

**SOME UNEXPECTED CONSEQUENCES OF IMPLEMENTING GENDER  
“NEUTRAL” REPRODUCTIVE PROGRAMS AND POLICIES**

by

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**Abstract**

Historically, sexual and reproductive health programs in Mexico and the U.S. all but ignored male partners. The past decade’s significant shift to accord greater attention to men, however, may paradoxically subordinate women’s interests, goals, and needs. We illustrate this observation with data from a study of 156 women of Mexican background and their male partners in a California program offering prenatal genetic testing and abortion for birth anomalies in “high risk” pregnancies. When genetic counselors sensed ambivalence from women, they clearly allied themselves with the male partners to gain consent for procedures. The resultant male empowerment, coupled with problematical fetal diagnoses, could ignite or exacerbate domestic conflict.

**Biography**

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## **SOME UNEXPECTED CONSEQUENCES OF IMPLEMENTING GENDER “NEUTRAL” REPRODUCTIVE PROGRAMS AND POLICIES**

Despite the fact that both sexes are essential to human procreation, until recently sexual and reproductive health research, programs, and policies focused overwhelmingly on women only. But this is no longer the case. After conducting an analysis of the recent literature, Greene and Biddlecom (2000:90) assure us that, “One 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.”

Yet we still lack good understanding of men’s reproductive behavior, and the nature and dynamics of the gendered politics of reproduction. To my mind, this is mainly because most work on the subject still stems from a narrow, “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 “men’s role” to a single or small number of discrete variables. But as Gutmann recently pointed out, “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). This approach to men and reproduction will, in addition, offer unique insight into the mechanisms at the core of “biopower” (Hardt and Negri 2000:24), as it casts new light on the broad dynamics that shape an entire range of social issues.

Two recent attempts to find meaningful ways to conceptualize gender in the context of reproductive health interventions are the so-called “equity” paradigm, which assumes that women and men have fundamentally different reproductive-health rights and responsibilities, and the “men as partners” framework, which recognizes both men’s contributions to women’s reproductive health and men’s own needs (Dudgeon and Inhorn 2004). But even these paradigms are limited, for reasons Figueroa-Perea eloquently states in his plea for a “gendered perspective” on reproductive health. He calls for analyzing the relational, social, and often antagonistic nature of human reproduction, in which tensions, conflicts, and disagreements between men and women invariably exist within broader socio-cultural and political environments (Figueroa-Perea 2003:114).

My objective is to apply Figueroa-Perea’s gendered perspective to analyze aspects of the reproductive behavior of a group of pregnant Mexican-origin women in southern California, and their male partners, and to show how such behavior was shaped by domestic politics and other broad social factors. The research was designed to determine what factors led these women to accept or decline offers of amniocentesis to detect the possible presence of birth anomalies. The women had all been classified “high risk” for bearing a child with an anomaly because they 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).

## Background and Methods

Although some regard fetal diagnosis as inherently problematic because virtually all anomalies have no treatment or cure, other than aborting the affected pregnancy, in most parts of the U.S., the practice has become a standard part of prenatal care. The consultation is intended to be “non-directive,” in that counselors are trained to avoid giving advice or personal opinions.

In California, a typical prenatal genetic consultation lasts 30 to 45 minutes and is provided by a certified genetic counselor who has been trained to the master’s level in genetics and counseling techniques. Whenever possible, the consultation is offered to the couple as a unit. This is mainly because the genetic counselor must obtain detailed family medical histories of both parents, but also because, although legally only the pregnant woman has the right to accept or decline fetal diagnosis, the conventional view among U.S. 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. Yet there is ample evidence that couples can—and often do—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).

It is particularly in this regard that we still understand little about the impact of prenatal genetic consultations on amniocentesis decisions. Researchers have found that genetic counselors played a greater role in the decision when the impetus for testing came from a clinician rather than the woman herself and that interaction with genetic counselors was consequential when the couple disagreed, or was undecided, about whether to be tested (Verjaal et al. 1982; Scholz et al. 1989). These findings may have special relevance for understanding the prenatal genetic counseling experiences and amniocentesis decisions of Mexican-origin women, particularly recent immigrants. Many have only a vague idea 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 they may be fearful of the procedure’s known risks or have an exaggerated picture of them (Browner et al. 1999). Those who are better informed may be loathe to admit—to themselves or to anyone else—that they are considering fetal diagnosis because of its link to abortion. We 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, she would ally herself with the male partner to gain consent. We will also show that the resultant male empowerment could exacerbate domestic conflict related to the pregnancy and other issues.

