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women's secrets: bases for reproductive and social autonomy in a Mexican community

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The means by which women exercise social power are not yet well understood. Some research has demonstrated relationships between female power and women's control over material resources, human beings, or societal institutions (Rogers 1978; Stamm and Ryff 1984). Other studies have linked female power to women's ability to form solidarity groups, or to the existence of feminist or matriarchal ideologies (Dixon 1978; Sanday 1981; Whyte 1978; Youssef 1982). Still others associate female power with their access to sacred or ritual knowledge (Lewis 1971; Ngubane 1977; Paul and Paul 1978). But these theories fail to account for the ability of some women to maintain control over their own or others' lives in societies where formal power is otherwise concentrated in the hands of men. Such theoretical formulations also seem to uncritically assume that women embrace power as an unambiguous goal; in fact, the sexes may not be equally motivated in this quest. Schlegel (1977:8–9) has therefore argued that any comprehensive theory of sexual stratification involves three dimensions: power, or the ability to exert control over others by any means; authority, the socially recognized right to make decisions for others; and autonomy, the freedom from control by others. Although Schlegel believes that power, or control over others, is always most important, it may instead be that autonomy is more highly valued by women when they live in strongly male-dominated societies and lack legitimate opportunities to control other adults by any means.

Yet what does female autonomy mean in societies where women are denied control over the circumstances of their existence? This research hypothesized that in male-dominated societies the essence of female autonomy lay in women's ability to control their own fertility, and that reproductive autonomy might also provide women a model for personal autonomy in other societal domains. Although all female behavior in male-controlled societies is carefully monitored by others, female reproductive behavior is usually given closest attention because women's value lies largely in their ability to reproduce. However, in such situations, although women's own fertility goals and desires are frequently considered irrelevant and are thus ignored, these desires and goals are not necessarily absent (Gordon 1977; Petchesky 1984). We therefore theorized that the more independently a woman could control her fertility, the more likely she would be to implement her own fertility goals rather than those of others.

Research in a highland Chinantec (Mexico) community hypothesized that women there monopolized knowledge about medicinal plants for the management of reproduction, which allowed them to regulate their own fertility without male intervention. It was further hypothesized that women who most effectively exercised reproductive autonomy would function more autonomously in other areas of their social lives as well. Instead it was found that women and men shared a great deal of knowledge about plants for reproduction, that some of the most effective fertility-limiting remedies were known only by men, and that reproductive autonomy and social autonomy did not necessarily co-occur. [medical anthropology, reproduction, gender roles, Mesoamerica]

One way that women in male-dominated societies may achieve reproductive autonomy is by restricting access to certain kinds of information. Throughout much of the world there are prohibitions against men knowing the details of female physiology, fetal development, childbirth, and other aspects of reproduction (see, for example, Browner 1980, 1985b; Heisel 1973; Mandelbaum 1974; Maxwell 1970; Molnos 1973; Olusanya 1969; Paul 1974; Reid 1979; Sargent 1982). Native informants and ethnographers use vaguely defined cultural standards of “shame” or “modesty” to account for this situation. However, women’s refusal to share information about reproduction with men may serve a more concrete function. By monopolizing such information, women maintain ultimate control over fertility in societies where men, too, have obvious individual and collective interests in influencing the patterning of reproduction.

To test this theoretical framework, three main hypotheses were proposed for the present study.

First, that in strongly male-dominated societies where female fertility is strictly supervised and high fertility is a societal goal, women maintain exclusive access to knowledge about fertility-regulating plants and other techniques, which allows them to autonomously decide the frequency and timing of their pregnancies. Men do not have access to this information.

Second, women who have extensive knowledge of fertility-regulating techniques will exercise reproductive autonomy more effectively than those who must obtain information from others.

Third, women who exercise reproductive autonomy will also function more autonomously in other areas of their lives.

background

The data offered here were collected during a one-year field study conducted by one of us (CHB) in San Francisco,¹ a bilingual Chinantec-Spanish-speaking *municipio* (township) of 1800 inhabitants located in highland Oaxaca, Mexico. The *municipio* consists of a head town (*cabecera*) and a number of small hamlets (*ranchos*) dispersed over a 50 kilometer range. Its 306 households rely on subsistence cultivation along with the production of coffee and intermittent wage labor to meet basic needs. Most Franciscanos (68 percent) either live permanently in the *cabecera* or divide their time between the *cabecera* and their lowland farms, based on the requirements of the agricultural cycle. The rest reside year-round in the lowlands unless they are serving in civil or religious offices when they are required to live full time in the *cabecera*.

