NOTES

1. *Testimonies of the Life, Character, Revelations and Doctrines of our Ever Blessed Mother Ann Lee, and the Elders With Her* (Hancock, MA: J. Talcott and J. Deming, Junrs., 1816), p. 47.
2. Ibid., p. 200.
3. Ibid., p. 211.
4. For further information on the Shakers' business dealings, see Edward Deming Andrews, *The Community Industries of the Shakers* (University of the State of New York, 1933; New York State Museum Handbook No. 15).
5. The actual peak population of Shaker communities is disputed. Compare Edward Deming Andrews, *The People Called Shakers* (New York: Dover Publications, 1953), p. 224; Priscilla J. Brewer, *Shaker Communities, Shaker Lives* (Hanover, NH: University Press of New England, 1986), p. 156; and William Sims Bainbridge, "Shaker Demographics 1840–1900: An Example of the Use of U.S. Census Enumeration Schedule," *Journal For the Scientific Study of Religion* 21 (1982), p. 355.
6. At present the Shaker communities of Sabbathday Lake, Maine, and Canterbury, New Hampshire, are the only occupied communities.
7. *Testimonies* (1816), p. 2.
8. Benjamin Seth Youngs, *The Testimony of Christ's Second Appearing* (Albany: The United Society, 1810, Second Edition), p. 440.
9. Seth Y. Wells, compiler, *Millennial Praises* (Hancock, MA: Josiah Talcott, 1813), p. 105.
10. Ibid., p. 35.
11. Youngs, p. 537.
12. Wells, p. 1.
13. Youngs, p. 454.
14. Shaker manuscript collections such as those found at the Western Reserve Historical Society, the Shaker Museum at Old Chatham, New York, and the Archives and Manuscript Division of the New York Public Library have large numbers of recorded gift drawings and messages from this period, most of them by women.
15. David R. Lamson, *Two Years' Experience Among the Shakers* (West Boylston, MA: Published by the Author, 1848), p. 95.
16. See Barbara Welter, "The Cult of True Womanhood," *American Quarterly* 18 (1966), pp. 151–174.
17. Paulina Bates, *The Divine Book of Holy Wisdom* (Canterbury, NH: n.p., 1849), p. 661.
18. "Address of Antoinette Doolittle, Troy, NY, March 24, 1872," *The Shaker* 2.6 (June 1872), p. 43.
19. Wells, p. 250.

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X.

Gender, Politics, and Reproduction

All human reproductive behavior is culturally patterned. This cultural patterning includes menstrual beliefs and practices; restrictions on the circumstances in which sexual activity may occur; beliefs and practices surrounding pregnancy, labor, and the postpartum period; understandings and treatment of infertility; and the significance of the menopause. While research on human biological reproduction has been dominated by medical concerns such as normal and abnormal physiological processes, an increasing anthropological literature addresses reproduction as a sociocultural process. Biological reproduction refers to the production of human beings, but this process is always a social activity, leading to the perpetuation of social systems and social relations. The ways in which societies structure human reproductive behavior reflect core social values and principles, informed by changing political and economic conditions (Browner and Sargent 1990:215).

Much of the available anthropological data on reproduction prior to 1970 is to be found within ethnographies devoted to other subjects. For example, Montagu analyzed concepts of conception and fetal development among Australian aborigines, and Malinowski wrote about reproductive concepts and practices among the Trobriand Islanders (Montagu 1949; Malinowski 1932). Several surveys of ethnographic data on reproduction were compiled, such as Ford's (1964) study of customs surrounding the reproductive cycle or Spencer's (1949–1950) list of reproductive practices around the world.

In the past twenty years anthropologists have sought to use cross-cultural data from preindustrial societies to help resolve women's health problems in the industrialized world (Oakley 1977; Jordan 1978). For example, comparative research on birth practices has raised questions regarding the medicalization of childbirth in the United States. Anthropologists have also involved themselves in international public health efforts to improve maternal and child health around the world. In addition, anthropological research has helped to clarify the

relationship between population growth and poverty. While some analysts have held the view that overpopulation is a determinant of poverty and the poor must control their fertility to overcome impoverishment, others argue the reverse: people have many children *because* they are poor (Rubinstein and Lane 1991:386).

Concern with population growth has often focused on women as the potential users of contraceptives, although women's personal desires to limit fertility may not be translated into action because of opposition from husbands, female relations, or others with influence or decision-making power. In this area of research anthropologists have an important contribution to make in examining such factors as cultural concepts regarding fertility and family size, the value of children, dynamics of decision making within the family and community, and the relationship between women's reproductive and productive roles.

Since the 1970s anthropological interest has turned to the linkages between cultural constructions of gender, the cultural shaping of motherhood, and reproductive beliefs and practices. In many societies throughout the world the relationship between women's status and maternity is clear: a woman attains adult status by childbearing, and her prestige may be greatly enhanced by bearing numerous male children (Browner and Sargent 1990:218). Thus, in the Middle East a woman is "raised for marriage and procreation [and] acquires her own social status only by fecundity" (Vieille 1978:456), while in parts of Africa pressures to be prolific weigh heavily on women (Sargent 1982).

In much of the world infertility is dreaded by men and women alike but is a particular burden to women (Browner and Sargent 1990:219). Such pressure to reproduce is especially intense in agrarian societies, which have a high demand for labor. However, in many hunter-gatherer and horticultural societies, motherhood and reproduction are less emphasized. As Collier and Rosaldo observe, "Contrary to our expectation that motherhood provides women everywhere with a natural source of emotional satisfaction and cultural value, we found that neither women nor men in very simple societies celebrate women as nurturers or women's unique capacity to give life" (1981:275).

Just as beliefs and practices regarding fertility are culturally patterned, birth itself is a cultural production (Jordan 1978). As Romalis notes, "The act of giving birth to a child is never simply a physiological act but rather a performance defined by and enacted within a cultural context" (Romalis 1981:6). Even in advanced industrial societies such as the United States, childbirth experiences are molded by cultural, political, and economic processes (Oakley 1980; Martin 1987; Michaelson et al. 1988). Studying the cultural patterning of birth practices can illuminate the nature of domestic power relations and the roles of women as reproductive health specialists, and it can increase our understanding of the relations between men and women cross-culturally.

While reproduction is culturally patterned, not all individuals in a society share reproductive goals. As Browner (this book) points out, reproductive behavior is influenced by the interests of a woman's kin, neighbors, and other members of the community, and these interests may conflict. Government policies regarding the size and distribution of population may differ from the interests of reproducing women. Women's goals in turn may not be shared by their partners or other individuals and groups in the society. Browner examines the ways in which access to power in a society determines how conflicts concerning reproduction are carried out and dealt with by analyzing population practices in a Chinantec-Spanish-speaking township in Oaxaca, Mexico.

In this community the government's policy to encourage fertility reduction was imposed on a preexisting conflict between the local community as a whole, which encouraged increased fertility, and women of the community, who sought to limit family size. Women and men manifested very different attitudes concerning fertility desires: women sought much smaller families than men. As children increasingly attend school their economic benefits appeared slight to their mothers. Further, women viewed pregnancy as stressful and debilitating. Yet despite these negative views, women felt they could not ignore pressures to reproduce.

Such pressure came from community men, who valued a large community for the interests of the defense and well-being of the collectivity, and from other women, who, while not desiring more children themselves, wanted other women to bear children in the interests of the group. In spite of the ease of obtaining government contraceptives, women rejected their use. Some felt that state policy promoting family planning was in fact cultural genocide, designed to eliminate indigenous Indian populations. In this cultural, political, and economic context, local women experienced conflict between personal desires to have few children and local pressures to be prolific.

Ginsburg (in this book) also discusses reproduction as a contested domain, using the example of abortion in American culture. She suggests that the focus of this conflict of interests is the relationship between reproduction, nurturance, sex, and gender. Using life histories of prolife and prochoice activists in Fargo, North Dakota, she reveals how different historical conditions affect reproductive decisions. The activist protesters in Fargo vie for the power to define womanhood in light of a basic American cultural script, in which pregnancy results in childbirth and motherhood in the context of marriage. Ginsburg argues that the struggle over abortion rights is a contest for control over the meanings attached to reproduction in America and suggests that "female social activism in the American context operates to mediate the construction of self and gender with larger social, political, and cultural processes."

Similarly, Whitbeck argues that controversy over abortion rights in the United States must be understood in relation to a cultural context that neglects women's experiences and the status of women as "moral individuals." Rather, American culture regards women and women's bodies as "property to be bartered, bestowed, and used by men" (Whitbeck 1983:259). Concern with restricting access to abortions derives from the interest of the state or others in power to control women's bodies and their reproductive capacity (Whitbeck 1983:260).

