C. H. BROWNER
Center for Culture and Health
Department of Psychiatry and Biobehavioral Sciences
University of California–Los Angeles
Los Angeles, CA 90024-1759

Situating Women's Reproductive Activities

In her pathbreaking book, *Abortion and Woman's Choice,* Rosalind Pollack Petchesky astutely observed that, in many societies, control over the methods and goals of reproduction is a critical site of contest, particularly between women and men. Yet the circumstances under which reproductive relations will be characterized by conflict, consensus, or some of both have seldom been systematically explored. In this paper, I therefore offer three examples of different structural contexts in which either women or men had the preponderance of power to influence key aspects of women's reproductive activities. I argue that while structural factors, notably the distribution of economic, political, and institutional resources, are fundamental, they do not only act directly but are experienced, interpreted, and made meaningful through specific cultural processes, particularly gender ideologies, norms about morality, and beliefs about how women should behave. It is together that these structural factors and cultural processes shape the climates and contexts within which women's reproductive activities are situated and take place. *[reproduction, gender politics, Latin America, Mexican Americans]*

Little theoretical or empirical attention has been paid to the influence of male partners on women's reproductive activities. Instead, it is generally assumed that even in communities where men are publically dominant, such as in Latino communities in Latin America and in the United States, women's decisions concerning reproduction are made by women themselves. A small literature, produced primarily during the last quarter of the twentieth century, found that while men may be highly influential in their wives' reproductive activities, women often act independently, particularly in the case of abortion (Keller 1973; Kinzer 1973; Requena 1965; Scrimshaw 1978, 1985; Shedlin and Hollerbach 1981; Stycos 1955, 1968). Yet the actual circumstances under which women incorporate the wishes of their male partners into their own reproductive activities—or even subordinate their wishes to those of the men—have seldom been considered in depth or detail.

This is in large part due to the fact that those who would be expected to be interested in the topic, anthropologists, for instance, have historically seen reproduction as a "woman's topic" and therefore not central to the field (Browner and Sargent 1996; Ginsburg and Rapp 1991). A similar lack of attention may be seen in related disciplines. Research in demography and population studies has typically been informed by consensus models, whether the unit of analysis was the couple, the family, or the larger social group (Greenhalgh 1995a). Within such models, it is generally assumed that the interests of a society's reproductive-age women and those of their male partners and other significant relationships are, for the most part, the same.

It wasn't until the late seventies, and the growing body of work by feminist scholars, that the intellectual focus broadened to acknowledge that "the methods—and goals of reproduction, and control over them, may themselves be a contested area within [a] culture—particularly between women and men" (Petchesky 1984:10). Scholarship began to acknowledge that differential access to a society's sources of power would determine how conflicts over reproduction would be articulated, conducted, and resolved—and even whether resolution would ever take place (Kaler 2000).

As Petchesky points out, it was Karl Marx who first observed that biological reproduction is itself a social activity, separate and distinct from the activity of childrearing, and determined by changing material conditions and social relations. In *The German Ideology,* Marx defines "three aspects of social activity": "the production of material life," "the production of new needs," and human procreation. By this he meant that human procreation involved not only "natural," or biological, relations but also social relations among women and men by way of sexual and procreative practices. Reproduction, then, can be considered social in a Marxian sense insofar as it is cooperative, purposive, and above all conscious (Marx and Engels 1970).

Unlike other biological beings, a woman does not simply "get pregnant" and "give birth." She does so within the context of explicit and variable material conditions, including

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opportunities for employment, particularly for women, and broader economic relations; class divisions; the nature of health care and access to it; and the types of birth control that are available (Ginsburg and Rapp 1995). In addition, a woman becomes pregnant within a specific network of social relations, which include her sexual partner or partners, her children, other relatives, neighbors, employers, reproductive health care providers (physicians, midwives, nurses, etc.), birth control manufacturers, and the authorities associated with religious institutions and the state (Greenhalgh 1995b). These social arrangements, which are typically based on differential access to resources and other forms of power, profoundly shape the institutional and cultural arrangements through which biology, sexuality, and reproduction are expressed. And they are as likely to be antagonistic as mutually supportive (Petchesky 1984).

Yet the circumstances under which reproductive relations will be characterized predominantly by consensus or conflict—and if by conflict, who is apt to have the upper hand—have seldom been systematically explored. My intent, therefore, is to offer three examples of different structural contexts in which either women or men had the preponderance of power to influence key aspects of women's reproductive behavior (cf. Hollerbach 1980:149–154). All three examples come from Latino communities, two in Latin America and one in the United States. Despite certain broad similarities, gender ideologies differ in the three settings (Melhuus and Stølen 1996), as do key structural conditions including patterns associated with, for instance, social class, ethnicity, nationality, and immigration. I will describe two sets of circumstances under which women generally incorporated the wishes of their male partners into their own reproductive activities and one under which for the most part they did not. In particular, I seek to examine how reproductive behaviors are played out within the context of the gendered meanings women give to their own personal experience and behavior.

Why, however, focus on individual women and their conjugal partners? For as I said, couples are not the only unit of consequence in the analysis of women's reproductive activities; particularly within extended families, intergenerational relations can also be critical. But in the three examples offered here, the nuclear household is both the cultural ideal and the statistical norm and, in each of the three communities, the conjugal unit is regarded as primary in decision making about reproductive issues. Nor should my argument be viewed as overly deterministic. In any society, each individual woman has her own particular political relationship with her male partner. But how any individual couple goes about negotiating this relationship is influenced by broader structural and cultural processes. I will refer to this negotiation process as the "conjugal dynamic." Theoretically, this dynamic can be male controlled, female controlled, shared, or vary according to situation (cf. Hollerbach 1980:151–154).

My argument is as follows: social structural factors, including the distribution of economic, political, and institutional resources (e.g. education, health care, social security benefits), are fundamental in shaping the conjugal dynamics that in turn influence reproductive activities (cf. Handwerker 1989). Yet, in and of themselves, these are not the only factors. As the three examples show, social structural factors are both experienced directly by individuals and interpreted and made meaningful through cultural processes, by which I mean the images, representations, discourses, worldviews, values, and identities that exist within specific contexts that are both social and historical (Ortner 1999:989). This formulation is in keeping with a view that has been more common among European than American anthropologists, where culture is understood to be the content of social relations rather than some distinct entity (Goody 1993). Goodenough put it well when he described culture not as behavior but as a mechanism of it (Goodenough 1957:167 in Goody 1994:251). Since then, anthropologists such as Geertz have retained the distinction between cultural symbols as "vehicles of thought" and social structure as "forms of human association"; at the same time, they recognize "reciprocal interplay" occurring continually between them (Geertz 1973:89). Culture provides rationales and explanations for behavior, and it gives shape to constraints and opportunities. Of particular relevance for the material that follows, culture provides the scripts or moral values about how women and men should behave, along with justifications for gendered behavior. Following Keesing, then, I regard the production and reproduction of cultural forms as problematic; my intent is to examine some of the ways that the symbolic production of gender and associated ideologies are linked to gender hierarchy (Keesing 1987) and ultimately to reproduction.