In the past San Francisco easily fit Wolf’s criteria for a closed corporate peasant community including endogamy, local government by consensus, and a stable social system displaying structural integrity over time (Wolf 1955, 1957). Such communities were ordinarily described in the literature as isolated, autonomous, and self-sufficient. Although these communities also served crucial state interests in a number of ways (Dennis 1979; Young 1976, 1978), few members had extensive or ongoing contact with outsiders. Today the macrolevel socioeconomic and political forces that have “opened up” most of rural Mexico have also been felt to some extent in San Francisco (Cardoso and Faletto 1969; Frank 1967; Smith 1977). However, temporary and permanent migration remain the main means by which Franciscanos have sustained contact with the outside world. The community is still highly endogamous, and aside from a small number of federally supported schoolteachers and health care workers who reside in San Francisco, few non-natives spend any extended time there. Moreover, 42 percent of the women interviewed and 16 percent of the men have never been more than a few miles outside the community.

Health care and reproduction continue to be organized largely along traditional lines, and herbal remedies are still widely used. For example, 82 percent of the 180 women interviewed used only herbs for postpartum recovery following their last delivery. This was despite the fact

that modern health care is available in the township for a nominal or no fee through two health care centers in the head town operated by the Mexican federal government. Both offer prenatal care and one also provides maternity services. Most Franciscanos, however, still prefer locally grown or cultivated herbal medicines for political, social, and cultural reasons (Rubel 1983).

The *municipio's* political system is similar to others found throughout rural Mesoamerica in that it is a civil-religious hierarchy or *cargo* system (Cancian 1967; DeWalt 1975; Downing 1979:162–167; Kearney 1972:16–21; Lees 1973:10–11; Nader 1964:252–264; see Browner 1986a for more detail). All married men are required to serve without pay as either civil or religious authorities in a series of hierarchically ranked positions. Civil authorities oversee the community's internal political affairs while religious authorities concern themselves with the community's spiritual well-being. All matters that affect the collectivity as a whole are resolved in public assemblies attended by all men of the *municipio* between 18 and 50 years of age. (Older men may attend if they wish but they are not obligated to do so.) Married women do not perform community service, but they are acknowledged for their contributions to their husband's *cargos* (cf. Slade 1975).

Married male Franciscanos are ordinarily considered heads of their own families even when two or more related families share a common dwelling. Therefore, although postmarriage residence is normally patrilocal, at least initially, men become family heads upon marriage, even while they still live in their parents' home. Absolute domestic authority and responsibility rest with the male head. He represents his family in all external affairs from disputes with neighbors, to the payment of taxes and fines, to attendance at town meetings, where his vote counts for his entire household, unless it is a state or regional election when by community custom he votes twice: once for himself and once for his wife. Women are considered family heads only in the absence of men. A spouseless woman is under the formal authority of her household's senior male, even when the woman owns the house and its property, or is generationally senior to all of the household's adult men.

methods

In addition to participant observation and intensive interviewing of selected key informants, single interviews were conducted with a 54 percent sample of the *municipio's* adult women and their husbands. One-hundred eighty women and 126 men were interviewed,² with the sample constructed to represent the age, residential, and linguistic backgrounds of San Francisco's adult population. Spouses were interviewed separately, usually at different times, with every effort made to provide complete privacy. Eighty-six percent of the interviews were carried out by the first author (CHB) or her chief assistant, a local Chinantec woman; the remainder were conducted by one of five other trained local Chinantec assistants. Interviews were conducted by the first author in Spanish with informants who were sufficiently bilingual to respond in that language to the open-ended questions. The assistants conducted their interviews in Chinantec, with both bilingual and monolingual informants. All interview responses were transcribed in Spanish directly onto the interview schedule.

