

Chapter 5

CAN GENDER "EQUITY" IN PRENATAL GENETIC SERVICES UNINTENTIONALLY REINFORCE MALE AUTHORITY?

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Introduction

Despite the fact that both sexes are essential to human procreation, it was only until recently that sexual and reproductive health research, programs, and policies focused overwhelmingly just on women. This is no longer the case. After conducting an analysis of the recent literature, Margaret E. Greene and Ann E. Biddlecom assure us that "[o]ne can no longer assert that men are missing from the literature.... [T]he past two decades show consistently about three female references to every male reference, with a very slow annual increase on men alone" (2000: 90).

Still, insight remains limited, in large part because most work on the subject derives from a narrowly focused "problem-oriented" approach. For example, the many studies of "men's role" in massive social issues such as the spread of HIV, rising rates of single motherhood, or pregnancy in adolescent women reduce their role to a single or small number of variables. As valuable as these contributions are for understanding the dynamics of particular social issues, the broader picture of men and reproduction remains woefully incomplete. In an effort to respond, Matthew C. Gutmann recently observed,

"We need studies that concentrate on men and masculinities, on men as engendered and engendering beings ... because we know too little about men-*as-men* ..." (2003: 1, emphasis in original).

Such research would shed light on social dynamics far beyond the specific issues at hand. A broad focus on men and reproduction can illuminate the mechanisms at the core of "biopower," that state of affairs where what is at stake is nothing less than the production and reproduction of life itself through the exercise of a power "that extends throughout the depths of consciousness and bodies of the population—and at the same time across the entirety of social relations" (Hardt and Negri 2000: 24).

Research attention to men as gendered and engendering beings has begun to reveal the subject's true complexity. Power emanates from multiple sources—gender politics, cultural ideologies, material factors, and institutional policies, to name some of the most obvious—each of which has its own momentum that may be mutually reinforcing or work at cross-purposes. To what extent, for example, should gender determine the selection of who runs and staffs programs in women's reproductive health? Many such programs, particularly in the global South, are controlled by male policymakers, administrators, and providers who tend to privilege their own views over those of their largely female clientele (Greene 2000). Yet the opposite is just as problematic, as when women are the sole focus, and men's needs in the areas of sexual and reproductive health are subordinated or altogether ignored (Dudgeon and Inhorn 2004: 1381). Examples of this have been reported from parts of Mexico where some women uncritically privilege physician's knowledge over their husband's as well as their own (Lerner et al. 1994 as cited in Figueroa-Perea 2003: 117).

Recent attempts to find more meaningful ways to conceptualize reproductive health interventions have stemmed from two distinct conceptual orientations. One derives from the assumption that due to pervasive and persistent gender-based differences in access to power and resources, women and men have fundamentally different rights and responsibilities with regard to reproduction and reproductive health. "Interventions following from this framework ... tend to focus on the reproductive health problems *caused* by men, along with approaches *empowering* women" (Dudgeon and Inhorn 2004: 1382 emphasis in original). The objectives within this framework are to advance reproductive health equity but not equality. Yet, as A. M. Basu observes, focusing on equity may undermine the progress it seeks to achieve if men are excluded from the very interven-

tions in which their endorsement, if not participation, might be most needed (1996). The second framework, typically called "Men as Partners," explicitly recognizes both men's contributions to women's reproductive health and men's own needs, thereby prioritizing equality over equity. However, by seeking to reconcile what might be conflicting reproductive goals, this framework tends to downplay the potentially different sexual and reproductive strategies that may be pursued by men and women (Wegner, Landry, Wilkinson, and Tzanis 1998).

In reality, both approaches are limited, for reasons Juan Guillermo Figueroa-Perea outlines in his eloquent plea for "gendered perspective" on reproductive health. He writes, "A more accurate analysis of men's presence in reproductive health would situate them in specific heterogeneous contexts, so as to avoid single and simplistic readings of a process as complex as reproduction" (2003: 114). Doing so would involve analyzing the relational, social, and often antagonistic nature of human reproduction, in which tensions, conflicts, and disagreements between men and women exist within broader socio-cultural and political environments, and reproductive activities and reproductive health are shaped—if not determined—by multiple actors playing multiple roles (Greene and Biddlecom 2000: 84, 88). Focusing on men's participation in women's health is an important first step, but in and of itself insufficient. Men need to be seen as actors in their own right, with sexuality, health, reproductive, and concrete material needs of their own.