Our data come from three sources: patient charts, face-to-face interviews, and systematic observations.

**Chart Sample** We reviewed the charts of all women who were patients at four southern California genetics clinics during 1996 and obtained the following data for the 379 Spanish-surnamed women who screened positive: 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 the woman to the genetic consultation. We developed our own codebook for coding the data and calculated descriptive statistics.

**Interview Sample** We conducted semi-structured, face-to-face interviews lasting one to several hours with two waves of Mexican-origin women who were offered amniocentesis because they had screened positive. When possible, we also interviewed the male partners. Our interview data therefore consist of 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 et al. 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 were to be interviewed separately, but this often proved impractical. Forty-nine percent of the couples were interviewed together.

**Observational Sample** We systematically observed the genetic consultations of 73 Mexican-origin women who had been referred for prenatal counseling because they had screened positive. We used a paper and pencil instrument of our own design to record data, including information conveyed, questions asked, and content and effect of interaction among participants. Observational data were analyzed quantitatively and for content, with frequency counts made of the responses to the open-ended questions.

## Results

While most of both genders interviewed rated the genetic consultation favorably, many also indicated discomfort with what they felt was implicit—or explicit—pressure to consent to an amniocentesis. This is very important since the large majority indicated that they had come to the genetic consultation undecided about a course of action. Less than 15 percent said they had made up their minds beforehand, in stark contrast with the nearly 75 percent who told us they had decided “on the spot.” Of even greater note was the striking association in both our chart and interview data between men attending the genetic consultation and women accepting amniocentesis: women accompanied by male partners were more than three times as likely to agree to the procedure (Browner and Preloran 1999). Because this powerful link was unexpected—and its reasons not obvious—we turn to our interview and observational data for the light they cast on its dynamics.

First I will describe a representative case of one couple who easily reached consensus as a direct result of their genetic consultation. Susana, 27 years, and Adrian, 25 years, (all proper names are pseudonyms) grew up in working class families in Jalisco, Mexico. They had a three-year-old son with no known medical problems and no known family history of birth anomalies. This was her second pregnancy. Susana said she cried and cried when she learned of the positive screening test, terrified that the baby would have Down syndrome. Adrian said he was also worried—and confused. “How could this be?” he told us. “I don’t take drugs, I don’t beat my wife. I was really frightened.” After a 35-minute genetics consultation, and an inconclusive high-resolution ultrasound, they agreed to the amniocentesis they were offered. They said it took

just “five minutes” to decide. “We said yes to get rid of the doubt” (*para sacarse la espina*), Adrian explained. “They said they had to get to the bottom of it... for the good of the baby.” This couple’s experience was not unique: both acceptors and refusers said the genetic consultation provided information, clarification, and justification for a course of action.

Our observations revealed that, while interactions between a couple and the genetic counselor were mostly circumscribed, restrained, and generally at the counselor’s initiative, there were fascinating gender differences. While the women often sat mute, teary-eyed, or with an averted gaze, the men consistently appeared relaxed, confident, and in charge; generally they spoke directly to the counselor. Some came with a written set of questions; others took notes throughout the consultation, things we never observed in women. Men also tended to adopt the role of advocate or intermediary, often repeating to their wives what the counselor had said in an effort to allay the women’s fears. For example, Juan exclaimed to Lisa, “Now, you see! She says it hurts even less than a tooth extraction.” Others intervened to voice what they believed were their partners’ concerns. “I know she wants to do it,” Rogelio told the counselor in a confidential tone, “but she’s afraid.”

The men served to bridge their partners to the worlds of technology and medicine. Roberto, for example, told us, “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.” We asked whether helping his wife “to see” could have influenced her decision. “Of course,” he replied, “I told her that she couldn’t be swayed by what she hears in the streets, that she had to see the truth of science” (Browner and Preloran 1999).

When asked whose opinion counted most in the amniocentesis decision, 52 percent of women said their own—and 50 percent of the men agreed; only 13 and 14 percent respectively attributed the decision to the man. And when describing their male partners’ role in the decision process, *apoyar* (support) was the term most often heard. As Alma explained, “Just knowing he’s there makes me more comfortable and relaxed.”