Ginsburg's research shows that prochoice activists in Fargo cluster in a group born in the 1940s and influenced by the social movements of the 1960s and 1970s. These movements offered a new vision of a world defined not only by reproduction and motherhood, but filled with broader possibilities. Right-to-life women comprised one cohort born in the 1920s and a second cohort born in the 1950s. Many of these women experienced their commitment to the right-to-life movement as a sort of conversion, occurring at the time they moved out of the paid work force to stay home with children. Women's life histories indicate that embracing a prolife or prochoice position "emerges specifically out of a confluence of reproductive and generational experiences." Reproduction, often defined in American culture as a biological domain, takes on meaning within a historically specific set of cultural conditions.

While Ginsburg discusses how abortion activists seek to define American womanhood in relation to cultural ideals of motherhood and nurturance, Gruenbaum (this book) shows that cultural expectations of marriage and motherhood in Sudan form the context for the deeply embedded practice of female circumcision. Female circumcision is reported to exist in at least twenty-six countries, and estimates of the number of women of all ages who have been circumcised in Africa reach 80 million; other estimates suggest that as many as 5 million children are operated on each year (Kouba and Muasher 1985; Sargent 1991). The various forms of female circumcision present serious risks, such as infection and hemorrhage at the time of the procedure and future risks to childbearing; therefore, social scientists, feminists, and public health organizations have opposed the practices. However, as Gruenbaum observes, female circumcision "forms part of a complex sociocultural arrangement of female subjugation in a strongly patrilineal, patriarchal society" and continues to be most strongly defended by women, who carry out the practice.

Women in Sudan derive status and security as wives and mothers. Virginity is a prerequisite for marriage, and in this context clitoridectomy and infibulation, the major forms of circumcision, are perceived as protecting morality. Thus, these practices persist because they are linked to the important goal of maintaining the reputation and marriageability of daughters. Forty years of policy formulated by the Sudanese government and by international health organizations em-

phasizing the physically dangerous dimensions of female circumcision and prohibiting the most extensive forms of the practice have not resulted in its elimination.

As Gruenbaum notes, clitoridectomy and infibulation are considered by Sudanese men and women to enhance a woman's ability to please her husband sexually, while attenuating inappropriate sexual desire outside marriage. Insofar as women are dependent on husbands for social and economic support and have few opportunities for educational advancement or viable employment, female circumcision is unlikely to be eradicated on medical grounds.

Miller's discussion of female infanticide and child neglect in North India (this book) is also set in a strongly patrilineal, patriarchal society and dramatically illustrates the links between gender ideology, reproduction, and health. In North India family survival depends on the reproduction of sons for the rural labor force, and preference for male children is evident in substantial ethnographic data documenting discrimination against girls. In this region preferences for male children result in celebrations at the birth of a boy, while a girl's birth goes unremarked. Sex-selective child care and female infanticide also indicate cultural favoring of male children.

Reports of female infanticide in India have occurred since the eighteenth century. There is evidence that a few villages in North India had never raised one daughter. In spite of legislation prohibiting female infanticide, the practice has not totally disappeared, although Miller argues that direct female infanticide has been replaced by indirect infanticide or neglect of female children. Indirect female infanticide is accomplished by nutritional and health-care deprivation of female children, a phenomenon also discussed by Charlton (see Part XI). Miller argues that the strong preference for sons in rural North India is related to the economic and social functions of sons.

The preference for male children has important repercussions in the increasing demand for abortion of female fetuses following amniocentesis. For example, in one clinic in North India 95% of female fetuses were aborted following prenatal sex determination. Thus, new reproductive technologies such as amniocentesis are seen to be manipulated in patriarchal interests. Miller suggests that, ultimately, understanding the patriarchal culture of north India may help promote more effective health care and enhanced survival chances for female children.

The readings in this part illustrate the ways in which human reproductive behavior is socially constructed and influenced by economic and political processes. Rather than perceiving reproductive health in a narrow biological or purely personal framework, cross-cultural research suggests that women's health needs should be addressed in the context of their multifaceted productive, reproductive, and social roles. Consequently, decisions about such reproductive health issues as family size and composition are never left to the individual woman, but are influenced by kin, community, and state interests. These interests are often contested with the introduction of new reproductive technologies enabling sophisticated prenatal testing, treatment for infertility, and surrogate mothering. As these technologies increasingly spread throughout the world, their availability will raise important questions regarding cultural definitions of parenting, concepts of personhood, and gender roles and relations.

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The Politics of Reproduction in a Mexican Village

Carole H. Browner

Although women in all societies bear children in private, or with only a select few present, human reproduction is never entirely a personal affair. Kin, neighbors, and other members of the larger collectives of which women are a part seek to influence reproductive behavior in their groups. Their concerns, however, about who reproduces, how often, and when frequently conflict quite sharply with the desires of the reproducers themselves.[1] At the state level, governments develop policies with which they try to shape the size, composition, and distribution of their populations. These policies inevitably seek to influence the reproductive activities of individuals. They may be directed toward the fertility of the whole society or selectively imposed on particular classes, subcultures, or other internal groups,[2] but they are usually promoted without much consideration for the individual women who bear and raise the children, and, as a result, they may not be embraced by their target groups. Further, state-initiated population policies are sometimes challenged by

internal groups whose objectives differ from those of the state.[3]

It is surprising that conflicts between the reproductive desires of a society's fecund women and the demographic interests of other individuals, groups, and political entities are rarely explored. After a comprehensive review of research in demography, population studies, and the anthropology and sociology of reproduction, Rosalind Pollack Petchesky reports, "Utterly lacking [in these fields] is any sense that the methods and goals of reproduction, and control over them, may themselves be a contested area within [a] culture."[4] Also absent from this research is the recognition that differential access to a society's sources of power determines how conflicts over reproduction are conducted and resolved, and even whether resolution ever occurs.

The following account analyzes the relationship between the population practices in one indigenous community in Mexico and the Mexican government's recent effort to reduce population growth. It shows that the government's fertility-reducing policy was superimposed on a long-standing local conflict between this community's women, who wished to limit the size of their own families, and the community as a whole, which wanted all of its female members to reproduce abundantly. Despite their apparent concordance with the goals of the state, the women refused the government's contraceptive services. They continued to have many children instead. The discussion will consider both why these indigenous rural women did not act on the fertility desires they expressed and why the demographic policies of Mexico have met uncertain success; for the two are outcomes of the same phenomenon: an overriding cultural prohibition in that community against any kind of fertility control.

BACKGROUND

The data presented here were collected in 1980–81 in a community I will call San Francisco, a Chinantec-Spanish-speaking *municipio* (township) located five hours by bus from the capital of the state of Oaxaca. The *municipio* was made up of a *cabecera* (head town) and a number of *ranchos* (hamlets) spread over a fifty-kilometer range. A year's participant observation was combined with interviews from a sample selected from the 336 adult women who lived in San Francisco. This sample consisted of 180 women selected to represent the age, residence, and linguistic background of the women. The husbands of the married women were also interviewed, a total of 126 men.

Historically, an important element in women's attempts to control their fertility was the use of medicinal plants. In addition to learning the respondents' reproductive desires and attitudes toward childbearing and child rearing, one aim of the interviews was to determine how the knowledge and use of such plants for management of reproduction and the maintenance of reproductive health were distributed and what might be the social implications of this distribution of knowledge before and after the Mexican government's introduction of modern birth control techniques. Demographic, economic, and health data were also obtained.

The *municipio* consisted of just over three hundred families of subsistence farmers who lived dispersed over its 18,300 hectares. Nearly two-thirds of the households (65 percent) cultivated the community's abundant communal landholdings in the tropical lowlands thirty miles east of the *cabecera*, or three hours from there by bus. The remainder used private plots located either in the *cabecera* or in the highland territory that individual Franciscanos purchased in 1930 from a neighboring *municipio*, or they farmed in both places. About a third of the families (32 percent) lived permanently on lowland ranches while most of the rest divided their time between the town center and the lowlands. Although only 5 percent of the households worked solely for wages, another 80 percent reported cash income from at least occasional wage labor.

Most full-time *rancho* residents had regular contact with the *cabecera*. Men made the trip several times each year to attend mandatory town assemblies. Men were also required to reside in the head town during their terms of civil and/or religious community service (*cargos*), which required several years of full-time commitment over the course of their lifetimes. Women had no formal reason for regular visits to the *cabecera*, but they sometimes went during holidays. In addition, they were expected to help their husbands carry out *cargo* responsibilities and often moved with them to the *cabecera* during their husbands' terms of office.