Within most contemporary societies, the cultural norms and ideologies surrounding gender and reproduction are, by their very nature, highly charged, fluid, fragmented, contradictory, and generally contested. This may be even more true today than in the past, for today gender ideologies are produced and reproduced within the shifting contexts of national and international struggles for women's rights, including women's reproductive rights, along with the opposition to these struggles waged by the Catholic church, fundamentalist churches, and the forces of structural adjustment. Other critical broad contextual factors include ideas about, laws concerning, and public responses to domestic battering. Along with gender ideologies, these broader ideologies provide the climate and context that shape reproduction and its social relations (Rapp 1999).

My goal here, however, is not to analyze where cultural factors come from, who defines them, how they are reproduced, or why they take their particular form. Rather it is to offer three examples of interacting structural and cultural

contexts within which women either were able to implement their own reproductive agendas or found it quite difficult to do so. And because each of the three examples is unique in both its structural and its cultural features, it is impossible to distinguish the independent contribution of each. I have, therefore, set for myself what I see as a more realistic agenda: to explicate some of the ways that structural and cultural factors can act together to influence conjugal dynamics and, through them, the organization of reproduction (cf. Nelson and Grossberg 1988; Scott 1985).

Clandestine Abortion Decisions in Cali, Colombia[1]

Although data are unreliable, Latin America appears to have one of the highest incidences of induced abortion in the developing world (Paxman et al. 1993:207; Zamudio et al. 1994). Recent evidence indicates that between one-fourth and one-third of pregnancies are intentionally aborted (Jacobson 1990). Frejka and colleagues (1989) conclude that more than half of Latin American women will experience at least one induced abortion during their lifetimes. This situation should be somewhat surprising since throughout Latin America the practice of abortion is illegal, dangerous, contrary to dominant religious teachings, and regarded as highly stigmatizing (Tietze 1980). Clandestine abortion is, in fact, the major cause of maternal mortality and a chief source of maternal morbidity throughout the continent (David and Pick de Weiss 1992). In South America, Colombia has one of the continent's highest reported rates of induced abortion and the second highest death rate from abortion complications (Paxman et al. 1993). A recent epidemiological study based on a national sample found that 22.9% of women ages 15–55 reported at least one induced abortion; in some regions the rates were over 30% (Zamudio et al. 1999:19–20).

The circumstances that lead urban Colombian women who, for the most part, are fully cognizant of the risks and costs associated with induced abortion to end their pregnancies were the basis of a mid-1970s ethnographic investigation (Browner 1979, 1980). One hundred and eight pregnant women from Cali's working-class *barrios* who indicated that they had had at least one unintended pregnancy were interviewed about the factors that led them to continue the pregnancies or end them.

Data were obtained from the women on 123 unintended conceptions. One-third of those who participated in the study were patients at an ambulatory health care facility that served three of Cali's largest working-class *barrios.* The rest were recruited through referrals from women who had already participated in the study. The women in the study were more likely to be single than a randomly drawn sample of health center users and more likely to have a history of use of contraceptives, but they were similar on

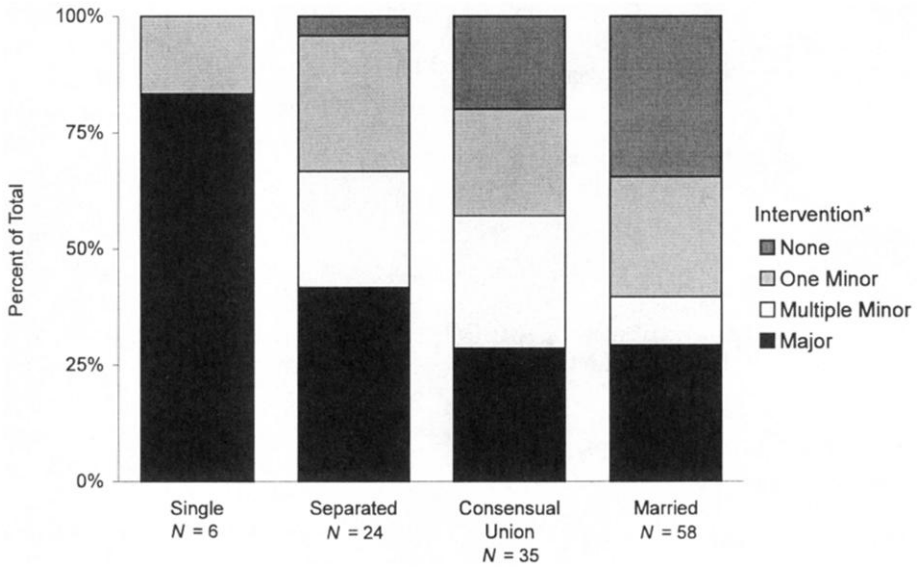

Figure 1. Caleñas abortion decisions by conjugal status ($N = 123$ pregnancies).

* *None* describes pregnancies women classified as unwanted from the time of conception, although they made no attempt to interfere in the pregnancy's course. *One minor intervention* describes one-time use of herbal teas or douches, commercially manufactured pills, or injections sold specifically to cause abortion, self-inflicted trauma, and preparations not explicitly abortifacients but said to be effective if used in proper combination under the appropriate conditions (e.g., boiled beer mixed with aspirin taken three consecutive days upon rising). *Multiple minor interventions* refers to pregnancies in which women used several of the remedies described above, sequentially or simultaneously. *Major intervention* describes pregnancies terminated by surgical means such as catheter or dilation and curretage.

other standard sociodemographic characteristics (e.g., age, education, parity). Fifty percent said they were using a contraceptive when they became pregnant and the overwhelming majority (88%) attributed the pregnancy to contraceptive method failure. Those not using contraceptives said it was because they did not trust their efficacy since that was how they had previously inadvertently become pregnant or because they feared the immediate or potential side effects of the methods available, notably contraceptive pills and IUDs.[2] Their average age was 31.1; 78% had completed between one and four years of formal schooling. Sixty-four percent of the husbands were employed as laborers. All the women had been raised Catholic.

Most women indicated that their decisions about whether or not to continue the unintended pregnancy were strongly influenced by their male partner's response to it. This is not to say that these decisions were necessarily simple or straightforward; women typically described them as fraught with contradiction, ambiguity, and uncertainty. Yet in 80% of the cases, if the man said he was enthusiastic, accepted the pregnancy, or was indifferent to its outcome, the women took no significant steps to end it, despite the fact that conception had been unintended. In contrast, in 70% of the cases, if her partner denied paternity, abandoned her, recommended or insisted on an abortion, the woman ended the pregnancy.

