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# Gender, Health, and Medicine in Latin America

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## Introduction

Since the 19<sup>th</sup> century, medical-scientific knowledge has constituted the most recognized form of knowledge of the body, thus legitimizing discourses and practices of health as well as expanding the reach of medical professionals' control over public health policies. In many Latin American countries, new attention to public health burgeoned with industrialization and urbanization at the turn of the last century. Political leaders and doctors agreed that national development and the health of the population were inseparably linked. They often collaborated to protect their nation's human capital as they developed systems of hygiene and public health. In their framing of public health measures, officials employed gendered understanding of citizens' responsibilities and rights.

Just as medical science gained legitimacy as the language of truth in the nineteenth century, scientific studies on sexual difference supplied unprecedented justifications for restricting women's choices in order to protect their "natural" maternal roles. In the process of instructing the population about health and hygiene, medical professionals promoted policies that emphasized gender differences. Doctors stressed women's maternal role and cautioned against higher education and professional training as dangerous distractions from this role. Men's sense of entitlement to give expert advice to women on matters of health and reproduction—rooted in nineteenth-century patriarchal medical practice—became even more firmly entrenched in the twentieth century.

By the turn of the last century, the woman-mother and her children were the focus of many public health campaigns across the Americas. This was inspired by high infant mortality and unresolved social questions – such as prostitution, alcoholism, and crime in growing cities with an expanding industrial labor force. Doctors' attention to the mother-child unit was further accelerated by claims of the need for

protection of families, allegedly threatened by women's growing participation in the paid labor force outside their homes. Health officials worked to protect women's familial roles, although many women across the Americas had long made a living under difficult circumstances or had raised their children as single mothers. Other problems, like domestic violence, often remained outside the focus of the state and its institutions.

Public health measures were, at times, driven by goals unrelated to individual patient care but were inspired by larger economic and political goals of nation building. Moral sanitary movements are a case in point: while the terminologies of medical science appeared to replace religion as the moral base of gendered social control, scientific measures had moral dimensions as well. This became evident when health officials regulated female prostitutes, and not male clients, to control the spread of venereal disease, and when they depicted female sexuality as a source of moral decay and disease in the urban environment of the early twentieth century. It was just as evident in maternal care and puericulture throughout the twentieth century, when doctors and health officials treated female patients as dependent, in need of help, and not as individuals with the ability and right to make informed choices about proper mothering and infant care. Public health measures professed to protect motherhood, but they also limited women's professional choices or employment opportunities in "unsuitable" industries. Simultaneously, health officials prescribed remedies for infant mortality and routines for infant care (such as healthy nutrition) that remained out of reach for poor women.

In the 20<sup>th</sup> century, new reproductive technologies transformed the nature of medical care, moving birth control to the center of gendered public discourses on matters of health and population. The contraceptive pill and intra-uterine devices (IUDs) revolutionized birth control and could potentially make motherhood a choice – but couples and individuals' choices were constrained by the gendered politics of reproduction and limited access to contraceptive technologies. The first contraceptive pills were tested in Puerto Rico and the United States in the 1950s. The pill's initial trials, often conducted without the informed consent of participating women, well exemplified existing tensions between the progress of medicine, the goals of population control, and officials' views on the need for family planning. Women's access to these

technologies depended on national and local policies, often designed in response to human capital considerations or to neo-Malthusian goals of population control. Those differed in different national settings and time periods, at times either honoring mothers of large families or, alternatively, holding women responsible for contributing to population problems if they failed to control family size. During the Cold War, scientists' and politicians' emphasis of neo-Malthusian justifications for fertility regulation distracted from the liberating potential that family planning programs could provide to women.

Histories of family planning in such places as Colombia, Guatemala, Peru, and the United States have shown that reformers who implemented health policies were often driven by eugenic concerns or by economic development goals, and not by women's needs. Women's wishes remained a blind spot in policy making because their individual rights were simply not recognized, a gender bias that made the politics of health comparable across the Americas. Still, the patriarchal and professional characteristics that shaped doctors' impact on policy making and on patients' lives varied widely. Individual doctors made choices, built relationships, and set priorities that shaped the specifics of patriarchal and professional practices in individual countries.

The contributions to this volume highlight some of the gendered elements of knowledge production in medical research – and convey some of the implications medical knowledge had on public policies and people's lives. Authors demonstrate that the historical lens of health and medicine offers new insights into the complexity of gender and women's rights. They also make clear that we need to pay attention to the visible and hidden contexts of gender violence that have been part of the gendered histories of health from the 19<sup>th</sup> to the 21<sup>st</sup> centuries.

**Mirta Lobato** looks at violated female bodies and explores how Argentine society dealt with what we today refer to as “gendered violence.” She focuses on a period of transition in a rapidly changing immigrant society around the turn of the last century. Based on evidence from judiciary documents as well as newspaper reports and popular literature she reconstructs cases of violent conflicts which show the fragility of bodies and lives of mainly poor girls and women. Violated within the family or the neighborhood, their bodies are markers of a society where men felt entitled to exercise violence if women failed to act “properly”.

Even as the state began to establish norms and laws to regulate people's public and private lives through corresponding judiciary institutions, regulation proved insufficient to address gendered violence adequately. Institutions failed to challenge existing notions of male supremacy and the supposed right to rule over children and women within the family. Lobato's evidence reveals that administrators in charge were not sufficiently equipped – materially or personally – to investigate cases of severe violence against women. The utter failure to do justice to the victims was also a result of the fact that the female voices were not considered in the same way as the male ones.