Until about 1965, the *municipio* fit the model of a closed corporate peasant community,[5] maintaining only sporadic contact with the world outside. Since that time, San Francisco's isolation had been sharply reduced by mandatory primary education, the construction of the Oaxaca-Tuxtepec highway and a feeder road connecting the *cabecera* in it, and a growing stream of migrants leaving the area for Oaxaca City, Mexico City, and the United States. Nevertheless, for many residents, daily life was much as it had always been: 42 percent of the women interviewed and 16 percent of the men had never been more than a few miles outside the community.

WOMEN'S ATTITUDES TOWARD PREGNANCY AND CHILDREN

Women in San Francisco expressed sharply negative attitudes about childbearing and child rearing, an unexpected finding that is contrary to the results of most other studies of peasants' attitudes toward fertility in Latin America.[6] While most research has suggested that peasant women want fewer children than they actually have, it has also suggested that, among these women, three to five children is considered the ideal family size and childlessness is considered a great misfortune. In San Francisco, a very different picture emerged. Among my study population, it was not unusual for women to volunteer that they would have preferred to remain childless or to have far smaller families than they did have. (Sixty of the 180 women interviewed had five or more children.) Sixty-three percent believed that there were women in their community who would choose childlessness if they could. As one informant explained, "The women without children, they're the smart ones"; and yet, as we shall see, choosing childlessness was socially very problematic.[7]

The differences in fertility desires between women and men in San Francisco underscored the women's negative attitudes. Respondents were asked whether they wanted to have more children. The majority of both sexes who still considered themselves of childbearing age said they wanted no more (see Table 1), but women were satisfied with far smaller families than were men. The overwhelming majority of the women (80 percent) who had at least one living child said they were content with their present family size. Moreover, of the small number of childless women ($N = 9$), one-third indicated that they were satisfied to remain so. However, most of the men who were satisfied with family size had at least four children (60 percent), and of the childless men ($N = 6$), none indicated that he was satisfied.

Women with large families said they resented the demands of child care and the limitations it placed on them. Many saw children as a burden. They considered them too much work, too hard to raise, a source of problems, "war," and domestic strife. They viewed children as pesky disturbances who kept them tied to the house. One woman told me, "[The people of the community] want us to have many children. That's fine for them to say. They don't have to take care of them and keep them clean. My husband sleeps peacefully through the night, but I have to get up when the children need something. I'm the one the baby urinates on; sometimes I have to get out of bed in the cold and change both our clothes. They wake me when they're sick or thirsty, my husband sleeps through it all."

This resentment was balanced to some extent by the women's perception of advantages associated with children. They particularly valued the physical and emotional companionship of their children, in part because the

TABLE 1. Fertility Goals of Adults in a Mexican Municipio, 1980

Living Children (N)	*Women*				*Men*			
	No	*Yes*	*Total*	*Yes (%)*	*No*	*Yes*	*Total*	*Yes (%)*
0	3	6	9	67	0	6	6	100
1	7	4	11	36	3	3	6	50
2	9	4	13	31	5	5	10	50
3	16	7	23	30	10	13	23	57
4	11	3	14	21	13	2	15	13
5	11	3	14	21	6	4	10	40
6+	31	1	32	3	23	1	24	4
Totals	88	28	116	24	60	34	94	36

NOTE—Number of responses to the question. "Do you want more children?" by number of living children. The remaining responses among women and men are: Women ($N = 180$): too old, 47; no husband, 8; ambiguous, 3; missing data, 6. Men ($N = 126$): too old, 25; ambiguous, 3; missing data, 4. (The response "no wife" was not possible since all men in the sample were the husbands of women interviewed.)

women were extremely reluctant to be at home alone, especially at night. They feared ghosts, phantoms, and spirits and worried about drunks reputed to harass solitary women. Women also tried to avoid going alone on errands out of town, for they feared wild animals and unknown men. They always sought out a child—their own or someone else's—if no other companion could be found.

Overall, however, most Franciscanas did not perceive much practical advantage in rearing large families. There was little economic benefit seen, for the women considered their offspring lazy or too busy with other activities to be of much help. Since mandatory school attendance was strictly enforced in San Francisco, and children were encouraged by school authorities to attend frequent after-school activities, mothers often felt saddled with chores that their children should have done. Although women hoped their offspring would care for them in their old age, the expectation that they would actually do so was changing as children left the village to find employment elsewhere. Interestingly, mothers expressed greater support for their children's migration than did fathers.[8] Nevertheless, the women felt disappointed when they realized that they had been forgotten at home.

In addition to resenting the hard work of raising children and the frustrations of its uncertain rewards, the women in this sample saw frequent pregnancies as physically stressful and even debilitating. In their view, much of a women's blood supply during pregnancy was devoted to nourishing the developing fetus. This left their own bodies unbalanced and susceptible to the large number of disorders that could be caused by penetration of cold and *aire* (air, winds). They also saw parturition as a threat to their health, believing that, during childbirth, the womb—and the rest of the body—must "open" to expel the newborn and that this process increased the body's already heightened vulnerability to *aire*.

Postpartum complications were common among Franciscanas. Of the 180 interviewed, two-thirds reported at least one. They ranged from conditions the women considered relatively minor, such as facial swelling and backaches, to such serious conditions as uterine prolapsis and uncontrolled bleeding. Emotional complications were sometimes mentioned as well. For instance, one woman reported that, after the birth of her second child, she was unable to tolerate criticism from her husband's relatives, with whom she and her family then lived. "I wanted to get up and run and run, I had no idea to where," she told me. In addition to the complications of pregnancy per se, women also feared that frequent childbirth and short birth intervals caused menstrual hemorrhaging, exhaustion, and early death. There are no reliable data on postpartum mortality for this particular population, but examples existed in the memories of all women interviewed.

The women's illness experiences that were not related to pregnancy reinforced their understanding that frequent pregnancies harmed their general health. Those who had had four or more pregnancies were significantly more likely than the rest to report at least one serious illness ($\chi^2 = 7.06$, $P < .001$). Even when age was controlled for, this pattern occurred. Women with four or more pregnancies were also significantly more likely to report a greater number of minor health problems overall, including headaches, backaches, breast problems, and *coraje* (anger sickness; $\chi^2 = 6.38$, $P < .025$). Again with age controlled for, women who had had four or more pregnancies were less healthy overall than women who had had fewer pregnancies.

THE CASE FOR LARGE FAMILIES

Despite the desires of many Franciscanas to have few (or no) children, they did not think that they could actually do so. The pressures on them to reproduce were simply too great to ignore. These pressures came most often and overtly from the community's men, who argued that a populous community was vital to the defense of the collectivity and its interests. Women were another source of pressure. Although most wanted few children themselves, they felt that other women were obligated by the needs of the collectivity to bear many children.

Maintaining a sufficient population base was a constant source of concern. San Francisco was surrounded by communities that coveted its comparatively large landholdings. It needed a sizable male population to defend its borders in case of armed attack by neighboring enemy communities who still threatened the *municipio*. One particularly bloody battle in the 1950s claimed the lives of thirteen Franciscanos. Residents also felt threatened by indications that the federal government might resettle members of other communities or ethnic groups onto San Francisco's lands or allocate territory to other *municipios* that were litigating for it because, unlike many rural *municipios*, San Francisco had more land than its population required. Residents were also concerned about the regional government's proposals to consolidate San Francisco with neighboring *municipios* because it was considered far too small to remain independent. The most likely of these plans would combine San Francisco with its most hated and feared enemy.

A number of endogenous factors also threatened the community's population base. Despite the presence in the *cabecera* of two government health centers, disease continued to take a significant toll. The rate of infant mortality in the state was one of Mexico's highest. On average, deaths from all causes in San Francisco had not declined during the past fifteen years.[9] Migration from the community to the state and national capitals and to the United States was also taking increasing numbers of the most able-bodied women and men. In the past two decades, the state of Oaxaca had experienced Mexico's highest rate of out-migration, suffering a net population loss of 290,000 between 1960 and 1970 alone. Because this trend had continued, Oaxaca's population had grown more slowly than that of any other Mexican state.[10] San Francisco had been acutely affected by these broader demographic trends. Of the women interviewed whose children were grown, nearly two-thirds reported having at least one child who resided outside the *municipio*, and more than one-fourth reported that all their grown children lived elsewhere.