My objective in this chapter is to utilize Figueroa-Perea's gendered perspective to explicate aspects of the reproductive behavior of a group of pregnant Mexican-origin women living in Southern California and their male partners, and to show how such behavior is shaped by domestic politics and other broad social factors. The classic accounts of Mexican culture consistently described the "separate spheres" of social life, which gave women power and authority in the domestic domain, particularly in the areas of reproduction and family health and welfare (a pattern also not so different from the idealized European-American model). A newer US standard favoring husbands' participation in domestic activities, including all aspects of women's pregnancies, prenatal care, and parturition, is rather alien to most working-class Mexicans who immigrate to the US. Neither gender can reach a consensus on the consequences of this change: some welcome it; others feel it has eroded their traditional sources of autonomy and power; and for others, it has meant some of both (Hongladareu-Sotelo 1994; Hirsch 2003).

Prenatal Genetic Screening in the US

The research was designed to determine what factors led a group of women of Mexican origin to accept or decline offers of amniocentesis to detect the possible presence of birth anomalies. The women had all been classified as "high risk" for bearing a child with an anomaly because they had screened positive on a routine prenatal blood test (ACOG 1996). As with any type of medical screening, a positive result indicates only the possible presence of a problem, and diagnostic testing is needed to determine whether anything is in fact wrong with the pregnancy. For fetal diagnosis, the most commonly used diagnostic procedures are ultrasound and amniocentesis, up to 99 percent of which show the woman to be carrying a normal, healthy fetus (Alteneder et al. 1998).

Some regard the practice of fetal diagnosis as inherently problematic because virtually all anomalies detected have no cure. In the event of a positive diagnosis, women are offered the option of abortion. When correctly performed, the blood tests and ultrasound carry virtually no iatrogenic risk; however, amniocentesis can cause a variety of minor medical complications, as well as miscarriage (Blatt 1988). And while any miscarriage or abortion can be a traumatic experience, abortion to avert the birth of a child with an anomaly may produce particular anguish because it is typically performed late in the second trimester of pregnancy and can require an overnight stay in the hospital.

From its start, prenatal diagnosis evoked such intense controversy in some sectors as to lead even former Surgeon General C. Everett Koop to denounce the tests as "search and destroy" missions. Those who advocate its use as providing expectant parents with essential options take shelter from such criticism behind the ethical principle that parents should be free to opt for prenatal diagnosis and to use the information it provides as they see fit. This ethic of parental autonomy and self-determination is institutionalized in the form of "non-directive" genetic counseling, in which the intended role of the medical professional is to provide information to help clients "understand their options and the present state of medical knowledge so they [themselves] can make informed decisions" (Fletcher and Wertz 1993). Genetics service providers are trained to avoid giving personal opinions when providing genetic counseling. If a client should ask, "What would you do in my situation?" a standard reply is, "Since I'm not you, what I would do is not important" (author's field notes 1999).

In California, a typical prenatal genetic consultation lasts thirty to forty-five minutes and is provided by a licensed genetic counselor with master's-level training in genetics and counseling techniques. Whenever possible, prenatal counseling is offered to the couple as a unit. This is mainly because the genetic counselor must obtain detailed family medical histories from both parents to get an accurate picture of the "risk status" of the fetus, and many pregnant women know little about their husband's family's medical history. It is also because although only the woman has the legal right to accept or decline fetal diagnosis, the conventional view among US prenatal care providers is that it should be the couple's decision. This assumes, of course, that "the couple" can and should be regarded as a unit, with common attitudes, interests, and goals. Yet there is ample evidence that, as in anything else, couples can differ in their views on prenatal diagnosis (Rapp 2000; Kolker and Burke 1994), reasons for seeking prenatal genetic counseling (Sorenson and Wertz 1986), attitudes about the potential difficulties of raising a child with disabilities (Beeson and Golbus 1985), and abortion for genetic reasons (Adler and Kushnick 1982; Pauker and Pauker 1987; Rothman 1986).