The interviews covered a number of areas that were expected to illuminate the ways in which the knowledge and use of medicinal plants for reproductive health and the management of reproduction were distributed throughout San Francisco, and the implications of this distribution of knowledge for power relations between the sexes and for the control of fertility.³ Women were asked about their backgrounds; their own and their households' access to economic resources; the distribution of power within their households; their menstrual, reproductive, and health histories; their childbearing experiences; and their own and their spouses' fertility attitudes and desires. In separate interviews, men were asked about their own backgrounds, their wives' reproductive and health histories, their own views on the distribution of power within

their households, the nature and extent of their involvement in their wives' deliveries and postpartum convalescences, and their own and their spouses' fertility attitudes and desires.

All female and male informants were also asked to name any herbal or other remedies or techniques they knew for the following reproduction-related events: to treat fertility, to prevent pregnancy, to terminate pregnancy, to treat amenorrhea, menorrhagia, dysmenorrhea, menstrual hemorrhaging, and to stop a threatened abortion. These questions were developed after a series of pilot interviews determined that they covered the range of female reproductive health concerns that were recognized and treated in San Francisco.⁴ Those who reported knowledge of specific herbal remedies were also asked to provide information on the substances' medicinal and nonmedicinal uses, their preparation, administration, and why they were thought to be efficacious.

In addition, women were asked to name the remedies or other techniques they used during their first and last pregnancies to accelerate labor and/or ease their labor pains, and the remedies they used to facilitate their first and last postpartum recoveries. Husbands were asked to name the remedies or other techniques they knew for these three conditions. A subsample of women and men were also asked to name all the herbal or other remedies or techniques they knew for the treatment of six common nonreproductive health conditions.

Because of the exploratory nature of this study, results are presented using descriptive statistics rather than as hypothesis-testing findings. The emphases of the data analysis are to understand what aspects of the interview data best answer the research questions posed, and to evaluate the general forms of the distributions involved.

potential sources of bias Although the sample was constructed to be representative of the larger population, there are certain biases in a study of this sort which may be unavoidable despite representative sampling. The possible effects of under- or over-reporting should be considered when interpreting the findings presented here. The nature of the identification task itself, discomfort with the interview format, mistrust of the interviewer's or investigator's motives, or other reasons, may have led informants to deny knowledge of remedies that they actually knew or to report remedies that in fact were not used for the condition about which they were being questioned. One man, for instance, indicated that a particular type of moss could be used to treat menstrual hemorrhaging, yet the women we asked about the remedy said they knew only that it could stop nosebleeds. Other informants occasionally approached us days or weeks after they had been interviewed to tell us of remedies they had previously neglected to mention. This was especially common in women's reports of remedies for fertility limitation, as will be discussed below. When informants indicated that they knew of remedies but could not name them, we asked them for as detailed a description as they could provide. If we could recognize the plant from the description, we noted its name and credited the informant with the response. In the event that we could not recognize the plant from the description, we asked the informant to take us to where it grew, or to bring us a specimen. Sometimes even these efforts failed to produce an identifiable specimen because, for instance, the plant grew only at a great distance or was out of season. These responses have been coded as "yes, unidentified species."

results

The data we collected failed to support the three hypotheses as they had been formulated. Although women reported a large number of herbal and other traditional remedies for reproductive health and reproduction, to our surprise nearly as many men as women reported such remedies as well. Moreover, some of the most effective fertility-limiting remedies used by women were reported only by men. And finally, reproductive autonomy and social autonomy did not necessarily co-occur. Each of these findings will be discussed in turn.

the distribution of knowledge by gender The domain of plants and other remedies used in San Francisco for the treatment of women's reproductive health problems and the management of reproduction is extensive. In all, 111 herbal and 39 other remedies were named during the 306 interviews, with 80 percent of the remedies reported by more than one informant. Non-herbal remedies included pharmaceuticals ($n = 14$), foods and condiments ($n = 13$), oils, unguents, and other materials used in massages or to bind together other ingredients to make poultices ($n = 9$), behaviors (for example, intentional falling to induce an abortion) ($n = 7$), and alcoholic beverages as supplemental ingredients in the preparation of herbal remedies ($n = 6$). This discussion will be restricted to herbal and other traditional remedies.

Because the anecdotal ethnographic literature for other parts of the world often implies that women seek to maintain exclusive control over childbearing and other aspects of biological reproduction, we hypothesized that this would be the case in the research community as well. There were no previous data on the subject for either the Chinantec or other similar indigenous Mesoamerican populations. However, contrary to the expectation that women would monopolize knowledge of medicinal plants and other traditional remedies related to reproduction, women and men named remedies for similar proportions of the eight reproductive health conditions. More men than women indicated that they knew no remedies for any of the eight reproductive health conditions under study, but equal proportions knew about either one or more (54 percent versus 52 percent); the distribution was nearly the same for both men and women with knowledge of more than one problem (Table 1). For example, 9 percent of the women and 11 percent of the men knew remedies for five or more conditions.