Half of San Francisco's adult population was now over forty years old. As a result of this aging trend, an increasing proportion of the population were experiencing declining physical strength and productivity, which residents felt boded ill for the community's future. One concrete and very important manifestation of these difficulties was the inability

of the *municipio* to find enough men to fill the annual eighteen-man quota for civil and religious *cargo* positions. Moreover, there had been increasing pressure for independence from San Francisco on the part of some of the lowland *rancho* subcommunities (*agencias*); two had already won semiautonomous status from the regional government, and at least one of these was continuing to press for even greater independence.[11] All of these trends led residents of San Francisco to worry about the collectivity's future and to seek ways to diminish the impact of depopulation.

THE BIRTH CONTROL TREE

Although some of the reasons for the depopulation of San Francisco were new, concern about the size and strength of the collectivity was not. The conflict between the collective desire for a large and populous community and individual women's wishes to have few children had had a long, dramatic history in the *municipio*.

On many occasions during my fieldwork, men told me how, some twenty years before, they had cut down a tree whose bark was used by women as a contraceptive. They needed to eliminate the tree, they said, because so many women were refusing to bear children. This is the story the men told: Not far from the town center and just off a popular path to the lowland hamlets was a tree without a name. Its bark turned red when stripped from its trunk and was said to prevent conception. The large old tree was the only one of its kind known to the people of San Francisco. "Who knows where the seed came from," said one elderly resident; "strange it was the only one." Women who wished to avoid pregnancy brewed tea from the bark and drank it prior to intercourse. This would "burn" their wombs and render them temporarily sterile. This tea was dangerous and powerful, "like poison," some said. It could kill an incautious user. Women who drank the tea several times grew emaciated and weak. Even if they subsequently wished to bear children, as many as eight years might pass before a pregnancy.

Some said the users went secretly at night to get bark from the tree. Others thought that itinerant peddler women from an enemy town secretly sold Franciscanas strips of the dried bark along with other wares. Said one man, "It was they who deceived our women into not wanting children because they didn't want our town to grow."

A group of San Francisco's men were at work one day cutting back brush from the path that passed near the tree. They could see it from where they worked, almost stripped of its bark from frequent use. "Let's get rid of it," one of them said quietly; "we must have more children in this town." The others quickly agreed. "So," explained one who had been there, "we cut down the tree and tore its roots right out." They used the trunk to restore a nearby bridge in disrepair and returned home tired but satisfied with their work. (In an alternate version of the story, the men saw the tree, were angered, and stripped it entirely of its bark, causing it to die.)

I asked some of the men who said they were responsible for the act why they had killed the tree. "We were angry," one told me. "The women weren't having babies. They were lazy and didn't want to produce children." Another said that the women "had stopped making children. We were working hard with our men's work, but they weren't doing any of their women's work." One who said he remembered the incident explained that "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." A woman I interviewed saw the men's motives differently. "The men depended on the women," she said. "They couldn't have their children by themselves. But the women were walking free. The men pulled out the tree to control the women so they'd have children for them."

My research in San Francisco led me to ask often about the birth control tree. Every man I asked had heard of it although none could tell me its name or show me one like it. These days, they explained, people seldom passed the spot where it had grown because a better road to the lowlands had been built. After

weeks of asking, I nearly concluded that the tree was only a myth. Persistence finally led me to a woman who said her husband could show me the tree. He was more than reluctant to comply. "What if people found out that it has grown back?" he said. "What if they began to use it again? Then what would happen to the town?"

I continued to press him. Finally, he said he would not show me the tree but would take my field assistant's nine-year-old son to see it. The boy could later lead me to the spot. During the same period, one of the men who said he had participated in the destruction of the tree agreed to see if it had possibly regenerated. During different weeks, each of the two informants independently led me to the same clump of *Styrax argenteus*. As the second man showed me the abundant young growth, he expressed surprise that several had grown where only one had been.

The women I asked about the tree were consistently less informative than the men. While all the men knew of the birth control tree, the majority of women said they had never even heard of it, let alone used it to avoid pregnancy. The men did not believe the women were as ignorant as they claimed. I asked one man how the men had learned of the tree if the women had used it only in secret. He replied, "Of course the women think they have their secrets. But we men were able to find out. They have no secrets from us."

THE WOMEN'S RESPONSES TO PRESSURES TO REPRODUCE

There are several morals to this story, but the inevitability of negative reactions to behaviors that place individual interests above those of the collectivity is a very important one. In San Francisco, married women with few or no children were seen as selfish and socially negligent regardless of whether their low fertility was natural or willfully induced. Such women were particularly vulnerable to gossip, much of which centered on their fertility behavior. They were sharply and repeatedly criticized for causing miscarriages and using contraceptives. Some were even accused of infanticide. All of their acts were carefully monitored by relatives and other interested parties to detect any efforts to avoid pregnancy. For example, lemon juice was widely regarded as a contraceptive and an abortifacient.[12] After failing to conceive during her first year of marriage, one woman fell subject to her mother-in-law's constant gossip and criticism for avoiding her reproductive responsibilities by eating too much of the fruit. Another woman determinedly broke her young daughter of the habit of enjoying lemons, for she feared that they would damage her daughter's fertility.

Women with small families were susceptible to gossip about marital infidelity, which diminished the social status of their husbands as well. As a middle-aged mother of six explained, "The women who are most likely to go with other men are the ones who don't have much work to do. They have time for sex. But if you have a lot of kids like I do, you have to work very hard all the time. The tiredness takes over at the end of the day and you don't have time to think about the husbands of other women. You don't have time to go out looking for men." The targets of such gossip attributed it to envy of the relative wealth and freedom they enjoyed as a result of having small families—and they adamantly denied that their low fertility was due to contraceptives.

Contraceptives were, however, readily available at the town's two government-run health centers; one even provided the services free of charge. The Mexican government's interest in lowering its national birth rate had led it since 1972 to promote family planning aggressively.[13] The walls of both clinics were decorated almost exclusively with posters demonstrating the benefits of small families and *paternidad responsable* (responsible parenthood).[14] They were written in simple language with humorous illustrations. The text of a typical one read: "What will happen when we are more? We will have less money . . . less food . . . less education . . . less space . . . less clothing . . . less peace. You can avoid these problems if you plan your family. Now planning is easier! Consult the

family doctor at the Social Security Clinic although you may not be insured. *The consultation is free.*"[15] Each clinic assigned its staff monthly inscription quotas for new contraceptive users. Health center personnel were expected to undertake house-to-house campaigns to introduce fecund women to modern birth control techniques.

Overwhelmingly, Franciscanas rejected these government services. For the period between January 1980 and February 1981, records from the two clinics indicated that thirteen Franciscanas initiated contraceptive use—only 7 percent of women between the ages of eighteen and forty-five. These women used contraceptives for an average of just 3.5 months before stopping, and only one continued using contraceptives for longer than six months.

When I asked several who said they wanted no more children why they did not seek the means to avoid pregnancy, they revealed an extreme reluctance to engage in socially disapproved behavior. Some indicated they would never consider obtaining birth control from government clinics because they would be ashamed to be publicly "registered" as a user of contraceptives. This same fear of community censure led women to avoid other means of fertility control and even the kinds of behavior that could be construed as attempts at fertility limitation. When I naively asked one of the town midwives if she had ever been asked to perform an abortion, she looked at me and said, "They wouldn't dare." Similarly, a Franciscana suffering from menstrual delay was afraid to inquire locally for a remedy. Even though she was convinced that she was not pregnant, she was sure she would be accused of abortion if she took a remedy to induce menstrual bleeding.

The women responded to these pressures to reproduce not simply by refusing to use contraceptives but also by denying they knew anything whatsoever about ways to limit fertility. It seemed they felt that merely possessing information would be interpreted as evidence of their malevolent intentions. When I asked women the direct question, "Do you know of any herbs or other remedies that can be used to avoid pregnancy?" only 11 percent mentioned specific techniques such as the infamous birth control tree. Another 6 percent said they believed that ways existed but knew of none themselves. The remaining 83 percent said they believed there were no traditional ways to avoid getting pregnant. An even larger proportion (86 percent) said they knew no ways to induce an abortion. Even Franciscanas who considered themselves authorities on a great many subjects pleaded ignorance when it came to birth limitation.

Denial, however, did not necessarily imply ignorance. Probes revealed that 60 percent who had initially said they knew no ways to limit births had at least heard of the existence of techniques for fertility limitation. The vast majority of these respondents named modern rather than traditional methods and the responses were often quite oblique. For example, to the questions, "Is there *anything* that can be done to not have children if one doesn't want to have them? If so, what things?" typical responses were: "Yes, in the health center"; "I know the doctor has some"; "They say there are pills, medicines." Other replies explicitly identified the government as the source of contraceptives, shifting the question away from indigenous techniques for birth limitation to methods made available from outside the community. For example, "These days the government doesn't allow people to have so many children. It gives them medicines so they won't"; and "There used to be lots of herbs. Now, the government sends us doctors."

