treated as if they were white. Accumulating money and being treated well does whiten—marking whiter relations of care, such as the private medical care found in Ecuador’s urban

centers. Raza constitutes a “political economy of the body” (Lancaster 1992) that involves practices, behavior, and appearance; it does not entail notions of deep, ahistorical, unchanging interiority. In the early 2000s, cesarean section was one of these practices.

Cesarean section scars and plastic surgery are part of a nexus of medical care and race in Ecuador and across many Latin American nations. Plastic surgery is discussed and displayed, not hidden. Transgender women and born women who undergo plastic surgery in Brazil and Venezuela do not want their surgery subtle since no one could read the signs of their ability to participate in the conspicuously consumptive care practices that display their whitening (Kulick and Meneley 2005; Ochoa 2008; Edmonds 2010). Surgery is an expensive procedure that marks its bearer’s ability to cultivate their body—a body that is presumed to be malleable rather than one that should be kept pure or untouched in medical encounters. Plastic surgery is not as prevalent in Ecuador as it is in Brazil and Venezuela but it is becoming more available. Anecdotally, nose jobs, which remove high bumps to make their bearer look less indigenous, are some of the most popular plastic surgeries in Ecuador. I came more in contact with women preoccupied with fat, like Linda, the IVF biologist who wanted her fat removed by the traveling Argentine plastic surgeon. Both her new flatter belly and the private care she received made her whiter. Abdominal scars in Ecuador are not made as visible as plastic surgery in Brazil. They are usually kept hidden, under clothing, although as we saw with Ana, sometimes they are indicated by women telling their birth story to their children, family members, or anthropologists. The scar is not for public display or scrutiny, just as their bearer’s body is not for display or scrutiny in public hospitals, marking her as the privately administered subject of a physician paid out of pocket.

Conclusion

The surgical penetration of women in unregulated private clinics outside of Ecuadorian state control continued the whitening project carried out on haciendas through the impregnation of Indian women by whiter men from the colonial period into the republican era (Lyons 2006). Like haciendas, private reproductive clinics serve the national project of whitening evoked by General Lara, conducted apart from state governance and surveillance. The whiter surgeon gathers women into relations that involve money, the cultivation of whiter, reproductively dysfunctional bodies, and paternalistic medical care that enhance whiteness. This national project continues with the surgical invasion of darker and lighter women in contemporary unregulated private gynecological clinics.

Ecuadorian women’s willingness to open their bodies to surgery indexes a Catholic woman who suffers to become reproductive without opening herself sexually, or opening herself to the indignities of public state-funded care. A scarless,

blank abdomen, the blank of a vaginal birth, is the mark of a poor woman, who cannot afford to keep herself sexually closed. A woman's cesarean section scar is also proof of whiter suffering and reproductive dysfunction. She can endure the pain of surgical invasion even though she cannot withstand a "normal birth." It's no wonder that working-class and poor women wanted private cesarean sections too. For working-class and poorer women who have undergone a cesarean section, their scars were marks of upward mobility. Their scars, red at first, turned white. In turn the scar whitened them, proof that they could not give birth "normally," that they had the means to overcome their dysfunction, and that they were not made subject to state neglect in public medical facilities. Their whiteness and their children's whiteness were cultivated inside the clinic by a doctor who cut them tenderly, like a father, not a pishtaco. With the transformation of state institutions under Correa, it is unclear how these economic relations of bodily care and the production of race through bodily markings will be reformulated.

In millennial Ecuador, the body was political, but it is not citizenship per se that everyone sought. When patients received care in private clinics from private physicians, they remained distinct from the governed, browner masses that "needed" to make public citizenship claims for social services on state institutions. Both the hidden cesarean scars of Ecuadorian women and the public wounding of crucified Ecuadorian prisoners involved material bodies that can be transformed through differential care, but their scars made them into different kinds of subjects and people. The prisoners wanted care and attention from the Ecuadorian state, which guaranteed their own existence. When women and their families paid for cesarean sections outside of state supervision, the private scars made them whiter, and more worthy of the nation—their scars were their reward for taking nothing from the state.

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Notes

¹See Ozyurek (2004) for an account of the miniaturization of Ataturk's formerly monumental image in Turkey, which provides a useful comparison to my discussion of scars in Ecuador. Making Ataturk's image small, intimate, and personal by displaying him on the body signals a transformed view of the political in Turkey in relation to neoliberal economic processes, similar to what is described here for Ecuador. On the other hand, Ataturk is potent symbol of the state, which is precisely an association Ecuadorian cesarean section recipients wished to avoid.

²Some women organized payment for various forms of gynecological care, such as cesarean sections, IVE, and private hospital stays, by organizing raffles and community games of bingo with family, which also served to separate patients from state services (see Roberts 2012).

³In her research on cesarean section in Pelotas, Brazil, anthropologist Dominique Béhague found that poorer women, who birthed in public hospitals, knew that wealthier women have cesarean sections as a matter of course, and that physicians were actively withholding cesarean sections from them. These women approached labor and birth strategically in order to obtain their own cesarean sections at public hospitals, resulting in more attention from more thoroughly trained doctors (Behague 2002).

⁴More so than in North America, in Latin America, there is a long history of physicians occupying political office (Voekel 2002).

⁵These separations from state institutions are well documented for much of Latin America (Low 1996; Caldeira 2000).

⁶Creoles were “pureblood” whites born in the colonies. But Creole has come to mean *homegrown* over time. So it could mean native (as in *mestizo*) cunning, or white cunning.

⁷Of course, from the point of view of state actors there might have been benefits to being considered an inferior provider in the time of IMF mandated austerity measures and decreased social spending.

⁸In Das’ research in poor Delhi neighborhoods, she found that families do interact with the state in seeking care, but these groupings are not biosocial because biosociality presumes “the individual as the subject of a liberal political regime, which Das finds foreign to the types of socialites at work for the urban poor in India. These new “alignments between family and state embody a politics of domesticity,” which involve connected body selves not liberal individuals” (Das 2001:3).

⁹For instance, the historian of Bolivian medicine Ann Zulawski explains how elites could not “biologically distance themselves from Indians, so culture became the convenient means of marking difference” (Zulawski 2007). Her formulation implies that Bolivian elites used the malleability of culture to cover over the truth of biology—a distinction not necessarily as relevant in Bolivia as it is in the United States.

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