In this regard, the role that genetic consultation may play in amniocentesis decisions is not well understood. In large part, there has been little research because the earliest users of fetal diagnosis were a self-selected group who actively sought testing so they might end the pregnancy if an anomaly were found. Increasingly routine use of blood screening and ultrasonography, however, has introduced amniocentesis to entirely new constituencies of women (and their partners) for whom the genetic consultation, in and of itself, might be more consequential. There is a small amount of evidence to support this view. M. Verjaal et al. (1982) found that genetic counselors played a greater role when the initial impetus for testing came from a physician or midwife rather than the woman herself, while C. Scholz et al. (1989) report that interaction with prenatal genetic counselors was instrumental when the couple disagreed or were undecided about whether to have the test.

These findings may have particular relevance for understanding the prenatal genetic counseling experiences and amniocentesis decisions of Mexican-origin women, particularly recent immigrants. Many have only a vague idea as to why they have been referred for a genetic consultation and what services may be offered (Hunt et al. 2005). Others know that an amniocentesis may be an option and may be fearful of the procedures' known risks or have an exaggerated picture (Browner et al. 1999). Those who are better informed

may be loathe to admit to themselves or anyone else that they are considering fetal diagnosis because of its link to abortion.

I therefore hypothesized that genetic counselors would be more influential when the woman was ambivalent about whether to have the procedure and further, that when a genetic counselor sensed ambivalence from a woman, s/he allied herself with the male partner to gain consent—and that the resultant male empowerment could exacerbate domestic conflict related to the pregnancy and other issues.

Data for this chapter come from three sources: patient charts, face-to-face interviews, and systematic observations.

Chart Sample

The 1996 charts of 379 Spanish-surnamed women at four Southern California genetics clinics who screened positive were abstracted for age, occupation, education, place of birth, religion, reproductive history (including any children born with a disability), previous amniocentesis experience, screening-test result (i.e., high, low), amniocentesis decision, whether any family member was born with a disability, and whether her male partner accompanied her to the genetic consultation. A process was developed for coding the data, and descriptive statistics were calculated.

Interview Sample

Semistructured face-to-face interviews lasting one hour to several hours were conducted with two waves of Mexican-origin women and their male partners who were offered amniocentesis because the women had screened positive: an opportunistically recruited pilot sample of 25 couples and a systematically recruited main sample of 128 couples (plus an additional 28 women without partners) (see Preloran, Browner, and Lieber 2001, for more on recruitment methods and sample selection). Interview results reported here are based on combining the responses from the pilot and main samples. The research design had specified that women and men be interviewed separately, but as this often proved impractical, 49 percent of the couples were interviewed together.

Observational Sample

Systematic observations were conducted of the genetic consultations of sixty-five Mexican-origin women referred for prenatal genetic counseling because they had screened positive. A paper-and-pencil instrument was designed to record data including information conveyed, questions asked, content, and effect of interaction among par-

ticipants. Observational data were analyzed quantitatively and for content, with frequency counts made of the responses to the open-ended questions.

Genetic Screening and Gendered Ambivalence

Study participants reported favorably on their prenatal genetic consultation—asked to rate their satisfaction on a 10 point scale, the mean rating was 8.5. Only 12 percent of the women interviewed said they felt pressured by the counselor to accept amniocentesis, while 32 percent said they would have liked counselors to have been more directive or at least more explicit about their own opinions regarding the value of fetal diagnosis. At the same time, many participants felt uncomfortable with what they perceived to be the counselor's implicit pressure that they consent to amniocentesis. Several said they would have preferred that the counselor had terminated the consultation the first time the woman declined the offer. Instead, counselors always continued until they had completed their protocols, typically asking several times more if the woman was sure she did not want the procedure.

These findings are important because it was very common for the women to say they had arrived at the genetic consultation undecided as to whether to have amniocentesis. Only 14 percent indicated they had made up their minds beforehand, while 72 percent said they had decided "on the spot." Moreover, while there were few quantitative correlates of amniocentesis acceptance or refusal in either the chart or interview samples, there was a striking association in both samples between amniocentesis acceptance and the male partner's presence at the genetic consultation ($\chi^2=93.91$; $p=.000$; Browner and Preloran 1999: 96). It was specifically the male partner's presence and *not* that of other relatives or friends that was linked to amniocentesis acceptance. Women who attended the genetic consultation accompanied by others were no more likely to agree to amniocentesis than those who attended alone.