Yet none of the affirmative responses to the questions about knowledge of birth control could be interpreted as endorsements of contraceptive use. No respondent seemed to regard the available fertility-limiting techniques as liberating or as helping them to achieve their expressed goals of having small families. In fact, when responding affirmatively to the probe concerning their knowledge of contraceptives, the women would frequently volunteer a disclaimer in an apparent effort to dissociate themselves even further from the information, even though the probe did not concern their own experiences with contraceptives. For instance; "Well, yes, I have heard that there are medicines available, but I haven't tried them"; "Yes, there are remedies in the health center, but I haven't looked into it"; and, "They say there are medicines in the health center, but I myself haven't used any." Even most of those few in my study population (four out of six women) whose health center records revealed a history of contraceptive use strenuously denied use when directly asked during interviews.

Others told me with extreme caution what they knew about contraception. Some who during interviews had denied all knowledge of contraceptive methods subsequently came to my house to tell me about plants or other techniques that had previously "escaped" their memories. Even knowledge that seemed to me benign was very reluctantly conveyed if it pertained to birth limitation. For example, after initially denying she knew any remedies to induce an abortion, one woman reconsidered and whispered, "I don't know if this would really work, but some say that it can: carrying heavy loads, carrying heavy tumplines of firewood every day, doing a lot of laundry. It's said this can make one abort." Although this idea might be inferred from the circumstances under which miscarriages were observed to have occurred, women carefully guarded even this much knowledge, for they feared it would be incriminating.

IMPLICATIONS OF THE RESEARCH

These data shed light on the context in which a national population planning program was experienced in a rural indigenous community. The context was political, economic, civic, and cultural. On the part of the Mexican government, the decision to promote family planning among indigenous populations was politically delicate, for many Mexican nationalists regard the preservation of their Indian cultural heritage as fundamental to their cultural identity as Mexicans, and aggressive programs to limit the growth of indigenous groups may be perceived as cultural genocide.[16] However, because economic development could not keep pace, the need to check population growth proved more pressing than the state's concerns with the politics of ethnic preservation. Terry L. McCoy has shown, moreover, that the recognition that the government could be destabilized by unchecked growth among less than fully loyal social classes and cultural groups provided significant impetus for the Mexican population policy.[17] In Mexico, as in other developing countries, such policies are used to further state consolidation.

A reduction in San Francisco's rate of population growth was, as we have seen, the last thing the male guardians of the collectivity wanted. While appreciating the value of birth control for the nation in the abstract, and in some cases even wishing for relatively small families themselves, the men unambivalently rejected family planning for the people of San Francisco. In contrast, the women were caught between their desires to have very few children and inexorable local social pressures to be prolific. Because of this pressure, government family planning services could not help the women achieve their own fertility goals. In fact, the existence of these services may have made it even more difficult for the women to practice covert fertility limitation: with the availability of modern contraceptives in the community, women fell under even more suspicion than before.

It has all too often been assumed that women's reproductive goals could be understood by analyzing those of the larger collectivities of which they are a part. However, when collectivities have specific fertility goals, it is reasonable to expect that these goals will conflict with the reproductive desires of at least some of the female members of the group. The extent to which women successfully implement their individual fertility goals depends on a number of factors that vary according to the characteristics of the particular society in which they live. These include the nature of the gender-based power relations and the extent to which women feel they can support one another in controversy. In stratified societies, issues related to social class and

ethnicity also play a part, and women may be torn by conflicting sets of interests.[18] Studies that fail to consider *both* these broad sociopolitical conditions and the interests and desires of individual women will understate the complexity, misrepresent the realities, and yield questionable conclusions about reproductive policy and reproductive behavior.

NOTES

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Procreation Stories: Reproduction, Nurturance, and Procreation in Life Narratives of Abortion Activists

Faye Ginsburg

The residents of Fargo, North Dakota—a small metropolitan center providing commercial and service industries for the surrounding rural area—pride themselves on their clean air, regular church attendance, rich topsoil, and their actual and metaphorical distance from places like New York City. The orderly pace of Fargo's daily life was disrupted in the fall of 1981 when the Fargo Woman's Health Center—the first free-standing facility in the state to publicly offer abortions—opened for business. A right-to-life[1] coalition against the clinic formed immediately. Soon after, a pro-choice group emerged to respond to the antiabortion activities. Each side asked for support by presenting itself as under attack, yet simultaneously claimed to represent the "true" interests of the community. The groups have evolved and fissioned. There are approximately 1000 potentially active supporters on each side and a hard core of 10 to 20 activists.

Broadly sketched, two positions emerged. For the pro-life movement in Fargo, the availability of abortion in their own community represented the intrusion of secularism, narcissism, materialism, and anomie, and the reshaping of women into structural men. Pro-choice activists reacted to right-to-life protesters as the forces of narrow-minded intolerance who would deny women access to a choice that is seen as fundamental to women's freedom and ability to overcome sexual discrimination.

When pro-life forces failed to close the clinic through conventional political tactics,[2] they shifted their strategy. They currently are engaged in a battle for the clinic's clientele. Competition is focused increasingly on winning the minds, bodies, and power to define the women who might choose to violate a basic cultural script—the dominant American procreation story—in which pregnancy necessarily results in childbirth and motherhood, preferably within marriage.

The local controversy over the clinic opening in Fargo revealed at close range how the struggle over abortion rights has become a contested domain for control over the constellation of meanings attached to reproduction in America. In the course of fieldwork,[3] it became clear to me that this conflict does not indicate two fixed and irreconcilable positions. Rather, the social movements organized around abortion provide arenas for innovation where cultural and social definitions of gender are in the process of material and semiotic reorganization.

In each movement, then, a particular understanding of reproduction is demonstrated through abortion activism. This was especially apparent in life stories[4]—narratively shaped fragments of more comprehensive life histories—I collected with female abortion activists.[5] Such narratives, which I am calling procreation stories, reveal the way in which women use their activism to frame and interpret their experiences—both historical and biographical. The stories create provisional solutions to disruptions in a coherent cultural model for the place of reproduction and motherhood in the female life course in contemporary America. They illuminate how those dimensions of experience considered "private" in American culture intersect with particular social and historical conditions that distinguish the memberships of each group. In the ways that the rhetoric and action of abortion activism are incorporated into life stories, one can see how cultural definitions of the female life course, and the social consequences implied, are selected, rejected, reordered, and reproduced in new form.

This paper is based on my own fieldwork with local women activists engaged in the Fargo abortion controversy from 1981 to 1983. I chose subjects who were most prominent in local activity at the time and who reflected, in my estimation, the range of diversity encompassed in the active memberships of both pro-life and pro-choice groups in terms of age, socioeconomic status, religious affiliation, household and marriage arrangements, style of activism, and the like. Altogether I collected 21 life stories from right-to-life activists and 14 from pro-choice activists. While most of these people are still active, each side continues to undergo rapid permutations both locally and nationally. Thus, the benefits of in-depth participant observation research must be balanced against the debits of a small sample bound by the conditions of a particular time and setting. In addition, because of space limitations, I can present only a few cases, which are illustrative of themes that are prominent in the narratives more generally. However, my conclusions are confirmed in other qualitative studies of abortion activists (for example, Luker 1984), which also find abortion activism linked to a more general integrative process. For example, in an article discussing the role abortion seems to play in activists' lives, authors Callahan and Callahan write:

> The general debate has seen an effort, on all sides, to make abortion fit into some overall coherent scheme of values, one that can combine personal convictions and consistency with more broadly held social values. Abortion poses a supreme test in trying to achieve that coherence. It stands at the juncture of a number of value systems, which continually joust with each other for dominance, but none of which by itself can do full justice to all the values that, with varying degrees of insistence and historical rootedness, clamor for attention and respect [1984:219].

On the basis of such findings, it seems appropriate to use life stories as texts in which abortion is a key symbol around which activists are interpreting and reorienting their lives. More generally, this suggests a model for understanding how female social activism in the American context operates to mediate the construction of self and gender with larger social, political, and cultural processes.