Table 1. Distribution of knowledge.
Proportion with traditional remedy knowledge about problems.

No. problems known	Female ($n = 180$)		Male ($n = 126$)	
	Propor.	Cumul.	Propor.	Cumul.
0	.27	.27	.40	.40
1	.25	.52	.14	.54
2	.14	.66	.12	.66
3	.14	.80	.12	.78
4	.11	.91	.11	.89
5	.06	.97	.05	.94
6	.02	.99	.05	.99
7	.01	1.00	.01	1.00
8	0	1.00	0	1.00

Table 2. Distribution of knowledge by problem.
Proportion with any knowledge about each specific problem.

Problem	Proportion	
	Female ($n = 180$)	Male ($n = 126$)
Menorrhagia	.47	.38
Menstrual hemorrhaging	.44	.35
Dysmenorrhea	.32	.33
Amenorrhea	.13	.13
Infertility	.43	.40
Contraception	.24	.36
Provoke abortion	.19	.17
Prevent miscarriage	.24 ^a	.18 ^a

^aThis question was added after some interviews had been completed; missing data have been eliminated from these proportions. Adjusted n 's are: female, 67; male, 68.

Similar proportions of men and women also reported remedies for each specific condition. With the exception of menstrual hemorrhaging, men were about as likely as women to name a remedy for each condition, and they were more likely than women to name one for contraception (Table 2). Moreover, there was fundamental similarity in the specific remedies that were named by both sexes. Table 3 lists the ten remedies most often reported for any condition by sex. Eight remedies appear on both lists, often in similar relative positions.

These results are comparable to the sexual division of knowledge of medicinal plants for nonreproductive health problems. Twenty-three percent of the female study population and 29 percent of the male were asked about remedies for six common health conditions (flu, backache, *susto*, toothache, *nervios*, snakebite). Similar proportions of both sexes named remedies for each problem, and they named remedies for similar proportions of the six conditions.

Despite these overall similarities, women's and men's knowledge of herbal remedies for the management of reproduction and the treatment of women's reproductive health problems was found to be structured quite differently. For most conditions, men overall named nearly as many different remedies as women, even though 30 percent fewer men were interviewed (Table 4). In addition, a larger proportion of the men's remedies were mentioned by only one informant. That is, women were more likely than men to name remedies that others in their community

Table 3. Most frequently cited remedies.
Remedies cited for any problem by gender.

Remedy	Female (n = 180)		Remedy	Male (n = 126)	
	No. ^a	% ^b		No.	%
<i>Baccharis glutinosa</i> ^c	78	5.9	<i>Styrax argenteus</i>	46	4.8
<i>Baccharis glutinosa</i> ^c	43	3.2	<i>Baccharis glutinosa</i> ^c	27	2.8
<i>Iostephane trilobata</i>	38	2.9	<i>Psittacanthus calyculatus</i>	21	2.2
<i>Persea americana</i>	25	1.9	<i>Pleurothallis cardiothallis</i>	20	2.1
<i>Psittacanthus calyculatus</i>	24	1.8	<i>Clidemia setosa</i>	18	1.9
<i>Styrax argenteus</i>	24	1.8	<i>Iostephane trilobata</i>	15	1.6
<i>Anoda cristata</i>	23	1.7	<i>Baccharis glutinosa</i> ^c	12	1.3
<i>Mimosa albida</i>	21	1.6	<i>Tanacetum parthenium</i>	11	1.2
<i>Pleurothallis cardiothallis</i>	20	1.5	<i>Mimosa albida</i>	10	1.1
<i>Clidemia setosa</i>	20	1.5	<i>Pinus sp.</i>	7	0.7

^aTotal number of times cited for all problems.

^bPercentage of responses for all individuals and all problems, by gender.

^cVariants of the same species, they are regarded in San Francisco as different plants with different medicinal uses.

Table 4. Distribution of specific remedy knowledge.