The 51 percent of the sample's male partners who did not attend the genetic consultation had a variety of reasons for their absence, the most common being the difficulty of getting or taking time off from work or being out of town for work-related reasons. Others needed to watch their other children, could not find parking, were afraid to leave their car unattended, were uncomfortable or nervous in hospitals, or lacked the patience to endure the long waits that clin-

ical consultations typically entail. In some instances, women actively discouraged their partners from attending because this gave the women more autonomy. In others, it was a combination of factors: attending was problematic for the man, and the woman did not encourage him to make a special effort because she preferred to attend alone.

The powerful link between male-partner presence and amniocentesis acceptance was unexpected, and the reasons for it are not obvious. It may have been that women attending with partners had already made up their minds to have the procedure and wanted their partners present for moral or material support, while women who had already decided against the procedure had no motivation for their partners to attend. Yet I could find have no solid support for this scenario. Although some women who ultimately agreed to amniocentesis may have come to the genetics consultation "inclined" toward that course of action, the data demonstrate that they had not yet made a firm decision, and their partner's presence facilitated consent.

Couple Who Easily Reached Consensus

Susana, 27, and Adrian, 25 (pseudonyms used throughout), grew up in working-class families in Jalisco, Mexico. Each had six years of primary education. She had been in the US for ten years prior to the interview, and he for four. They had a 3-year-old son with no known medical problems and no known history of birth anomalies in either family. This was her second pregnancy. They were interviewed together one evening in the living room of their small apartment.

Susana said she was very upset when she learned of the positive screening test result and that she had cried and cried. She was particularly terrified that the baby would be born with Down Syndrome. Adrian said he was also worried—and confused. "How could this be?" he asked us. "I don't take drugs. I don't beat my wife. I was really frightened."

Susana asked Adrian to take time off from work so that he could accompany her to the genetics consultation because "the husband should also know the risks." He was receptive. "I went to give her support," he told us. "It's better for us to be together to decide." Although Susana had previously read about amniocentesis, it was "something new" for Adrian. After a 35-minute meeting with a genetics counselor and an inconclusive high-resolution ultrasound, they agreed to the counselor's recommendation of amniocentesis. They said it took them just "five minutes" to decide. "We accepted

to get rid of the doubt" (*para sacarse la espina*), Adrian explained. "They told me they had to get to the bottom of it ... for the good of the baby." Susana agreed. "[I wanted] to find out what I should expect—and to be calm [because] what affects me is going to affect the baby. I had to resolve my doubts" (Browner and Preloran 1999: 99).

The systematic observations reveal that Susana and Adrian's experience was not unique. Most others indicated that the genetic consultation provided information, clarification, and justification for either course of action. Only 13 percent said that they learned "nothing new" from the consultation. For the most part, however, interaction between the couple and the genetic counselor was circumscribed, restrained, and generally at the counselor's initiative.

Nevertheless, fascinating gender differences could be observed, with the men consistently acting much more comfortable and less openly fearful than the women. Many women sat through the genetics consultation with tears in their eyes, their eyes averted, or their gazes fixed on the counselor. Men, on the other hand, appeared relaxed, confident, and in charge; often they sat back in their seats and generally spoke directly to the counselor. Some men came with a written set of questions, while others took notes throughout the session, behaviors never observed in women. While in some couples, this pattern can be attributed to the man's greater English fluency, this was not always the situation. Some men's English was quite limited, but this did not deter their efforts, and in other instances, wives spoke the language better than their husbands yet were unwilling to assert their superior knowledge during the genetic consultation. Men and women also sought answers to different types of questions: women tended to express more "embodied" concerns (e.g., how painful is amniocentesis, how likely is a hemorrhage) while men's were more abstract (e.g., how are chromosomes counted or their condition assessed, what is the statistical risk of miscarriage) or even peripheral (e.g., how new are the computers, what kind of training is needed to run them).