REPRODUCTION, GENERATION, AND NURTURANCE

Surveys of representative samples of pro-life and pro-choice activists have not established any clear correlations between such activity and conventional social categories. Activists span and divide religious, ethnic, and occupational lines. The core of membership on both sides is primarily white, middle class,[6] and female[7] (Granberg 1981). Ideologically, the connections drawn between abortion activism and other social issues are diverse (Ginsburg 1986:76–81). Of the life stories I collected from abortion activists in Fargo, in almost all cases, pro-choice and pro-life alike, women described a coming to consciousness regarding abortion in relation to some critical realignment of personal and social identity, usually related to reproduction. Initially, this recognition only seemed to confound the problem of trying to understand the differences between the women on opposite sides of the issue. From accounts of the early histories of Fargo activists, up to the age of 18 or so, it would be hard to predict whether women would end up pro-choice or pro-life in their views. Devout Catholics became ardent feminists; middle-class, college-educated, liberal Protestants became staunch pro-lifers. As I puzzled over the seeming convergences in catalyzing experiences, social backgrounds, and even sentiments—most see themselves as

working toward the reform of society as a whole—and I began to notice a generational distinction.

The pro-choice activists cluster in a group born in the 1940s. For the most part, they had reached adulthood—which generally meant marriage and children—in the late 1960s and early 1970s. Their life stories indicate that contact with the social movements of that period, particularly the second wave of feminism, was a central experience for nearly all of them. They describe their encounter with these movements as a kind of awakening or passage from a world defined by motherhood into one seen as filled with broader possibilities. For most of these women, feminism offered new resources with which to understand and frame their lives; it provided an analysis, a community of others, and a means for engaging in social change that legitimated their own experience.

By contrast, the right-to-life women cluster in two groups. Those born in the 1920s were most active in pro-life work in the early 1970s. A second cohort, the one currently most active, was born in the 1950s. Typically, this latter group was made up of women who had worked prior to having children and left wage labor when they became mothers. This transition occurred in the late 1970s or even more recently, a period when feminism was on the wane as an active social movement and pro-life and anti-ERA activity were on the rise. This latter group claims to have been or even be feminist in many respects (that is, on issues such as comparable worth). Many describe their commitment to the right-to-life movement as a kind of conversion; it occurs most frequently around the birth of a first or second child when many women of this group decided to move out of the paid work force to stay home and raise children.

Let me clarify that I am not arguing that all abortion activists fall neatly into one or another historical cohort. As is the case in most anthropological studies in complex societies, my study is small and local, allowing for fine-grained, long-term study that can reveal new understandings but not necessarily support broad generalizations. In this case, the appearance of a generational shift, even in this small sample, is intended less as an explanation and more as a reminder of the importance of temporal factors in the dialectics of social movements. In other words, social activists may hold different positions due not only to social and ideological differences. Differing views may also be produced by historical changes, which include their experience of the opposition at different points over the life course. On the basis of my research, I would argue that this might be particularly relevant in conflicts tied so closely to life cycle events. In the narratives, *all* the women are struggling to come to terms with problematic life-cycle transitions, but in each group, the way they experience those as problematic is associated with very particular historical situations. Abortion activism seems to mediate between these two domains, as a frame for action and interpretation of the self in relation to the world. For most of these women, their procreation stories create harmonious narrative out of the dissonance of history, both personal and generational.

In his classic essay "The Problem of Generations," Karl Mannheim underscores the importance of this nexus between the individual life cycle and rapidly changing historical conditions in understanding generational shifts in the formation of political consciousness and social movements:

> in the case of generations, the "fresh contact" with the social and cultural heritage is determined not by mere social change but by fundamental biological factors. We can accordingly differentiate between two types of "fresh contact": one based on a shift in social relations, and the other in vital factors [1952:383].
>
> The *sociological* problem of generations . . . begins at that point where the sociological relevance of these biological factors is discovered [1952:381].

To use Mannheim's suggestion, one must consider the intersection of two unfolding processes in order to understand what attracts women to opposing movements in the abortion controversy. One is the "biological factors," the trajectory of a woman's sexual and reproductive experiences over her life course and her interpretation of those events. The second is the historical moment shaping the culture when these key transitional points occur. It is this moment of "fresh contact" that creates the conditions of "a changed relationship" and a "novel approach" to the culture that ensures its continual reorganization. Such "fresh contact" is manifest in the self-definition and social actions of women engaged in the abortion controversy, some of whose life stories are analyzed below. Their narratives reveal how the embracing of a pro-life or pro-choice position emerges specifically out of a confluence of reproductive and generational experiences. In the negotiation of critical moments in the female life course with an ever-shifting social environment, the contours of their own biographies and the larger cultural and historical landscape are measured, reformulated, and given new meaning.

Such reconstructing is most marked at critical transitional points in the life course. In situations of rapid change when the normative rules for an assumed life trajectory are in question, these life-cycle shifts are experienced as crises, revealing contention over cultural definitions. In other words, when the interpretation of a particular life event—abortion or more generally the transition to motherhood, for example—becomes the object of political struggle, it indicates a larger disruption occurring in the social order as well. What emerges in the biographical narratives of these women is an apparent dissonance between cultural codes, social process, and individual transformation in the life course. Analytically, then, life stories can be seen as the effort of individuals to create continuity between subjective and social experience, the past and current action and belief.

These orientations provide a useful framework for interpreting the narratives of abortion activists in relation to the social movements that engage them. The battles they fight are loci for potential cultural and social transformation; in life stories, change is incorporated, ordered, and assigned meaning by and for the individual. This process is central to the "changed relationships" of many women to American culture that have generated struggles over conflicting views of the interpretation of gender in the last two decades. Thus, in the case of abortion, two mutually exclusive interpretations and arenas of action are formulated, which give the narrator symbolic control over problematic transitions in the female life cycle.

I am arguing that these transitions constitute life crises for women at this moment in American history because of the gap between experiences of discontinuous changes in their own biographies and the available cultural models for marking them, both cognitively and socially. As increasing numbers of women are entering the wage labor market and traditional marriage and familial arrangements seem to be in disarray, it is hardly surprising that the relationship of women to reproduction, and mothering in particular, has been thrown open to reinterpretation.

In the United States, where the culture and economy are underwritten by an ideal of individual autonomy and achievement and the separation of workplace and home, the fact of dependency over the life course has been hidden in the household. Assigned to the "private realm"—the domain of unpaid labor performed by women serving as emotional and often material providers for infants, children, the sick, the elderly—nurturance thus escapes consideration as a larger cultural concern. Rather, the general social problem of caring for dependent human beings is linked to biological reproduction and childrearing in heterosexually organized families, all of which are conflated with the category female.[8] When women vote with their bodies to eschew the imperatives of American domesticity by remaining single, childless, and/or entering wage labor in large numbers, both the conditions and native understandings of nurturance and reproduction necessarily change.

Such changes are central themes in the procreation stories of abortion activists. While their "life scripts" are cast against each other, both provide ways for managing the structural opposition in America between work and parenthood that still shapes the lives of

most women and men in this culture. Because contrasting definitions of the cultural and personal meaning of reproduction are being created in a contested domain, they are shaped dialectically. Each side attempts to both incorporate and repudiate the claims to truth of their opposition, casting as unnatural, immoral, or false other possible formulations. In the abortion debate, both positions serve to "naturalize" constructions regarding women's work, sexuality, and motherhood, and the relationships among them, thus claiming a particular view of American culture and the place of men and women in it in a way that accommodates discontinuities and contradictions.

The location of and responsibility for nurturance in relationship to biological reproduction is of critical concern, the salient value and contradiction for women on both sides of the debate. Nurturance is claimed by activists as a source of moral authority for female action. Yet, it is also understood as the culturally assigned attribute that puts women at a disadvantage socially, economically, and politically, confining them to the unappreciated tasks of caring for dependent people. These two views of the "proper" place of reproduction and nurturance in the female life course are the poles around which activists' life stories are constituted.

Activists' views on abortion are linked to a very diverse range of moral, ethical, and religious question, which I discuss in more detail elsewhere (Ginsburg 1986).[9] In this paper, however, I have confined my analysis to the issues that emerge in their life stories. My goal here is an effort to understand how abortion activism and abstract notions tied to it mediate between historical experience, construction of self, and social action. What I think is striking about the emergence of nurturance as a central theme in these narratives is that it ties female life-cycle transitions to the central philosophical questions of each side: the pro-life concern with the protection of nascent life, and the pro-choice concern with the rights and obligations of women, those to whom the care of that nascent life is culturally assigned.