Problem	Females (n = 180)			Males (n = 126)		
	No. different remedies	Unique remedies		No. different remedies	Unique remedies	
		No.	Freq. ^a		No.	Freq. ^a
Menorrhagia	54	17	.20	36	18	.38
Menstrual hemorrhaging	49	18	.23	34	20	.45
Dysmenorrhea	44	17	.29	37	20	.49
Amenorrhea	26	14	.61	17	8	.50
Infertility	36	8	.10	32	7	.14
Contraception	14	6	.14	15	9	.20
Provoke abortion	27	14	.41	16	9	.41
Prevent miscarriage ^b	15	7	.44	13	6	.50

^aProportion of those with any knowledge for a specific problem who reported a unique remedy for that problem, by gender.

^bFemale n = 67; male n = 68.

also named. Their knowledge was more likely than the men's to be shared rather than idiosyncratic.

Differences in the organization of herbal knowledge by gender are even more clearly seen in a comparison of the remedy reports of spouses for the 120 couples interviewed. Despite the fact that the majority of each sex reported a remedy for at least one of the eight reproductive health conditions, only 37 percent of the couples reported remedies for an equal number of conditions, with the sharing of remedy reports for just one or two of the conditions by far the most common situation. In other words, the proportion of couples in which the man knew remedies for more conditions than the woman was the same as that in which the woman knew more. A content analysis of the specific remedies individual members of couples named for each condition provides additional evidence that individual members of couples shared little herbal knowledge despite an overall sharing along gender lines at the community level (Table 5). Only 25 percent of the couples reported knowing one or more specific remedies in common, and only 18 percent had any agreement on the conditions for which they were used.

These data may reflect individuals' and couples' theoretical knowledge rather than their personal experiences, since all eight reproductive health conditions may not have been experienced by each of the women interviewed. It was unclear whether the lack of shared knowledge within a couple derived from the absence of shared experiences, or whether men learned about herbal remedies for women's reproductive health problems from sources other than their wives. To assess the proportion of knowledge gained from experience, remedies that women used pre- and postpartum were compared with their husbands' reports of pre- and postpartum herbal remedies. Although virtually all the women used herbs and other traditional remedies during and after childbirth, and many of the men could name some, only about one-third of the men's reports matched their wives' experiences. Like the findings above, these are noteworthy because on the aggregate level the two groups tended to report the same herbal remedies for the management of childbirth.

Table 5. Specific remedy knowledge within couples (*n* = 120).

Couples citing at least one remedy in common:	
Regardless of agreement on use(s)	30 (25%)
With agreement on at least one use	22 (18%)
With disagreement on at least one use	15 (13%)
With no agreement on use(s)	8 (7%)

Note: Only the second and fourth categories are mutually exclusive.

Table 6. Chemically effective remedies.
Proportions of those with knowledge for a specific problem who report remedies known to be effective, by gender.

Problem	Female		Male	
	No.	Propor. ^a	No.	Propor. ^a
Menorrhagia	57	.68	14	.29
Menstrual hemorrhaging	44	.55	11	.25
Dysmenorrhea	43	.74	19	.46
Amenorrhea	13	.57	6	.38
Infertility ^b	0	0	0	0
Contraception	3	.07	4	.09
Provoke abortion	34	.50	5	.23
Prevent miscarriage ^b	0	0	0	0

^aProportion of individuals reporting any remedy for indicated problem.

^bZeros reflect lack of any herbal remedies that are known to be effective for those problems.

Table 7. Relationships between reproductive and social autonomy measures.

Social Autonomy Measures	Reproductive measures				
	Birth control		No. pregnancies		
	No	Yes	0–3	4–6	>6
Domestic Autonomy Score	(n = 134)	(n = 12)	(n = 44)	(n = 52)	(n = 54)
1 (most)	.40	.25	.27	.44	.41
2	.05	.08	.05	.04	.06
3	.43	.42	.50	.40	.41
4 (least)	.12	.25	.18	.12	.13
Economic Autonomy Score	(n = 153)	(n = 13)	(n = 56)	(n = 59)	(n = 56)
1 (most)	.08	.23	.07	.07	.13
2	.10	.00	.16	.05	.09
3	.23	.38	.25	.27	.18
4 (least)	.59	.38	.52	.61	.61

Note: Numbers given in parentheses show the number of cases for the reproductive measure category indicated at the top of the column who also had data for the given social autonomy measure.