While observing men, it was revealed that they tended to take on the role of advocate or intermediary. Some repeated what the counselor said to their wives, seemingly seeking to allay the women's fears, like Juan, who explained to Lisa, "Now, you see! [The counselor] says [amniocentesis] hurts even less than a tooth extraction!" Others, like Rogelio, intervened to voice what they believed were their partners' concerns: "I know she wants to do [the amniocentesis]," he told the counselor in a confidential tone, "but she's afraid." Men who attended the genetics consultation seemed to serve as a

bridge between the world of medicine and their wives, helping to control and to "contain" the women's fears (cf. Foehrenbach and Lane 1990). As Roberto explained, "I went to the genetics consultation to help her. And to know. Because he who does not know is like he who does not see." When asked whether helping his wife to "see" could have influenced her decision, he replied, "Of course. I told her that she couldn't be swayed by what she hears on the streets, that she had to see the truth of *science*."

When asked the direct question, "Whose opinion counted most in the amniocentesis decision?" 52 percent of the women said their own, and 50 percent of the men agreed; only 13 and 14 percent, respectively, attributed the decision to the man, while less than a quarter of each gender characterized it as a joint decision. When asked to further describe her partner's role in the woman's decision, whether she opted for or against the procedure, *apoyar* (to provide support) was the term most commonly employed. In one woman's words, "just knowing he's there makes me more comfortable and relaxed."

Clinicians in the study tended to agree with this assessment, preferring the male partner present because they allayed the women's anxieties and helped them reach more reasoned decisions. But their experience has also taught them that women who bring their partners are less apt to postpone deciding and less likely to turn down the procedure.

Of course, not every woman in the study welcomed her partner's participation, and some insisted on attending alone so they could decide without interference. One such example was Ana Lucia. When asked who decided about amniocentesis, she replied, "Me, alone.... Jorge wanted us to have the baby no matter what, but I know I can't count on him....He hasn't even found work [and] all he does is drink.... I thought it would be better not to have the baby if it was going to be born with problems."

Rocio's domestic situation was similar. But unlike Ana Lucia, Rocio was deeply fearful about the prospect of raising a child with an anomaly *and* deeply ambivalent about aborting her current pregnancy. I use this case to illustrate my main point that when a genetic counselor sensed a woman's ambivalence about amniocentesis, she sought to form an alliance with the male partner, an alliance that could exacerbate preexisting conflicts within the couple.

Woman with Profound Ambivalence

At forty-five, Rocio already had four grown children, two of whom had serious medical problems that likely had a genetic or develop-

mental source. Her relationship with Alberto, her current partner, was neither smooth nor supportive, and she had aborted her previous pregnancy because of her doubts (although she told Alberto she had miscarried). Rocio considered Alberto a poor provider and felt he resented her family's many serious medical problems. Although Alberto was forty-two, he had no biological children and was thrilled by the prospect of becoming a father.

Rocio told us she had invited Alberto to the genetic consultation because she needed transportation and because she expected to be offered an ultrasound and wanted Alberto to view the fetus. She also said she expected the genetic consultation to be similar to her regular prenatal visits, which were warmly personal, private, in Spanish, and quite brief. Although Alberto often drove her to these visits, he would wait outside. He similarly dropped her off at the genetics clinic and began what would be a protracted search for parking, and once arriving would find the genetics consultation already underway. In addition to Kelly, an English-speaking genetic counselor, was Ana, a clerk enlisted to translate for Rocio, who understood a fair amount of English but was uncomfortable speaking it.

Rocio appeared tired and stressed. She found it painful to tell the intake assistant about her own family's medical history and her fears about her current pregnancy. She also told the assistant that the uncertainty she had felt since learning she screened positive was "making her crazy" and she welcomed the promised reassurance of amniocentesis.

In Alberto's presence, the genetic counselor asked Rocio to again recount her family's medical history, unaware of the couple's long-standing, bitter conflicts on the subject. She seemed openly skeptical with the explanations Rocio offered for her children's medical problems and said, "I think it would be better if you had an amniocentesis because I'm just not sure about your daughter's illness, and I don't have your nephew's [medical] records. I can't tell if they had something similar. It could be something genetic."

Frowning in disagreement, Rocio murmured she was sure her younger daughter's chronic mental illness was caused by an iron injection administered in infancy by a Mexican physician. Rather than responding directly to Rocio, Kelly turned to explain to Alberto that the couple would be "having the pleasure of christening" the clinic's brand new ultrasound machine. The two continued talking animatedly in English about the wonders of technology and the importance of fetal diagnosis for the couple, effectively excluding Rocio from their conversation.