THE LIFE STORIES

The Pro-Choice Narratives

The pro-choice narratives were drawn from women activists who organized to defend the Fargo abortion clinic; most were born between 1942–52. They represent a range of backgrounds in terms of their natal families, yet all were influenced as young adults by the social unrest of the late 1960s and early 1970s, and by the women's movement in particular. While their current household, conjugal, and work arrangements differ, for almost all, the strong commitment to pro-choice activism was connected to specific life-cycle events, generally having to do with experiences and choices around sexuality, pregnancy, and childbearing, including the choice not to have children.

A central figure of the current controversy in Fargo is Kay Bellevue, an abortion rights activist since 1972. Kay grew up in the Midwest, the oldest of seven children. Her father was a Baptist minister; her mother worked as a homemaker and part-time public school teacher. In her senior year of college, Kay got pregnant and married. Like almost *all* of the women activists, regardless of their position on abortion, Kay's transition to motherhood was surrounded by ambivalence.

> "I enjoyed being home, but I could never stay home all the time. I have never done that in my life. After being home one year and taking care of a kid, I felt my mind was a wasteland. And [my husband and I] were so poor we could almost never go out together."

Although her *behavior* was not that different from that of many right-to-life women—that is, as a young mother she became involved in community associations—Kay's interpretation of her actions stresses the limitations of motherhood; by contrast, pro-life women faced with the same dilemma emphasize the drawbacks of the workplace. Not surprisingly, for both groups of women, voluntary work for a "cause" was an acceptable and satisfying way of managing to balance the pleasures and duties of motherhood with the structural isolation of that work as it is organized in America. La Leche League, for example, is a group where one stands an equal chance of running into a pro-life or pro-choice women. In her early 20s, Kay became active in a local chapter of that organization, an international group promoting breast-feeding and natural childbirth. She marks this as a key event.

> "My first child had not been a pleasant birth experience so I went [to a La Leche meeting] and I was really intrigued. There were people talking about this childbirth experience like it was the most fantastic thing you'd ever been through. I certainly didn't feel that way. I had a very long labor. I screamed, I moaned, my husband thought I was dying. So . . . this group introduced me to a whole different conception of childbirth and my second experience was so different I couldn't believe it.
>
> And the way I came to feminism was that through all of this, I became acutely aware of how little physicians actually knew about women's bodies . . . So I became a real advocate for women to stand up for their rights, starting with breastfeeding."

Surprisingly, the concerns Kay voices are not so different from those articulated by her neighbors and fellow citizens who so vehemently oppose her work.

In 1972, Kay moved to Fargo; she remembers this transition as a time of crisis. Her parents were divorcing, one of her children was having problems, and Kay became pregnant for the fifth time.

> "Then I ended up having an abortion myself. My youngest was 18 months old and I accidentally got pregnant. We had four small kids at the time and we decided if we were going to make it as a family unit, we had all the stress we could tolerate if we were going to survive."

In her more public role, as was the case in these personal decisions regarding abortion, Kay always linked her activism to a strong commitment to maintain family ties. As such, she was responding to accusations made by right-to-life opponents that abortion advocacy means an oppositional stance toward marriage, children, and community.

> "I think it's easy for them to stereotype us as having values very different than theirs and that's not the case at all. Many of the people who get abortions have values very similar to the anti-abortion people. The Right-to-lifers don't know how deeply I care for my own family and how involved I am, since I have four children and spent the early years of my life working for a breast-feeding organization."

Kay particularly resents the casting of pro-choice activists by right-to-lifers as not only "antifamily" but "godless" as well. Although she stopped attending church services when she got married—something she feels could stigmatize her in a community noted for its church attendance—Kay nonetheless connects her activism to religious principles of social justice learned in her natal family.

> "I have always acted on what to me are Judeo-Christian principles. The Ten Commandments, plus love thy neighbor. I was raised by my family to have a very strong sense of ethics and it's still with me. I have a strong concern about people and social issues. I've had a tough time stomaching what goes on in the churches in the name of Christianity. I've found my sense of community elsewhere. I think pro-choice people have a very strong basis in theology for their loving, caring perspective. . . . It's very distressing to me that, particularly the people opposed to abortion will attempt to say their moral beliefs are the only correct ones."

Such stereotypes, to which most of the pro-choice women in Fargo were extremely sensitive, are addressed implicitly or explicitly in the repeated connections these activists made between abortion rights and a larger claim to the cultural values of nurturance which, in their view, women represent.

These concerns are prominent, for example, in the narratives of other abortion rights advocates. Janice Sundstrom, like most of the pro-choice activists in Fargo, frames her story by emphasizing her differentiation from, rather than integration with, her childhood milieu.

> "In 1945, shortly after I was born, my mom and dad moved here and brought me along and left all the other children with relations back in Illinois. I think I'm different from the rest of them because I had the experience of being the only child at a time when they had far too many children to deal with."

While the transformations Janice eventually experienced are cast, in her story, as almost predictable, they hardly seem the inevitable outcome of her youth and adolescence: 12 years in Catholic parochial school and marriage to her high-school sweetheart a year after graduation, followed immediately by two pregnancies.

> "We were both 19 then and I didn't want to have another child. We were both in school and working and there we were with this kid. But I didn't have any choice. There was no option for me about birth control because I was still strongly committed to the Church's teaching. And then, three months later, I was pregnant again. After Jodie was born I started taking pills and that's what ended the Church for me."

For Janice, ambivalent encounters with reproduction—in this case the problem of birth control that made her question her church—are key events in her story. In this way, her interpretation of her experiences resembles the way that pregnancy and pro-life activism are linked in the right-to-life narratives discussed later on. It is a central pivoting moment in her life, which turned her toward alternative cultural models.

> "Up to that time, I felt very strongly about abortion as my church had taught me to think and somehow between 1968 and 1971—those years were crucial to the political development of a lot of people in my generation—I came to have different feelings about abortion. My feeling toward abortion grew out of my personal experiences with friends who had abortions and a sensitivity to the place of women in this society."

What is striking in the connections Janice goes on to make to her abortion rights position is not its *difference* from that of her opponents, but its similarities. She is disturbed by cultural currents that promote, in her view, narcissistic attitudes toward sexuality and personal fulfillment in which the individual denies any responsibility to kin, community, and the larger social order. Several pro-choice women referred to this constellation of concerns as "midwestern feminism." They are described as natural attributes possessed and represented by women. In Janice's words,

> "It's important that we remember our place, that we remember we are the caregivers, that we remember that nurturing is important, that we maintain the value system that has been given to us and that has resided in us and that we bring it with us into that new structure. . . . It's important that we bring to that world the recognition that 80-hour work weeks aren't healthy for anyone—that children suffer if they miss relationships with their fathers and that fathers suffer from missing relationships with their children. This society has got to begin recognizing its responsibility for caring for its children."

Such concerns are emblematic of a broader goal of pro-choice women to improve conditions in a less than perfect world. More generally, the agenda of women on the pro-choice side is to use legal and political means to extend the boundaries of the domain of nurturance into the culture as a whole. They are attempting to reformulate the requirements of human reproduction and dependency as conditions to be met collectively. Their narratives reveal both an embracing of nurturance as a valued quality natural to women and the basis of their cultural authority, and their rejecting of it as an attribute that assigns women to childbearing, caretaking, and domesticity. These themes emerge in pro-choice stories as well as in action. In their view, nurturance is broadly defined. It includes the stated and actual preference for nonhierarchical relationships and group organization, and an insistence that their activism is not for personal gain or individual indulgence but in the interests of women and social justice. This utopian subtext of their position is rooted in their historical encounter with feminism. More directly, it is expressed as a desire to create a society more hospitable to the qualities and

tasks they identify as female: the reproduction of generative, compassionate, or at least tolerant relationships between family, friends, members of the community, people in the workplace, and even the nation as a whole. In the narratives they construct, their desire to control their own reproduction is linked to a larger goal of (re)producing cultural values of nurturance on a large social scale.

The Right-to-Life Narratives

Right-to-life activists express a similar concern for the preservation of female nurturance. While it is linked directly to biological reproduction, nurturance in their narratives is not natural but achieved. In all the stories of pregnancy and birth told by right-to-life women, the ambivalence of the mother towards that condition—either through reference to the storyteller's own mother or children, or experience of motherhood herself—is invoked and then overcome through a narrative strategy that stresses continuities between generations, as the following quote illustrates. The speaker is Shirley, a 63-year-old widow, part-time nurse, mother of six, and a well-known member of Fargo's comfortable middle class.

> "Our Senator, he's not pro-life, sent me a congratulations letter when [my son] John got a teacher of the year award in 1980. I wanted to take the letter back to him and say, "It was very inconvenient to have this son. My husband was in school and I was working. We thought we needed other things besides a child. And had abortion been available to me, I might have aborted the boy who was teacher of the year.' What a loss to society that would have been. What losses are we having in society now?"