The case of Rosa Inez was typical. (All proper names in this and the examples that follow are pseudonyms.) She had migrated to Cali when she was 19, moving in with her sister's family until she got herself established. Within a year, she met a man and became pregnant shortly thereafter. A week after telling her lover about her pregnancy, he left town.

> CHB: What did he say when you told him you were pregnant?
> Rosa Inez: He said we would have the baby. And then he left town.
> CHB: Did you want to have the baby?
> Rosa Inez: Yes. But how could I since he's gone?
> CHB: So at first you thought you would have it?
> Rosa Inez: Well, he said he would take me to another city to live with him. But after he said that, he left. So I took some things to get rid of it.
> CHB: Did he ever say you should abort?
> Rosa Inez: At first he did. Later he asked me if I wanted to have it. I said I wanted the baby if he was going to marry me. But if he wouldn't then, I didn't want to have it alone. So he said, "Well then, get rid of it." And then he left. [Browner 1979:103].

In fact, the sample had only a small proportion of women who, like Rosa, had been "seduced and abandoned" (see Figure 1). Most who were interviewed were married or involved in long-standing free unions and already had other children. Yet regardless of formal marital status, the dynamic in most cases was the same: the women said they aborted pregnancies to avoid becoming single mothers. Figure 1 also shows that the greater the perceived threat of single motherhood, the stronger the steps the woman took to end the pregnancy. That is, single women with no immediate prospect of male support took the strongest steps, such as self-administering quinine tablets or finding someone to perform a dilation and curretage (D&C) for them. In contrast, women who were married at the time of the unintended conception but feared their marriage was on the verge of dissolution sometimes took such drastic steps but were far less likely than either single or separated women to do so. Instead they made use of less dangerous but also less efficacious means such as herbal remedies reputed to sometimes cause an abortion.

Studies elsewhere in Latin America report similar findings. In Mexico, David and Pick de Weiss (1992) found that the most frequent reason for aborting a pregnancy was the woman's unwillingness to marry her partner because she saw him as a poor marital prospect. In Argentina, Llovet and Ramos (1988) similarly found that a key factor in women's decisions about whether to continue a pregnancy was the degree of future economic and emotional support they felt they would receive from their male partners.

For women such as these Caleñas, who had been raised Catholic and lived in a society where Catholicism was de facto the state religion, the decision to abort an unintended pregnancy was usually a costly one. Yet they rationalized their behavior to me—and perhaps to themselves—by saying, as Elena did, "Certainly it's a sin to abort a pregnancy, but isn't it a worse sin to bring an innocent child into the world only to have him die of starvation?" In fact, fully 53% of those interviewed felt that abortion was an acceptable response to an unintended conception if the family was too poor to have another child (cf. Scrimshaw 1985).

Why, however, did women allow their male partner's response to the pregnancy to determine their own actions? In large part, it was because the life of a single mother in countries such as Colombia, Mexico, and Argentina was then—and remains—exceedingly hard. At the time of this Colombian research, jobs for women with infants or small children were scarce. Most jobs for working-class women were in the service sector, and it was difficult, if not impossible, to combine them with simultaneous child care. Even if women had wanted to bring their children to work with them, most employers would have prohibited it. Additionally, there were neither adequate sources of public assistance available for single mothers nor affordable or reliable private or public child care. (While jobs for working-class men were not abundant either, those who were fathers did not face the added impediment of having to combine paid work with child care. They were therefore somewhat more economically viable as providers than most women were.)

Moreover, contrary to the conventional wisdom that kin would be quite available to help with child care on an ongoing basis, most women did not have relatives who

could—or would—do so, although most were willing to lend an occasional hand. Their own domestic responsibilities were simply too overwhelming. A woman's mother would have been the relative most likely to provide child care on a regular basis, but many circumstances precluded even this as a realistic alternative. Many women's mothers were dead; others had childbearing cycles that overlapped with their daughters' so that their primary commitment was to their own households. The mothers of still other women lived on the other side of the sprawling city or in another part of the country. Nor were post-marriage sibling ties necessarily strong. While financial and other types of emergency help were customary, they were usually neither anticipated nor offered on a daily basis. Less than 10% of the women with minor children had any children living with relatives in other households at the time of the study. Among this study population, then, the kinship network apparently did not play the role frequently ascribed to it.

Ideological factors interacted with and reinforced material ones in shaping these Caleñas' abortion decisions. Although women frequently challenged them either overtly or indirectly, ideologies in support of men's independence, autonomy, and authority were strong. This left many women afraid to openly oppose their partners' wishes, fearing that angering or alienating the men could cause them to leave, with disastrous economic repercussions. Men who left women or children without economic support were in no way stigmatized, and doing so did not impede a man's ability to start another family. Regardless of their prior domestic history, such men were welcomed in their new households, as much for the economic resources the men could provide as for the greater respect accrued to women, especially mothers, who lived with men. Fathering children without any commitment to them or their mothers was a male prerogative women abhorred but felt powerless against.

Therefore, broad economic inequalities outside Caleñas' households led to similar imbalances within. Women could not easily manage on their own, in either the public or the domestic domain. Moreover, their own values and beliefs about how to be a woman in the world made it even more difficult for them to do so. This led those I knew to give men the lead in decisions about the fate of unintended conceptions. When these Caleñas found themselves unintentionally pregnant, they sought to establish or maintain a dependable relationship with a male partner who they hoped would support them and their child(ren). Those unable or unwilling to do so turned to clandestine abortion.

Conjugal and Reproductive Dynamics in an Indigenous Mexican Village[3]

The next example concerns a village in Mexico where powerful pronatalist ideologies existed in concert with economic pressures associated with out-migration and birthrates that were high, despite state efforts to limit them. Lacking independent sources of economic, political, or ideological power, most women acceded to their husbands' wishes, which were generally to have far larger families than the women wished. The data were collected during a year of participant-observation in 1980–81 in a highland Oaxacan *municipio* (municipality). In addition, in-depth, open-ended interviews were conducted with 180 women and the husbands of those with spouses, a total of 126 men. This represented 54% of the community's adult members. Women and men were interviewed separately, usually at different times, with every effort made to assure independence of response to the questions.

The highland Chinantec municipio selected for this study (pseudonymously called San Francisco) consisted of approximately 1,800 subsistence cultivators and was located in northern Oaxaca. Until about 1965, the municipio closely fit Wolf's model of a closed corporate peasant community (Wolf 1957). At the same time, men controlled access to economic resources, and all formal political activities were in the hands of men. Beginning in the 1960s, a number of interdependent forces, including the construction of a road, a school, and a health center, began opening the community to the world outside.