Casually, Kelly next asked Alberto whether there were any medical problems in his family. "Everyone is very, very fine, super fine, 100 percent!" he responded. "My little sister died when she was two, but she was healthy. My father died when he chose to die." "Good, good. Congratulations," Kelly said, then adding, "You know that the ultrasound is not 100 percent ... because if the baby for example has his little hand in a fist, one can't know if he has [all] his little fingers." When Rocio shook her head as if to decline additional testing, Alberto quickly intervened. "Of course it is better to have [the amniocentesis]. You wanted it, didn't you?" For a moment Rocio was silent but then replied, "There'll be no need if the ultrasound comes out fine. And even if they tell me that the baby is abnormal, I'm not going to abort it." Alberto tried again. "This has nothing to do with [abortion]. It's only for knowing."

The ultrasound proved inconclusive (which occurs approximately 50 percent of the time when the woman has screened positive), and Rocio continued to voice her doubts and fears about amniocentesis: that it would be very painful, might provoke a miscarriage, and would prevent her from fulfilling her domestic responsibilities for several days after. Separately and in unison, Kelly and Alberto sought to assuage her fears, but Alberto soon grew impatient. "If you want to do it, you should decide right now!" Speaking directly to Ana, the clerk-translator, Rocio said she would prefer to wait for another day. "Fine," said Ana. "When?" "But he wants me to do it today," Rocio replied. "And what do you want?" Ana asked. After a short silence, Kelly bluntly asked again whether Rocio wanted the test. Softly she answered, "Yes" (Browner and Preloran 2004: 390–6, *passim*).

The Complexities of Gendered Decision-Making

My research objective had been to determine how conjugal dynamics, and gender politics more broadly, shaped one aspect of the reproductive behavior of a group of California-resident Mexican-origin women: the decision to undergo amniocentesis to prenatally detect birth anomalies. I had hypothesized that the male partner's wishes would prevail in the women's amniocentesis decisions, particularly among "less acculturated" study participants. Health care providers who work with this population attribute their proportionally higher rates of amniocentesis refusal to the fact that the men refuse to allow the women to be tested (Cunningham and Tompkinson 1999).

In fact, many Mexican-origin women tell providers that this is why they are declining the test.

In fact, it was just the opposite. The majority of both genders said that the amniocentesis decision had been the woman's, and—even more surprising—among those who said they deferred to their partner's wishes, women who agreed to amniocentesis outnumbered those who refused by three to one. This finding is consistent with dynamics observed during the genetic consultations. Many factors contributed to this unexpected pattern, ranging from wanting to appear more sophisticated and attuned to the technologies associated with modern medicine, to their greater ambivalence about raising a child with severe anomalies. Taken together, they meant that male partners were the stronger—or at least less ambivalent—advocates for fetal diagnosis, simultaneously manifesting more interest in, and greater comfort with, this and other technological aspects of medical care. These results are consistent with Ann K. Blanc's observation that "[m]en appear to be especially enthusiastic about and receptive to information that expands their knowledge of reproductive and sexual health" (2001: 200).

In some cases, men's greater English fluency likely contributed to the dynamics observed, because most of the genetic counselors spoke little if any Spanish. Yet the men served important functions beyond language-brokering. They gave the women, who were attracted to amniocentesis's promise of reassurance but fearful of its risks and stigma, the courage to overcome their fears. And through the rapport they established with the counselor and their endorsement of her clinical agenda, they validated the very enterprise of prenatal genetic counseling and fetal diagnosis.

Because studies of prenatal testing have generally focused on women, we know little about how the tests may affect the larger conjugal unit or men's experience of their wives' pregnancies. Similarly limited are data on men's values, attitudes, and needs concerning prenatal testing. The findings reported here are interestingly complex. They show substantial concordance in women's and men's accounts of their amniocentesis decision processes, in couples interviewed both together and separately. Still, men tended to inflate their own role in the decision process: they were more likely than the women to describe the decision as either joint or as their own. Also surprising was the pattern that partners of women refusing amniocentesis were more likely than the women themselves to say that the couple had decided together; in contrast, the partners of women accepting amniocentesis were more likely than their wives

to say that the women had decided on their own (none of these differences reached statistical significance). These findings demonstrate that simple assumptions about interactions among power, gender, and reproduction will inevitably fall far from the mark.