Of course, not every woman welcomed her partner’s participation, and some, like Ana Lucia, attended alone so they could decide without interference. When she was asked who made the decision, decisively she replied, “Me alone... Jorge wanted us to have the baby no matter what, but I know I can’t count on him... and that it would be better not to have the baby if it was going to be born with problems.”

Rocio’s domestic situation was similar to Ana Lucia’s. But while Rocio was similarly fearful of raising a child with an anomaly, she was also deeply ambivalent about aborting her pregnancy. Rocio’s case illustrates my main point: when a genetic counselor sensed a woman’s ambivalence, she sought an alliance with the male partner. Moreover, this alliance could exacerbate pre-existing conflicts within the couple.

At 45 years old, Rocio already had four grown children, two with serious medical problems that likely had a genetic or developmental origin. Her relationship with Alberto, her current partner, was neither smooth nor supportive. Rocio considered him a poor provider and felt he resented her family’s many serious medical problems. Although he was 42, Alberto had no biological children and was thrilled by the prospect of becoming a father.

Rocio told us she invited Alberto to the genetic consultation both for transportation and because she expected to be offered an ultrasound, and she wanted Alberto to view the fetus. She also said she expected the consultation would be similar to her regular prenatal visits, which were warmly personal, private, in Spanish, and quite brief. In addition to Kelly—a monolingual 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.

Although Alberto arrived too late to contribute to the medical history, in his presence the counselor Kelly asked Rocio to again recount her children's medical problems—unaware of longstanding bitter conflicts on the subject between the couple. Kelly seemed openly skeptical with the explanations Rocio offered for her children's medical conditions and repeated what she had said twice before: "I think it would be better if you had an amniocentesis...."

Frowning in disagreement, Rocio murmured she was sure her younger daughter's chronic mental illness was due to an iron injection administered in infancy by a Mexican physician. But rather than responding to Rocio, Kelly turned to Alberto to explain 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 about medical problems in his own family. "Everyone is very, very fine, super fine; 100 percent!" "Good, good. Congratulations," Kelly said, adding, "You know the ultrasound is not 100 percent...." But 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?" Silent for a moment, Rocio 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."

When the ultrasound did prove inconclusive (as happens about half the time), Rocio continued to voice doubts and fears about an amniocentesis. Separately and together, Kelly and Alberto sought to dispel each concern she raised. But soon Alberto grew impatient: "If you want to do it, you should decide right now!" Speaking directly to Ana, the clerk-translator, Rocio said she'd prefer to wait for another day. "Fine. When?" Ana asked. "But he wants me to do it today," Rocio said. "And what do you want?" Ana replied. After a short silence, Kelly bluntly asked again if Rocio wanted the test. Softly she said, "Yes" (Browner and Preloran 2004).

## **Discussion**

Our research objective had been to determine how conjugal dynamics—and gender politics more broadly—shaped the decisions by a group of Mexican American women to accept or refuse a medical procedure to prenatally detect birth anomalies. We had initially hypothesized that such women's higher rates of amniocentesis refusal than in other ethnic groups (Cunningham and Tompkinson 1999) were due to their partners' unwillingness to allow the women to be tested. But in fact, the majority of both genders said the final decision had been the woman's—and those few who said they had deferred to their partners were three times more likely to have

agreed to amniocentesis than to have declined the test. This is consistent with dynamics we observed during the genetic consultations, where men were the stronger advocates for fetal diagnosis. Many factors contributed to this unexpected pattern, ranging from their 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.

My observation that clinicians forged alliances with male partners when they perceived women's uncertainty or ambivalence does not mean, however, that the counselors were consciously—or even unconsciously—seeking to reinforce male authority or power. It's fair to conclude that the clinicians' main agenda (notwithstanding their “non-directive” training) was to encourage the women to do what they felt was in everyone's best interests: to have the amniocentesis. But in their efforts to achieve this narrow clinical goal, they sometimes inadvertently accomplished more.

Our results on the unexpected way that 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 (Pickard 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 the women 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 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 recently wrote that as men are given equal—or center—stage in development and other initiatives that promote social change, those entities will necessarily be transformed. This means that constant vigilance is required to avoid reproducing the very reality we seek to transcend. She cautions, “This 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 are actively involved in the production of authoritative discourses and the differential distribution of resources” (White 2000:39). This is why any valid analysis of social process must take gender dynamics—and their associated politics—into account. A perspective that recognizes reproduction as fundamentally a “gender relational process” is essential if we wish to move beyond standard, static conceptualizations of those very processes.

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