**Sandra Aguilar's** contribution explores the role of hygiene and nutrition in processes of modernization in post-revolutionary Mexico. Officials envisioned education and modern health concepts as pathways to change, and also leading to a new work ethic and discipline. Newly founded state institutions like the *Instituto Nacional de Nutrición* aimed at changing traditional alimentary practices as well as approaches to welfare services, for example by visiting nurses. Welfare policies targeted women and women were also key actors in policy implementation in their roles as nurses or social workers.

More than half of the population suffered from malnutrition or died from poor hygiene in the 1940s and 1950s, and the programs faced considerable challenges not only because of the sheer volume of the tasks, but also because of resistance to policy measures. Health brigades were often unwelcome, seen as disrespectful of traditional local knowledge, and guided by paternalism and clientelism. For example, the memoirs of one of the visiting nurses, Helia, also uncover how the *campesinas* challenged and adapted state policies to their contexts and interests. Helia's experience exemplifies the efforts of postrevolutionary governments to transform peasant practices. It also shows how different worldviews and unequal access to resources hindered the implementation of welfare programs and led to tensions of gender, class, and race.

The themes of gender, health, and human reproduction stand out as core subjects of this volume. Three contributions explore the regulation of women's reproduction and provide an excellent opportunity to analyze the use of medical-scientific knowledge for radically different political agendas. In Bolivia, pro-natalist campaigns of the 1950s addressed women-mothers with many children as saviors of a nation

that suffered from “underpopulation.” In Colombia, health officials employed survey data to incite family planning initiatives in the 1960s. Medical-demographic knowledge production thus produced unusual new relationships – such as alliances among medical doctors and feminists who supported access to family planning, albeit for different reasons. In Paraguay, public health initiatives of the 1970s focused on the prevention of induced abortion. In the process, one of the leading doctors mobilized medical knowledge to inspire women to learn about sexuality and family planning.

**Nicole Pacino’s** study of Bolivia illustrates just how central demographic concerns were to the gendered politics of fertility regulation even before effective family planning measures (like the contraceptive pill) became available. She shows that Bolivian officials identified “underpopulation” to be one of the causes of the nation’s development problems. As a result, national public health measures not only sought to lower morbidity and mortality rates, but also to prevent birth control. The leftist revolutionary government under the leadership of the *Movimiento Nacional Revolucionario* (MNR) prioritized pronatalist and eugenic policies in the name of development, thus counting on women to give birth for the sake of national progress. While the MNR’s revolutionary nationalism rejected population control measures proposed by the United States and international development agencies, its politics of gender and reproduction remained deeply conservative and restricted women’s reproductive choices.

In other nations, health officials argued that their populations were too large. **Teresa Huhle** reveals how doctors connected survey data on women’s reproductive behavior to strategies of population control in Colombia, supporting the neo-Malthusian agenda that gained steam in the midst of the Cold War. Fertility regulation, instead of women’s individual choices about children, drove officials’ incentive to promote family planning. In 1960s and 1970s Colombia, physicians feared the dangerous consequences of an alleged “population explosion,” and relied on fertility surveys not only to document people’s attitudes about family size, but also to instill a sense of urgency that required specific reproductive behavior. Both the surveys and their result offer important clues about officials’ gendered assumptions about women, men, and sexuality. Huhle’s study not only places the subjective production of medical-demographic knowledge in the broader political

context of development and modernization debates in Colombia, but also shows new spaces for women's empowerment. Feminists who sought to plan pregnancies found allies in medical doctors' advocacy for responsible parenthood. While physicians prioritized demographic concerns, women could benefit from policies that allowed them to combine planned motherhood with education and access to the job market.

**Bridget Chesterton** traces comparable developments in Paraguay, where one leading medical doctor's patriarchal discourse informed women about how to avoid abortion by using contraception. In the process of his campaigns, he encouraged his patients to learn about their own sexuality. Chesterton tells the remarkable story of Dr. Dario Castagnino, demonstrating that individual initiatives within larger organizations may offer important clues about historical change. Castagnino, who led Paraguay's first population center, the *Centro Paraguayo de Estudios de la Población (CEPEP)* used the networks of the organization to spread information on sexual education and methods of birth control. Chesterton's use of oral testimony provides a window on the complexity of these information campaigns.

We also find rich evidence to show that the gendered politics of health are not confined to the subject of human reproduction. **Marisel Colautti** depicts problems of access to medication for the treatment of HIV-AIDS, and examines public, social movements and the state through the lens of gender and the right to health. While HIV was originally associated predominantly with men, it also affected women as mothers, partners, or children of a person living with HIV-AIDS. In Argentina, public pressure led to the early promulgation of laws which assured access to antiretroviral drugs in 1990. According to Colautti, this was due to the fact, that by the time HIV-AIDS irrupted in the country, female networks had already put questions of sexual and reproductive rights and, more generally, the right to health on the agenda.

The severe political and socio-economic crisis which affected the country in 2001 led to a health crisis of new dimensions which manifested itself - among other problems - in the difficulties of access to medicine. In this situation, movements of people living with HIV-AIDS, mostly lead by women, began to exercise pressure on state institutions and the public, and put the problem within the broader framework of

citizenship rights. A disease initially associated with shame, became a marker of the right to dignity.

Contributions to this volume thus provide new insights on the complexities of gendered health practices, medicine, and public health. Approaches to health and health policies are intimately connected to the specific environments in which they are produced. They also remain gendered, with multiple and varied results for individuals. Medical science, health policies and regulating institutions treat gendered bodies – in processes that reflect, contest or reproduce gendered differences, as shown in the articles of this dossier.