Village demographic concerns impinged on Franciscanas' reproductive activities as women found themselves under constant pressure from fellow villagers to be prolific. This was despite the fact that the Mexican state was supporting a strongly antinatalistic agenda, which it sought to implement by means of widely distributed contraceptive services and extensive propaganda (Urquidi et al. 1974). Nevertheless, men argued relentlessly that a populous community was vital to the defense of the collectivity and its interests; most women agreed. Although most did not want large families of their own, they felt that for the common welfare *other* women should bear many children (cf. Kaler 2000).

By the time of the research, like most municipios in the region, San Francisco was already experiencing significant out-migration, principally by able-bodied men. Of the women interviewed whose children were grown, nearly two-thirds reported that at least one child resided outside the municipio, and more than a fourth reported that all their grown children lived elsewhere. This contributed to the widespread belief among villagers that the community's vitality was being sapped. It had become so difficult to fill the township's 18 political offices including mayor, policemen, and judge (which were assigned collectively and rotated annually) that their number was reduced by half. At the same time, many feared they had insufficient men to defend the communities' lands against armed attacks by neighbors who coveted the municipio's sizeable arable holdings. Villagers felt further threatened by state proposals to place some of San Francisco's lands under the control of other municipios or to consolidate it with neighboring

(enemy) townships because state authorities considered the community far too small for it to maintain its status as an independent *municipio libre*. In addition, a number of San Francisco's politically dependent subcommunities were successfully pressing their own claims for autonomy.

Other factors threatened the community's demographic base as well. Infant mortality and disease still took a significant toll: deaths from all causes had not declined during the previous 15 years (Rubel 1990). Half of San Francisco's adult population was over 40 years old. Many villagers of both sexes felt that life as they knew it was fast disappearing and that women of childbearing age were responsible. They thought the community's birthrate (mean pregnancies per woman = 4.95; s.d. = 2.71, median = 5) was far too low because women were not sufficiently motivated to reproduce. Most women of childbearing age disagreed. None saw it as her personal responsibility to be prolific for either abstract political reasons or for the sake of maintaining village life (Browner 1986a). Most, moreover, indicated that they would have been happy with very few children, generally far fewer than they had at the time they were interviewed. In fact, 80% of the women with at least one living child said they were content with their present family size.

Virtually all of the women interviewed said that they found large families less a benefit than a burden (cf. Segura 1994). Said Marta, "[The people] want us to have many children. That's fine for them to say. They don't have to take care of them and keep them clean. My husband sleeps peacefully through the night, but I have to get up when the children need something. I'm the one the baby urinates on; sometimes I have to get out of bed at night in the cold and change both our clothes. They wake me when they're sick and thirsty. My husband sleeps through it all" (Browner 1986b:714).

Women reported getting far less help from their children than they needed with domestic and agricultural tasks. They attributed this to the impact of schooling, as well as to the demands of school-generated after-school activities. Although most believed that both were important for their children's future, they also saw these activities eroding their own ability to make demands on their children's time and labor. In contrast, the majority of men felt that large families were still needed—for their own well-being and for the community's. Most reported wanting more children than their wives. While, as indicated above, the vast majority (80%) of the women who had as few as one child said they were content with their present family size, most men (60%) had to have at least four children before saying they were satisfied with the number they had.

Yet women were blocked by their husbands, and by their fears of the larger community, from limiting their own fertility. In the community, this was achieved through gossip about and slander of women with few children. This censuring took two forms. The ability of low-fertility women to meet gender role expectations and their commitment to the well-being of their community were repeatedly called into question. Married women with few or no children were considered selfish and lazy, particularly by other women. They were accused of abortion, infanticide, and infidelity. As one mother of six explained, "The women most likely to go with other men are the ones who don't have much work because they have no children. They have time for sex. But if you have a lot of kids like I do, you have to work very hard all the time. The tiredness takes over at the end of the day and you don't even think about other women's husbands. You don't have time to go out looking for men" (Browner 1986b:720; cf. Handwerker 1993 for gossip serving a similar function in the Caribbean). Villagers further sought to control women's fertility through an ideology that insisted that the survival of the community—and San Francisco as a distinct and autonomous entity—depended on high natality. Husbands brought home the gossip they heard and prohibited their wives from making any efforts to limit their fertility.

In this municipio, there were, in fact, two government-run clinics offering biomedical contraceptive services. Yet few women would use them. Only 10 of the 180 I interviewed admitted to ever having tried any means of birth control, and just 7 said they were still contracepting at the time of the interview. Five of the 10 who acknowledged seeking birth control said they had done so over their husband's objections, and only 5 (not necessarily the same individuals) took personal responsibility for their decision. The rest said that permission to contracept had come from a nurse or a physician, who had urged them to use it for medical reasons. Even those who might have wanted to try herbal or other traditional means of contraception or abortion could not turn to midwives or other presumably knowledgeable local women. For example, when I asked the municipio's most renowned midwife/curer whether anyone had ever approached her with such requests, she incredulously replied, "They wouldn't dare."

Franciscanas further responded to spousal and community pressures to reproduce not simply by refusing to use contraceptives but denying they even *knew* anything about limiting fertility. Eighty three percent said they knew of no herbs or other remedies that could be used to avoid pregnancy; 86% said they knew no way to provoke an abortion. Denial, however, was generally not the same as ignorance. Probes revealed that 60% of those who had initially denied knowledge of all ways to limit births subsequently indicated they had at least heard that such techniques existed. However, the responses to these probes tended to be oblique and included denials of any personal experience: e.g.,"They say there are pills, medicines, but I myself haven't looked into them. . . ."; "There used to be a lot of herbs, but I never tried any of them." None of this proves, of course, that some Franciscanas were not, in fact, covertly limiting their fertility, as has been documented in

other highly pronatalistic societies (Browner 1980; Devereux 1955; Gordon 1977; McLaren 1990). But the data make abundantly clear the fact that any whose actions became known faced certain marginalization.

Although structural patterns and cultural configurations differed sharply in the first two examples, quite similar conjugal dynamics were seen. In San Francisco, community ideologies dictated that birthrates be as high as possible. Most men saw it in their own interest to support and reinforce these ideologies in their own homes. As in Cali, women in San Francisco generally lacked independent access to economic rewards and political power. Gender ideologies helped sustain this imbalance. At the same time, despite their inability to exercise effective control over their own reproductive activities, through gossip and slander these Franciscanas served collective and patriarchal objectives by helping to censure and stigmatize women who sought to challenge male dominance in reproduction. This case, then, demonstrates the power of local cultural ideological constructs that encourage maternity and high fertility over external institutional structures and ideologies intended to make it possible for women to limit their fertility.

Fetal Diagnosis for High-Risk Mexican-Origin Babies in the U.S.