Even when couples characterized their amniocentesis decision as "joint," it was generally still the women's wishes that prevailed. Male and female study participants offered similar reasons for this (Markens, Browner, and Preloran 2003). Most said that they thought the woman should have the final word because it was her body on which the procedure would be performed or because her greater knowledge and/or previous reproductive experiences made her more qualified to decide. Although many of the male partners were actively involved in the women's pregnancies (e.g., attending prenatal consultations and participating when she gave birth), both women and men regarded the male role as that of supportive helper rather than equal partner.

This view of men "supporting" rather than controlling women's reproductive activities seems at first glance to depart from traditional Mexican culture, which legitimizes male dominance in all aspects of social life. However, it is consistent with the "separate spheres" model of gender organization, in which women are responsible for family-related matters and men for economically maintaining the family. Study participants frequently saw their own families in this light, describing women's economically remunerative activities and men's domestic activities as supplemental, regardless of their actual extent. The male partner's role in these women's amniocentesis decisions similarly seems construed as to facilitate whichever decision the woman herself chose to make.

Reinforcing Male Authority?

My argument that clinicians forged alliances with male partners when they felt female uncertainty or ambivalence should not be taken to mean I think that the clinicians were consciously seeking to reinforce male authority or power within either particular family units or in the larger society. Instances in which genetic counselors allied themselves with female relatives or friends were also observed. It's fair to conclude that clinicians' only agenda was to encourage the women to do what they felt was in everyone's best interests, an amniocentesis, but in their efforts to achieve this narrow clinical goal, they sometimes inadvertently accomplished more.

These results on the unexpected way in which alliances between male clients and women's health service providers can sometimes undermine women's autonomy were serendipitous. Yet they are not unique. Lea Pickard's fascinating work on reproduction and reproductive health care among a group of K'iche' living in the Western Guatemalan highlands similarly describes a paradoxical consequence of incorporating male partners into women's reproductive health policies and programs (2003). She found that some women were attracted to biomedical prenatal care because it pushed their partners toward becoming more involved fathers, but male involvement came at a price, as they found themselves forced to sacrifice some of the autonomy they had had in the more traditional female-centered system. Pickard concludes that given that the gender system in the community where she worked—as much as in anywhere else—is intimately tied to other systems of power, women's decisions to seek biomedical care and to involve their male partners may unintentionally reinforce those as well as other structural inequalities.

Sarah White wrote that as men are given equal or center stage in development or other types of social change efforts, those entities will necessarily be transformed, and constant vigilance will be required to avoid reproducing the reality that we are seeking to transcend. She cautions that "[t]his suggests the need for much greater reflection on the part ... institutions play in *constituting* gender and other forms of social difference. They are not neutral observers, but actively involved in the production of authoritative discourses and the differential distribution of resources" (2000: 39).

Conclusions

Historically, women have borne the blame for all reproductive "disruptions," both at home, as when a couple experienced infertility, pregnancy loss, or childhood disability, and in larger contexts, as when a group failed to achieve its demographic goals or met other reproductive calamities. That traditional sexist stereotype has diminished somewhat over recent years as men's role in the biological and social patterning of reproductive activities has become better understood, a trend that should continue as men become an increasingly important focus of sexual and reproductive health research, policies, and programs, including those for the delivery of prenatal genetic services. Yet, as with any social change, such transformational processes are proceeding along an uneven course, and instead of

simply solving the problems they were designed to correct, they are revealing new complexities demanding further study and thought.

This chapter has shown how focusing on men and micropolitics of gender relations within the domain of human reproductive behavior can illuminate some of the hidden mechanisms through which bio-power and male authority can be mutually reinforcing—and not necessarily toward an undesirable outcome. Our case-study structure enabled us to situate each actor within an interactional arena motivated by each specific and unique agenda, a manifestation of diverse tensions and interactions among gender politics, cultural ideologies, material factors, and more. It showed that resulting alliances might be only temporary and often not predictable in advance. This chapter further demonstrates that any framework failing to take fully into account not just male partners' presence but the relational and often antagonistic nature of human reproduction, as well as the larger sociocultural, political, and economic environments shaping it at any particular place and time, may provide only a partial understanding of the enormously complex issues at play.

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