The proportions in the table are proportions of the social autonomy measure score within the reproductive measure category.

knowledge of chemically effective remedies We have shown that women and men reported knowledge of herbal remedies in approximately equal proportions for all eight reproductive health conditions. However, this is not to suggest that all of these remedies are equally efficacious. As Table 6 shows, a substantially smaller proportion of men with knowledge knew chemically effective remedies for most of these conditions (see also Ortiz de Montellano and Browner 1985).⁵ However, these data may underestimate men's knowledge of chemically effective herbal remedies since a greater proportion of the men named plants that could not be identified botanically because they could not be located. Eleven (2.5 percent) of the plants named only by women could not be identified in contrast to 19 (6.3 percent) of the plants named only by men. The only exception to this general pattern is seen in the remedies named for contraception. Here, few remedies were reported overall, and 9 percent of the men named effective remedies as compared with 7 percent of the women (Table 6).⁶

the relationship between reproductive and social autonomy We used Schlegel's definitions of gender-based power, authority, and autonomy to generate some empirical measures. She argues that any analysis of these dynamics must consider the following issues:

First, in what spheres and under what conditions are women or men in control of their own persons, activities, and products of their labor, and the persons, activities, and products of labor of the other sex? . . . Second, how do areas of female control compare with areas of male control—is one subsumed by the other, or do they exist in balance? . . . Third, do areas controlled by women include institutions that are central to social organization [Schlegel 1977:9]?

Space limitations prohibit us from presenting an in-depth assessment of these dynamics within the research community. Instead we will delineate the broad patterns we found concerning the relationship between reproductive and social autonomy.

We considered reproductive autonomy in two separate ways: First, we asked women whether they had ever used any means at all to prevent pregnancies. Second, we considered women's total fertility history.

We also evaluated social autonomy along two dimensions: the extent to which women controlled economically productive resources, and the extent to which they controlled their own activities. These dimensions were derived after pilot interviews with 12 female informants provided information on their own understandings of social autonomy. Economic control was determined by asking whether women earned cash and decided, either alone or with their hus-

bands, how their earnings would be spent, and whether they owned any lands, either with their husband or independently. To assess control over activities, we asked women whether they had to get someone else's permission when they wanted to leave their homes and whether decision making in their households was by the couple or dominated by their husbands.

We found no association between reproductive autonomy and either of the other two autonomy measures (Table 7). Women who had used contraceptives tended to control more economic resources than those who did not, but their fertility was not substantially lower.

discussion

Some male Franciscanos do hold the view that women have exclusive access to a body of secret knowledge that, among other things, enables women to control their own fertility free from the intervention of men. For instance, one man responded to a question asking whether breastfeeding could prevent pregnancy by saying, "I don't know. Those are women's secrets." And when asked for a remedy to speed labor, another man replied, "Those are things that only women know about. . . . We men know very little about women's medicines."

Men's beliefs in the existence of a well-defined domain of secret female knowledge are based in part on the way that knowledge of remedies for reproduction and reproductive health is structured in San Francisco. Despite the large number of men who reported remedies, and the large number of remedies reported by them overall, fully 40 percent of the men interviewed reported no remedies whatsoever for any of the eight reproductive health conditions, and 56 percent could not name any remedies for use during the pre- and postpartum periods. This imbalance in knowledge distribution undoubtedly helped create the male impression that women have exclusive female secrets. The fact that couples rarely agreed with one another on the remedies they reported, either for the eight reproductive health conditions or for pre- and postpartum use, probably added to men's convictions that women knew "things" that men did not.

In addition, many women actively sought to keep their knowledge from men, even while willingly sharing with a foreign female ethnographer. They would begin their answers with: "You're a woman, you'll understand . . ."; or, "You're a woman, I don't have to feel shy with you"; or, "Yes, I'll talk with you about these things. You're a woman, I don't feel shy with you. In front of my husband I do, and in front of other men, but I'm willing to tell you what you want to know."

When these women were asked why they were unwilling to talk about reproduction and reproductive health in the presence of men, many of their answers were vague: "These are things that don't really concern them." "We prefer to take care of ourselves." "There's greater trust among women." "What man would really be interested?" But in answering this same question, one of the midwives gave what seemed to be a more penetrating reply.