In the previous two examples, I showed that many women in two very different cultural settings allowed men's wishes to determine key aspects of their own reproductive behavior. In both situations, women lacked independent sources of economic power to which they could gain access only through men. Cultural ideologies reinforced this imbalance, making it meaningful to those involved. In contrast, in the next example, women were less economically dependent on male partners, and gender ideologies legitimated greater female autonomy. These enabled women to have more control over their reproductive activities. In this California study of Mexican-origin women's decisions about fetal diagnosis, economic, structural, and ideological factors worked together such that many women acted on their own wishes rather than acceding to those of their male partners; in other cases, couples together made the decision.

Since the mid-1980s, the state of California has offered all pregnant women who enroll in prenatal care prior to their 16th week of pregnancy a blood test that screens for serious fetal disabilities. Virtually none of the prenatally detected conditions has any treatment or cure (Blatt 1988). Inducing a second-trimester abortion is all medicine can offer in the event that a serious problem is detected. Although the blood screening test is voluntary, most women of all ethnic backgrounds who are offered fetal screening agree to be tested (Press and Browner 1998). This in and of itself is significant, since the vast majority say they would not abort their pregnancy even if a defect were found (Press and Browner 1997). Women who screen positive are advised to seek further testing. Initially this involves a high-resolution ultrasound. In about half the cases, the ultrasound explains why the woman screened positive, most often because of a misdated pregnancy or other benign situation (e.g., the presence of twins). Occasionally, the ultrasound detects a gross fetal defect. If the ultrasound cannot explain why the woman screened positive, she is generally offered amniocentesis.

Amniocentesis is an invasive diagnostic procedure in which a 3 1/2" hollow needle is used to withdraw a quantity of amniotic fluid from the womb for chromosomal analysis. It can cause a variety of minor medical complications but also has a small risk of miscarriage (Blatt 1988). Many women also find the prospect of having a needle inserted into their pregnant wombs frightening—or at least disconcerting. Our study was designed to investigate how a group of Mexican-origin women living in California and their male partners decide whether to have amniocentesis after the woman has screened positive and the high resolution ultrasound appears normal. At this point, clinicians suspect that something may be wrong with the fetus, but they cannot be certain without performing an amniocentesis.

I became interested in this issue because prenatal care providers who work with Mexican-origin women believe that their higher rates of amniocentesis refusal are higher than those for women from other ethnic backgrounds due largely to the fact that the women's husbands will not allow their wives to be tested. In fact, Mexican-origin women and other Latinas often tell clinicians that this is why they are declining the test. Based on my earlier work in Colombia and Mexico, where I found that many women put their male partners' wishes ahead of their own in other types of reproductive activities, this seemed a plausible explanation. I therefore designed a study in which I hypothesized that in the majority of Mexican-origin women's amniocentesis decisions, whether for or against the procedure, the woman would defer to the man.

We conducted face-to-face, semi-structured interviews with 147 pregnant Mexican-origin women who were offered prenatal genetics services at six southern California genetics clinics between 1996 and 1998. We also interviewed 120 male partners. About 2/3 of the women and men were born in Mexico and came to the United States as adolescents or adults; the rest were born in the U.S. to parents who traced their ancestry to Mexico, or they were born in Mexico but came to the U.S. as children and were educated here (8% of the male partners were Latino but not from Mexican backgrounds). While only about a quarter of study participants had gone beyond secondary school, those who did were significantly more likely to be Mexican American. Annual household income was also higher for the Mexican Americans: 22% of female immigrants

and 38% of the Mexican American women reported household incomes of more than $20,000 *per annum*. The sample was overwhelmingly (83%) Catholic but not particularly observant. Only 16% reported attending Mass every Sunday, and just 13% regularly went to confession and took communion. Comparing the women interviewed with all Spanish-surnamed women who were offered prenatal genetics services at the same six clinics in 1996, those we interviewed were somewhat younger, better educated, and slightly more likely to agree to amniocentesis, although none of these differences reached statistical significance. The reproductive histories of both groups of women had, for the most part, been uneventful, and there was no significant difference between them.

The male partners of 84% of the women interviewed were employed, with the vast majority (86%) working full-time. In contrast, characterizing the women's employment status was a less straightforward task. Less than 35% were working at the time of the interview, either full- or part-time, and an additional 12% had done so until their pregnancy. However, the responses of 41% did not fit standard categories. Several, for instance, engaged in various types of bartering such as child care in exchange for groceries. Another woman worked in the school kitchen of one of her children in exchange for lunch for herself and her youngest child. Still others had other types of informal arrangements, such as intermittently filling in on the job for a relative or a friend. Therefore, to get a sense of the extent to which the women in the study were dependent on male economic support, we asked a series of questions such as, "Do you contribute to the rent, food costs, clothing costs?" Fifty-nine percent of the women answered yes to the question about contributing to food expenses.

Contrary to expectation, over 50% of the women said that they themselves had decided whether to have amniocentesis and 23.5% said that they and their partners had jointly decided (Table 1). At the same time and also contrary to expectation, interesting variation apparently linked with acculturation was seen: recent immigrants of both sexes were significantly more likely than U.S.-born study participants to say that the decision had been exclusively the woman's rather than a joint decision (Markens et al. 2000). Only 14% of the women indicated that the decision had been made by the man, although again, recent immigrants were twice as likely as Mexican Americans to report this. The remaining 11% said that they had allowed someone else (e.g., parents, in-laws, siblings, etc.) to decide whether they should have amniocentesis. The male partners generally agreed with the women's reports: 51% said that the woman had decided alone, and 24% said they had decided together. Only 14.5% of the male partners indicated that they alone had decided about amniocentesis.

Table 1. Whose opinion counted most in the amniocentesis decision? (couples only, $N = 120$)[a]

	Women		Men	
Own	61	51.3%	16	14.5%
Spouse	17	14.3%	56	50.9%
Both	28	23.5%	26	23.6%
Other	13	10.9%	12	10.9%
Total	119	100.0%	110	100.0%

[a] Totals do not equal 120 for each sex due to missing data.

Clear explanations for these patterns are seen in women's and men's responses to the question, "Who had the final say in the amniocentesis decision?" As Ramona explained, "I knew all along that it was my decision because . . . the baby is inside me. . . . I know it's both our baby but mothers have that motherly instinct and I don't think I even asked. I know I asked him how he felt, but not necessarily what he wanted me to do." Teresa similarly said, "Basically it was my decision to make because I was the one who was going to get stabbed about 20 times with a 20-inch needle."[4] Men tended to offer similar rationales. Said Hector, married to Delores, "I left it up to her because I'm not the one they're sticking the needle into." And Rogelio explained, "I didn't force her to decide [against amniocentesis]. I went to the [genetic] consultation to support her. One can't do anything [else]. Besides, it's her body."

In this southern California setting, an array of social structural factors enabled women to decide about amniocentesis without necessarily consulting with their male partners. And, I must stress, the decision was seldom an easy one, for many in our study considered the risk of miscarriage associated with the test to be high and the procedure, therefore, a risky one (Browner and Preloran 2000a; Browner et al. 1999). Yet the California health care system assumes that a decision about amniocentesis will be made by the pregnant woman. While she must consent to the procedure, her partner's permission is not required, nor must he be present for the test to be administered. While men did not necessarily accept this with equanimity, they knew there was little they could do about it. Providers encourage women to involve their partners in the decision process and to bring them to the genetics consultation where amniocentesis will be offered, but neither the man's consent nor his presence is essential.

Other structural factors further facilitated women's ability to decide. First, most Mexican-origin women living in the U.S. are not as dependent on men for economic support as Caleñas, Franciscanas, or most other Latin American women. There are greater opportunities for employment, more extensive sources of public assistance, and more abundant child-care options. Moreover, U.S. gender ideologies allow women greater autonomy and stigmatize single mothers to a lesser degree, both of which make female independence a more viable option. Mexican-origin women, even very recent immigrants, are well aware of the fact that in the U.S. there is greater freedom for women and less societal support for extreme forms of male domination.

As Jennifer Hirsch, who worked with recent immigrants from Michoacán, Mexico, to Atlanta, Georgia, reports: "When a Mexican mother recently criticized her married daughter, who had migrated to Atlanta, for answering back to her husband, the daughter [is said to have] replied, "No mom, here the woman is the boss, it's not like back in Mexico where the men are the boss. . . . No, here, they don't hit you. . . . Here, the men are the ones who stand to lose" (Hirsch 1999:1340). This is clearly a naively idealized view of how the lives of recent Mexican immigrants change when they come to live in the U.S. Yet women's beliefs that these changes are not only possible but inevitable exert their own form of power. And it was these interacting dynamics, as much material as ideological, that made it possible for women themselves to decide whether to have an amniocentesis, incorporating their male partners when and only to the extent that they wished.

Yet a significant proportion of women did not decide on their own about amniocentesis. What led some women to incorporate their male partners into the amniocentesis decision process and others to decide on their own? Women incorporated the man if they were uncertain about his feelings about the pregnancy, and they wanted him involved in any decisions that could have long-term consequences for them both. Women consulted with their partners, for instance, if they were fearful that the child might be born handicapped and they wished to determine whether their partner was willing to rear and support a handicapped child. If the man said, "No, don't have amniocentesis, I want this child however it's born," they generally turned down the amniocentesis. But if he said, "Better have the test, I don't know if I could raise a handicapped child," they usually agreed to be tested to leave open the option of abortion. In contrast, women who believed they could not count on their partners' ongoing commitment to the relationship and/or his economic support decided about amniocentesis on their own. Acknowledging the possibility that they would be raising the child by themselves, they saw the amniocentesis decision as their own to make.

Ana's case was typical in this regard. She had migrated from rural Mexico, first to Tijuana and then to Los Angeles, intending to live with her sister until she became economically self-sufficient. Four months later, she was joined by her common-law husband, Jorge, and their two children, aged 15 and 10. Ana's sister found them a small, cheap apartment, but neither Ana nor Jorge were initially able to find full-time work. Ana was hired to clean a beauty parlor three times a week, and she supplemented this income by taking day jobs cleaning private homes when she could find them. Jorge only found intermittent work as a gardener. His drinking quickly intensified, and, as a result, he slept late each morning. Before long, even less work was forthcoming. Although their rent was just $280 monthly, it was far beyond their means and they found themselves facing eviction. In the midst of these crises, Ana discovered that she was pregnant. Jorge began drinking even more heavily, and Ana decided to move out on her own for a while. Her sister found her and her older son work as live-in domestics.

When asked who made the amniocentesis decision, Ana replied, "Me, alone. . . . Jorge wanted us to have the baby no matter what, but I know I can't count on him. Look how in all this time he hasn't even found work. . . . All he does is drink. So that's why I thought it would better not to have the baby if it was going to be born with problems. . . . How am I going to take care of another child if I can't even take care of the one I have? . . . [the little one is] still at my sister's. What would I do if this one were born sick?"

In contrast, couples decided together, that is, the woman incorporated the man into the decision process, if both wanted the child and she did not question his long-term commitment to her and their children. However, in the vast majority of these cases, it was still the woman's opinion that had the most weight in the decision about whether to have amniocentesis and risk miscarriage, opening up the possibility of a positive diagnosis and the difficult decision about abortion it would entail, or turn down the procedure and accept the possibility of bearing a handicapped child.

In these situations, however, while the amniocentesis decision was seen as primarily the woman's, both sexes saw the role of the man as to support *(apoyar)* her in the decision that she chose (Browner and Preloran 1999). Carmen, for instance, explained why she wanted her husband to accompany her to the genetics consultation, "I always want him there when stuff like. . . . He is the one that really asks the questions. . . . He is the one that helps me out." Diana's view was similar: "Usually I wouldn't like doctors . . . [but] just knowing he's there makes me more comfortable and relaxed."

Similarly, when men who accompanied their wives to their genetics consultation were asked why they went, replies like Antonio's were common: "I like to have to be there too. We're both pregnant, you know." Raúl concurred, "From the beginning . . . I wanted to be there with her, I wanted to be present—that is my part, because the child is from both of us." Victor expressed similar sentiments when asked why he regularly attends his wife's prenatal consultations, despite having to miss work to do so: "Just to be there for her at her side, in case she needs anything or if there's anything wrong that I need to hear about—and to support her. . . . That's all I can do really. I can't do anything besides be there for her." Not every man assumed the role of supportive spouse with equal interest or enthusiasm, and some women had to cajole their partners in accompanying them to the genetics consult where the amniocentesis offer would be made. And still other women, like Ana, above, felt they were better off attending the genetic consultation on their own (Browner and Preloran 2000b). At the same time, what it actually means when

men leave amniocentesis decisions to their female partners must also be questioned. Said one perinatalogist, herself a bilingual Latina with a large Latino clientele:

> It's such a double-edged sword because if she has that whole responsibility, it sounds good to be able to decide for yourself, but it really isn't good because she's also gonna have the whole responsibility if something goes wrong. . . . "And then, if I have a baby with a problem, it's gonna be my responsibility, too?" I hear guys say that [it's the woman's decision] a lot. It's a very big stress in the marriage when people aren't sure what to do. It's a very hard decision to make alone.

Nevertheless, I was struck by the extent to which many men in this study sought to aid and support their wives during their pregnancies, including encouraging the women to decide about amniocentesis despite the fact that their decisions might not have been what the men themselves would have chosen.