"Men will grossly criticize women for *any* reason they can find, so women try to keep their affairs very quiet and very private. Men will criticize women when they have miscarriages and when they have children, so women prefer that men know as little as possible about the details of what goes on with them. . . . Men will say, for example, 'Oh, you, you're nothing, your hole is so big that the baby just slipped right out without even a struggle when it was born.' So [women] kick the men out at the moment of birth so that they can't see. They prefer to do without the little help they could possibly bring."

Yet despite women's expressed desires to maintain exclusive control over a body of secret knowledge, the data clearly show that Franciscanas have few secrets from men. While women's and men's remedy reports were not identical, there was fundamental similarity in their overall responses. Rarely did women name remedies that men failed to mention. There was only one remedy listed by at least five women that was completely missing from the men's list of remedies for that problem (ingesting iron filings to treat menstrual hemorrhaging), and two remedies that men named in far lower proportions (*Anoda cristata* for menstrual pain and for

menstrual hemorrhaging; *Persea americana* for menstrual hemorrhaging and for menorrhagia). Occasionally men were also much more likely than women to report a particular remedy for a specific condition (for example, *Tanacetum parthenium* for menstrual pain was reported by 17 percent of the men who listed a remedy but only 10 percent of the women). Aside from these exceptions, the same remedies were reported by both groups in similar proportions, and differences in the two lists were primarily due to the fact that men's remedy reports were idiosyncratic more often than women's were.

But ubiquitous threats to the integrity of San Francisco have led men to believe that abundant fertility is essential if the *municipio* is to survive. External threats come from armed attacks by neighboring communities covetous of San Francisco's abundant lands⁷ and from state-government proposals to appropriate unused territory or to consolidate the community with neighboring ones. Other demographic challenges include persistently high rates of disease and infant mortality, and ever increasing rates of outmigration. Male Franciscanos fervently believe and eloquently argue that a populous community can more readily defend itself and resist government intervention. While women are also aware of the problems, they do not necessarily support the solution favored by the men (Browner 1986a, 1986b).

Men's wish to influence fertility patterns has led them to insinuate themselves into the reproductive process and to magnify the importance of their own contribution. For instance, although women laugh at the practice, it is not unusual for men to also drink their wives' postpartum herbal beverages. These are used by women to restore their bodies to pre-pregnancy physical condition so that eventually they will again conceive. "We both need to recover," say the men. Men also report that in order for some of the best-known herbal remedies for infertility to be effective, they alone must secretly collect, prepare, and administer them to their wives. And because different plants are selected for the conception of male and female children, men understand that this practice can allow them to choose the sex of their offspring. Although many women are also familiar with these particular infertility remedies, none had heard that they had to be administered secretly by men in order to work.

Moreover, many men also insist that they are entitled to know women's secrets simply because they are married to them. It was therefore common for men to want to be included in their wife's interviews, and it was sometimes with extreme reluctance that they granted us the privacy we needed to proceed. One man undoubtedly expressed his co-villagers' sentiments when he said to a female assistant, "It's all right for us to participate in the women's interviews because we men know all that goes on with our wives. Because we know all the things that they do and all the things that happen to them, they have no reason to keep any secrets from us."

implications

Under these circumstances, reproductive autonomy is a goal beyond the reach of Franciscanos. Not only is their fertility relentlessly monitored, but they are subject to endless social pressures impelling them to be prolific, including gossip, criticism, and social marginalization of women who have few children. During fieldwork these pressures were made manifest most dramatically in tales told by men about the destruction of the "birth control" tree (see Browner 1986b for more detail). According to men's accounts, until about 20 years ago, there grew a tree not far from the *cabecera* whose bark had contraceptive effects. Women of childbearing age who did not wish to conceive were said to secretly drink teas prepared from it. Fertility in San Francisco at the time was far lower than the men wished, and women were considered to blame. Said one man, "We were angry [back then]. The women weren't having babies. They were lazy and didn't want to produce. . . ." Said another, "We were working hard with our men's work, but the women weren't doing any of [theirs]." A third man added, "The town was

small and we wanted it to grow. We wanted a big town and we needed more people. But the women wouldn't cooperate" (Browner 1986b:718–719). A group of men banded together one day and tore the tree down.