Situating Women's Reproductive Activities

My intent has not been to explicitly compare the three examples but rather to illuminate the effects that variable structural conditions and normative patterns can have on conjugal dynamics, and ultimately on the ability of women to engage in reproductive activities on their own terms or on those of their male partners. The fact that these studies were conducted over a twenty-five-year period in three countries would make any direct comparison problematic. In addition, differences in structural conditions, gender and reproductive ideologies, and the reproductive activities that were the focus of each study would make it difficult to know exactly which dimensions to compare. And so, instead, my intent has been to offer three examples of how larger contexts that are both structural and social, and within which cultural values offer resources and opportunities as well as constraints and limitations, shape women's reproductive activities.

At the same time, any analysis that draws on data collected over a quarter of a century should be situated within my own intellectual history and the changing contours of the field. As indicated earlier, until the 1970s, human reproduction attracted little anthropological attention. At that time most research on the subject was concerned with the norms, beliefs, and values associated with reproductive behavior. As such, anthropological studies of human reproduction reflected the broader intellectual trends dominant at the time (McClain 1982). Issues of power in relation to reproduction were absent from anthropological thinking, and, despite its widespread practice, virtually no attention had been paid to illicit, induced abortion. Simultaneously, the importance of social networks in influencing individual behavior was gaining currency among anthropologists as they increasingly shifted their attention from tribes, villages, and other seemingly bounded units to urban settings (Barnes 1972; Gulliver 1971; Mitchell 1969).

In keeping with this changing orientation, in 1974 I designed the Cali abortion study to explore the means by which women drew on social networks when facing a decision about whether to continue or end an unintended pregnancy. Drawing inspiration from the newly emerging field of feminist anthropology, I planned to look primarily at the role and influence of female relatives and friends. It was only in the course of many months of listening to women's narrative accounts of their decisions about unintended pregnancies that I came to fully appreciate the centrality they attributed not to other women but to their male partners. Those Caleñas' self-depictions of powerlessness were consistent with an ideological norm that prized female passivity, dependency, and suffering. Given the strong sanctions against both female independence and induced abortion, it is unlikely that the women in my Cali study would have been able to depict themselves as agents, regardless of the actual extent to which this might have been the case. At the same time, the discovery that those Caleñas put their male partners at the center of their accounts of their abortion decisions forced me to attend to the consequences of such gender-based stratification for women's reproductive activities, such as their decisions about the highly stigmatized and dangerous act of illicit abortion.

By then, other feminist anthropologists had also begun to examine the social and individual consequences of gender hierarchies and the means by which women exercise autonomy in societies controlled by men (Miller 1993; Rogers 1978; Sanday 1981; Schlegel 1977). Drawing insight from my Colombia research but shifting to a Mexican rural community, in the Oaxaca study I hypothesized that the essence of female autonomy lay in women's ability to control their own fertility. I further hypothesized that women who most effectively exercised reproductive autonomy would function more autonomously in other areas of their lives as well. As it turned out, reproductive relations and activities were exceedingly highly charged topics in the particular community I chose for my research. However, much to my disappointment, I found minimal variation in the extent to which women functioned "autonomously" in the reproductive arena. Moreover, while some women were quite independent in other aspects of their existence, no relationship between reproductive autonomy and social autonomy was found (Browner and Perdue 1988:91). Today, nearly twenty years later, reproductive dynamics in San Francisco are much the same. Although a significant proportion of childbearing-age women have migrated from the community, those who never left are having even more children than women had in their mothers' generation (Morris et al. 1998).[5]

As the 1980s drew to a close, feminist anthropologists were working in greater numbers in postindustrial communities. Many had become intensely interested in the medicalization processes that were affecting women's health care in general, and reproduction in particular (Ginsburg

and Rapp 1995; Rapp and Ginsburg 1999). Within this context, attention was quickly turning to the growing role that technological information was coming to play in routine prenatal care. I myself had moved from a liberal arts anthropology department to a school of medicine, where the expectation was that I engage in U.S.-based research. All of this converged in my choice of a new research topic: how a group of pregnant women from Mexican backgrounds decided whether to avail themselves of fetal diagnostic information. My previous work with Latinas elsewhere and our own pilot research led me to believe that many—if not most—would defer to their male partners. I was therefore skeptical when both women and men indicated that this was not the case. I wondered if they were telling the truth or whether our amniocentesis decision-making data might be unique. Perhaps amniocentesis was perceived by our study participants to be a very specialized medical procedure that "belonged" to women, or one that men simply could not know enough about to render an opinion? Perhaps both genders were intuiting in providers' supposedly neutral discourses a bias that amniocentesis decisions should be made by women?

I therefore conducted a literature search to determine how our results on amniocentesis decisions compared with what others found for other types of reproductive decisions made by U.S. Latinas such as whether to use birth control, become pregnant, or have an abortion (Andrade 1980; Hahn and Muecke 1987; Salgado de Snyder 1987; Stroup-Benham and Treviño 1991; Zambrana 1990; Zambrana et al. 1991). In fact, other researchers find similar patterns. For instance, Amaro reports that a group of Mexican American Los Angeles women said that their decisions about whether and when to get pregnant and whether to use contraception and abortion were primarily their own (Amaro 1988). Similarly, Urdaneta found that Chicanas were willing to end unintended pregnancies over strong male objections if they themselves felt that they needed to do so (Urdaneta 1980). More recent research also shows that new Mexican immigrants say they prefer IUD, injectable, and oral contraceptives because they can be more easily used without their partners' knowledge (Harvey et al. 1997; Staunton 1999). However, the fact that the women in our California study saw it as legitimate to decide on their own about amniocentesis reflects not only a broader pattern of reproductive decision making among U.S. women from Mexican backgrounds but also changing ideas about what it means to be a woman and what is possible for Latino women to achieve. It does not seem to be an aberration associated with the particular type of reproductive activity under investigation.

All three studies were conducted among groups of Latino origin. Are there broader implications to be drawn from this fact? It is by now a truism that Latino culture is not a homogenous entity. Although people who call themselves—or are referred to by others as—Latinos may share a common language, religious tradition, and, for some, a common history, they also vary by gender and generation, as well as by social class, race, ethnicity, nationality, region, geography, migration history, and the like. Yet beyond sweeping generalizations, little research has looked closely at the implications of such structural variation for specific aspects of social life (Schur et al. 1987; Stroup and Treviño 1991). I have therefore given three examples in which varying structural conditions and normative systems in three Latino communities were associated with differences in the ways women viewed their reproductive options and engaged in reproductive activities.

In the three settings we saw, for instance, that the construct commonly glossed as machismo had different meanings and took on different forms, even as it varied within settings (Gutmann 1996; Melhuus and Stølen 1996). But speaking broadly, in Colombia it meant that a man who impregnates a woman had the right to deny paternity, abandon the woman, or insist on an abortion. In contrast, in the Oaxacan village, it generally meant that men imposed their desire for large families on their wives. In southern California, in many cases it meant that the *macho* was transformed into *un hombre familiar,* a family man whose power is derived from his ability to take care of his family (Mirandé 1986). And, of course, these options are not mutually exclusive; in each setting, variation on the more typical pattern could often be found. As such, these results support Del Castillo's observation that among Mexicans "gender ideology is much too complex and multifaceted to be essentially characterized as male-dominant . . . nor does ideal male dominant gender ideology [necessarily] translate into normative behavior at the local level" (Del Castillo 1993:239, 237; see also Benería and Roldán 1987).

Finally, throughout this paper I have argued that it was not structural factors alone that led the women in these examples either to perceive themselves as agents of their own reproductive destiny or not to do so. I have sought to show that cultural factors promoted or inhibited their ability as well. And, significantly, in each example, these normative factors had societal standards of female respect and morality at their core. In Colombia, many women stayed with men who were frankly abusive. When asked why, although economic explanations were common, just as typically women made statements like the following, "Certainly it's good to live with a husband. . . . Not only are the children more respected but you are more respected in the barrio besides. You can hold your head up and not feel ashamed of your life" (Browner and Lewin 1982:66; cf. Del Castillo 1993:248). Similarly, in the Oaxaca example, when women refused to use the birth control they knew was available, it was less because they feared losing their partners' economic support than because of the kinds of criticisms they

knew they would be forced to endure if their efforts to limit their fertility became known.

Similarly, the California data are consistent with a rather large literature that finds that many women from Third World countries who immigrate to the U.S. become more autonomous and assertive, and more insistent on more egalitarian unions (Grasmuck and Pessar 1991; Hondagneu-Sotelo 1994, 1999; Menjívar 1999; cf. Sargent and Cordell 1998). Obviously, these transformations derive in part from economics and in part from the knowledge that they do not have to tolerate being beaten by their spouses. But such women are also aware of the fact that there are broader differences between U.S. and Mexican cultures with regard to their societal expectations for women. Speaking about her husband and their marriage, one of our California study participants explained, "He's always given me my space, as much in Mexico as here. But here people don't see it as something bad. [In Mexico] they were always criticizing him for that."

The fact that Latin American immigrant women would seek to emulate a more "companionate" model of gender relations is neither unique nor a recent phenomenon. Sociologists like Joseph Folsom (1934) and William Goode (1964) described how worldwide industrialization and urbanization processes have contributed profoundly to the dissolution of the patriarchal extended family. And data from other parts of the world, not just the U.S., seem consistent in documenting gains for women when they migrate to industrialized societies. While Pessar has recently argued that these are only modest gains (Pessar 1999), I conclude that they are considerable in the eyes of the women experiencing them, certainly in the reproductive arena.

Summary and Conclusions

Different combinations of structural and cultural factors influenced the likelihood that women would incorporate their male partners' wishes into their reproductive activities in each of the three examples. At the same time, each example revealed some agency on the women's part: their actions were, at least to some extent, under their own control. What is clear from this material, then, is that women's reproductive activities are neither wholly free nor completely constrained (Lopez 1998). In this sense, it challenges the conventional dichotomy that women are either agents acting solely of their own free will or completely constrained by the actions of men. It also demonstrates the need to develop more nuanced conceptualizations of "agency," particularly when the objective is to understand the life choices and strategies of women—and members of other subordinated groups.

Economic factors were invariably important in each of the three examples, but not to the same degree in each. They were most important in the Colombian example. There, the lack of job opportunities for women, particularly single mothers, along with the absence of strong extended family support forced those with dependent children to either fend for themselves or depend on a man. These economic impediments worked in concert with cultural norms to legitimate female subordination while simultaneously reinforcing men's authority, independence, and autonomy. As a result, in the Caleñas' decisions about whether to continue an unintended pregnancy, they typically put the desires of their male partners ahead of their own wishes.

In San Francisco, Oaxaca, Mexico, economic factors were also important, but in a different way from the Colombian example. In a rural setting like this one, it is difficult, but not impossible, for a woman to raise children without a male partner. Single Franciscano mothers generally lived with their own families and, although single motherhood was not a desired option, in fact, single mothers did not experience significant stigma. This may have been partly due to the community's strongly pronatalistic ideology. In contrast, married women were subjected to relentless social pressures to bear many children, pressures that were both demographic and economic at their core. All of this produced a fear in most men that the community as they knew it would not survive unless many more children were born. Franciscanas, in contrast—denied access to every significant source of wealth, prestige, and power—held a lesser stake in the survival of the traditional community. Lacking any organized means to challenge the prevailing pronatalistic and gender ideologies, women subordinated their own wishes for small families to their husbands' for larger ones.

The California example was different. The California health care system expects that women will make their own reproductive decisions, in consultation with male partners if they choose. Nevertheless, I was struck by the extent to which the women in our California study were willing to exercise this prerogative, for the existence of an institutional structure that gives women the right to make reproductive decisions does not guarantee that this will occur. However, in addition to the existence of institutional supports, Mexican-origin women in the U.S. had access to economic and cultural resources that facilitated their ability to bring about the reproductive outcomes they chose. California Latinas, even those who are mothers, find it easier than their Latin American counterparts to find employment. They are not forced by economic factors to endure an untenable domestic situation as, for instance, many Caleñas were. At the same time, the ideologies of female subordination so powerful in the Cali and Oaxaca examples, and found to varying degrees throughout Latin America, are tempered somewhat in U.S. society. In California, then, economic and cultural factors worked in concert with institutional ones to give women far greater ability to determine their own reproductive activities.

I have offered three examples of how differing structural conditions in interaction with cultural factors lead women

to either generally put the wishes of their male partners ahead of their own or not do so in matters pertaining to reproduction. It would be illuminating to look at other examples to determine the extent to which these findings are generalizable and what other variations might be found. Nevertheless, these three examples demonstrate that reproduction is extremely well situated for generating and interrogating social theory. For it is within the shifting horizons produced by large-scale and local societal transformations that our collective—and individual—reproductive relations and practices take their particular form.

Notes

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1. Some of this material appeared in a somewhat different form in Browner (1979).

2. These fears, to some extent well founded, remain widespread throughout Latin America and elsewhere (Coeyteaux et al. 1993).

3. Some of the material that follows was published in Browner (1986b).

4. This is clearly an exaggeration on both counts: as indicated, the needle is in fact about 3 ½" long, and in none of our observations of 45 amniocenteses did the physician make multiple attempts to withdraw amniotic fluid. Yet it clearly reveals the extent and depth of the fear Teresa (and many others in her situation) associated with the procedure.

5. Fertility of one-time migrants: mean = 4.2, s.d. = 2.8, median = 4; fertility of women who never migrated: mean = 5.9, s.d. = 3.2, median = 6.

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