Although it is impossible to credit the fertility increase that followed to the demise of the tree alone, there were other direct repercussions. At the time of the field study (more than 20 years after the tree had been destroyed), even women who said they wanted no more children adamantly refused to artificially limit their fertility, citing fears of community censure as the reason why. Moreover, women seemed to feel forced to deny they *knew* anything whatsoever about fertility limitation. It was as if they feared that merely possessing information would be used as evidence against them. When female informants were directly asked if they knew any remedies or techniques that could prevent pregnancy or induce abortion, the proportions of affirmative replies were very low (see Table 2). Yet probes or subsequent interviews revealed that at least 60 percent of those who initially said they knew no ways to limit fertility had in fact heard that techniques did exist, although few were able or willing to describe them in any detail.

Even female awareness of the long-gone "birth control" tree was very cautiously conveyed, and the extent to which women actually knew about the tree remains unclear. While every man I asked said he had heard of the tree, and many gave detailed accounts of its destruction, the majority of the women said they had never even heard that a tree like that had existed in the *municipio*. Most were quick to add that even if it had, they would never dream of using it. Furthermore, information only loosely related to fertility regulation per se was communicated with reluctance or circumspection, such as the circumstances of an accidental miscarriage or the name of a remedy that could be used to treat nonpregnancy-related amenorrhea.

But male efforts to dominate reproduction materially or ideologically are clearly not restricted to a community like San Francisco. Similar attempts are seen in other contexts when men are concerned about their roles in reproductive processes, for as Lindenbaum accurately observes, "indigenous theories of human reproduction contain within them an implicit recipe for social reproduction" (Lindenbaum 1987:222). Her recent analysis of gender ideology and social reproduction in New Guinea reveals that in societies where women play increasingly prominent roles in subsistence production, men ideologically appropriate the process of biological reproduction by adopting myths of "sacred flutes" (Read 1952; Berndt 1962). According to such myths, the flutes were exclusive female property before they were stolen by men who then prohibited women from seeing, touching, or playing them. Contemporary male dominance is attributed, in part, to the fact that men control the ritual power essential to the well-being of the group. Moreover, flute myths and associated rituals have recently spread to societies experiencing forms of economic and social reorganization that require women to intensify their productive and reproductive activities (Lindenbaum 1987).

Through myths of sacred flutes, New Guinea men lay claim not only to dominance in the production of society, but to the ascendancy of male potency in a broad sense, and to a rhetoric that insists on the primacy of the masculine principle in nature and in social life (Read 1984:242). Similarly, male Franciscano's myths about the circumstances under which a "birth control" tree was destroyed make manifest their efforts to ritually control biological reproduction and, by extension, to ultimately shape society's character and course. Their "myth" of the birth control tree can be seen as evidence of attempts by males to control female reproduction through ideology as well as through practical knowledge.

notes

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¹A pseudonym is used at the community's request.

²Data from interviews with two men whose wives were not interviewed—one because she refused, the other because she was out of town for much of the data collection period—have been included as well.

³Copies of the interview schedules are available on request.

⁴Remedies used for either fertility reduction or enhancement were to have been the initial focus of data collection in this study of reproductive autonomy. Once in San Francisco, however, Browner discovered how deeply fertility concepts were embedded in broader understandings of reproductive health and reproductive physiology. She therefore developed additional questions to elicit information on the management of that broader class of reproduction-related events (see Browner 1985a for more detail). Because understandings of reproductive health and reproduction contextualize the phenomenon of fertility control in San Francisco, our data are presented here in a similarly contextualized manner.

⁵This article describes in detail the procedures we used to classify as chemically effective or ineffective the herbal and other traditional remedies used in San Francisco for reproductive health and reproduction. There we classify certain remedies as ineffective because we lack the data that would enable us to propose plausible chemical or biochemical mechanisms to account for the actions informants attribute to these remedies. Our evaluations are therefore reflections of our current state of knowledge rather than definitive assessments. For example, the Thongan custom of ingesting human semen to induce labor (Junod 1927:40) or the popular American belief that sexual intercourse late in pregnancy can cause premature labor were dismissed as superstitions until it was discovered that semen contains prostaglandins in the appropriate concentration to induce uterine contractions (Karim 1972:141).

⁶Tests are in progress in the laboratory of Dr. Eloy Rodriguez, University of California, Irvine, to determine whether *Styrax argenteus*, the contraceptive most commonly reported in San Francisco, contains effective chemicals.

⁷In the last 30 years, San Francisco has lost at least 15 men in border skirmishes.

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