The first wave of right-to-life activity in Fargo received much of its support from women of Shirley's cohort, many of whom had recently been widowed and were facing the loss of children from their immediate lives as well. At a moment in their life cycles when the household and kin context for a lifelong vocation of motherhood was diminishing, pro-life work provided an arena for extending that work beyond the boundaries of home and family.

Another woman of that cohort, Helen, also drew cross-generational connections through her right-to-life commitment. Raised in one of Fargo's elite Lutheran families, Helen fulfilled her mother's dream by attending an eastern "seven sisters' school" and going on for a master's degree in social work. After World War II, she married, returned to Fargo, and had three children. There, she has led the life appropriate for the wife of a local retail magnate. She was, until recently, a pro-choice advocate, a position of which her mother disapproved.

> "Years ago, as a social worker, even though I reverenced life, I can still see some of those families and how they lived. I was pro-choice because I thought of those little children and how they lived. And I remember my mother saying 'Helena,' (she always called me Helena when it was serious) 'That's murder . . . ' And I said, 'Better those children were never born, mother. They live a hell on earth . . . ' and she never talked about it to me after that but I'm sure it hurt."

When the clinic opened in 1981, Helen was asked by a member of one of her prayer groups to join the pro-life coalition against the clinic, which she did. She saw her "conversion" to the right-to-life movement as a repudiation of a prior sense of self that had separated her from her mother, who recently died. She links all of these to the circumstances of her own birth.

> "I had a sister killed in a car accident before I was born and . . . I don't know if I ever would have been if she hadn't died . . . My mother was so sick when she was pregnant with me because she was still grieving. They wanted to abort her and she said, 'No way.'
>
> So when she died last year and all these checks came in, I gave them to LIFE Coalition and as a thank you note to people, I told them about her story . . . It brought life to me that at her death this could go on.
>
> You know there is one scripture in Isaiah 44 that I especially pray for my family and that says

'I knew you before you were formed in your mother's womb. Fear not, for you are my witness.'

In this fragment, Helen establishes metaphorical continuity between her pro-life conviction and the opening story of her narrative, in which she reconstucts her own sojourn in her mother's womb, identifying herself simultaneously with her earliest moments of existence and with her mother's trauma as well. As in Shirley's story, the denial and acceptance of mother and child of each other's lives are merged, and then given larger significance as reproductive events are linked figuratively and materially to the right-to-life movement and given new meaning.

The connections of the right-to-life position with overcoming ambivalence toward pregnancy, and the merging of divergent generational identities in the act of recollection are present, though less prominent, in the procreation stories of younger pro-life women as well. Sally Nordsen is part of a cohort of women born between 1952–62 who make up the majority and most dedicated members of Fargo's antiabortion activists. Like most of the other pro-life women of this group, Sally went to college and married soon after her graduation; she worked for seven years as a social worker. In her late 20s, she got pregnant and decided to leave the work force in order to raise her children. Sally regards this decision as a positive one; nonetheless, it was marked by ambivalence.

"I had two days left of work before my resignation was official but Dick was born earlier than expected. So I left the work on my desk and never went back to it. There were so many things that were abrupt. When I went into the hospital it was raining, and when I came out it was snowing. A change of seasons, a change of work habits, a new baby in my life. It was hard. I was so anxious to get home and show this baby off. And when I walked in the door, it was like the weight of the world and I thought, 'What am I going to do with him now?' Well, these fears faded.

So it was a change. When Ken would come home, I would practically meet him at the door with my coat and purse cause I wanted to get out of there. I couldn't stand it, you know. And that's still the case sometimes. But the joys outweigh the desire to go back to work."

For Sally and the other pro-life activists her age, the move from wage labor to motherhood occurred in the late 1970s or more recently. Feminism was identified, more often than not, with its distorted reconstruction in the popular media. Women like Sally, who have decided to leave the work force for a "reproductive phase" of their life cycle, are keenly aware that the choices they have made are at odds with the images they see in the popular media of young, single, upwardly mobile corporate women. Sally's colleague, Roberta makes the case succinctly.

"They paint the job world as so glamorous, as if women are all in executive positions. But really, what is the average woman doing? Mostly office work, secretarial stuff. When you watch TV, there aren't women being pictured working at grocery store check-outs."

For Roberta, her decision to leave the workplace represents a critique of what she considers to be the materialism of the dominant culture. For example, she sees in abortion a reevaluation of biological reproduction in the cost-benefit language and mores of the marketplace, and an extension of a more pervasive condition, the increasing commercialization of human relations, especially those involving dependents.

"You know, reasons given for most abortions is how much kids cost. How much work kids are, how much they can change your lifestyle, how they interrupt the timing of your goals. What is ten years out of a 70-year life span? . . . If you don't have your family, if you don't have your values, then what's money, you know?"

In this view, legal abortion represents the loss of a locus of unconditional nurturance in the social order and the steady penetration of the forces of the market. In concrete terms, the threat is constituted in the public endorsement of sexuality disengaged from

motherhood. From the right-to-life perspective, this situation serves to weaken social pressure on men to take responsibility for the reproductive consequences of intercourse. Pro-life women are fully cognizant of the fragility of traditional marriage arrangements and recognize as well the lack of other social forms that might ensure the emotional and material support of women with children or other dependents. Nonetheless, the movement's supporters continue to be stereotyped as reactionary right-wing housewives unaware of alternative possibilities. Almost all of the Fargo pro-life activists were aware of these representations and addressed them in a dialectical fashion, using them to confirm their own position. As Roberta explained,

"The image that's presented of us as having a lot of kids hanging around and that's all you do at home and you don't get anything else done, that's really untrue. In fact, when we do mailings here, my little one stands between my legs and I use her tongue as a sponge. She loves it and that's the heart of grassroots involvement. That's the bottom. That's the stuff and the substance that makes it all worth it. Kids are what it boils down to. My husband and I really prize them; they are our future and that is what we feel is the root of the whole pro-life thing."

The collective portrait that emerges from these stories, then, is much more complex than the media portrayals of right-to-life women as housewives and others passed by in the sweep of social change. It is not that they discovered an ideology that "fit" some prior sociological category (see notes 6 and 7). Their sense of identification evolves from their own changing experiences with motherhood and wage labor, and in the very process of voicing their views against abortion. In their narratives and the regular performance of their activism, they are, simultaneously, transforming themselves, projecting their vision of the culture onto their own past and future, both pragmatically and symbolically. Sally, for example, describes her former "liberated" ideas about sexuality as a repression of her true self:

"You're looking at somebody who used to think the opposite. I used to think that sex outside of marriage was fine. I think there was part of me that never fully agreed. It wasn't a complete turnaround. It was kind of like inside you know it's not right but you make yourself think it's OK."

Rather than simply defining themselves in opposition to what they understand feminist ideology and practice to be, many of the younger right-to-life women claim to have held that position and to have transcended it. For example, a popular lecture in Fargo in 1984 was entitled, "I Was A Pro-choice Feminist But Now I'm Pro-Life." Much in the same way that pro-choice women embraced feminism, right-to-life women find in *their* movement a particular symbolic frame that integrates their experiences of work, reproduction, and marriage with shifting ideas of gender and politics that they encounter around them.

In the pro-life view of the world, to subvert the fertile union of men and women, either by denying procreative sex or the differentiation of male and female character, is to destroy the bases of biological, cultural, and social reproduction. This chain of associations to reproductive, heterosexual sex is central to the organization of meaning in pro-life discourse. For most right-to-lifers, abortion is not simply the termination of an individual potential life, or even that act multiplied a million-fold. It represents an active denial of the reproductive consequences of sex and a rejection of female nurturance, and thus sets forth the possibility of women structurally becoming men. This prospect threatens the union of opposites on which the continuity of the social whole is presumed to rest. In the words of a national pro-life leader

"Abortion is of crucial importance because it negates the one irrefutable difference between men and women. It symbolically destroys the precious essence of womanliness—nurturance. . . . Pro-abortion feminists open themselves to charges of crass hypocrisy by indulging in the very same behavior for which they condemn men: the unethical use of power to usurp the rights of the less powerful."

For pro-life women, then, their work is a gesture against what they see as the final triumph of self-interest. In their image of the unborn child ripped from the womb, they have symbolized the final penetration and destruction of the last arena of women's domain thought to be exempt from the truncated relations identified with both male sexuality and commercial exchange: reproduction and motherhood. At a time when wombs can be rented and zygotes are commodities, abortion is understood by right-to-lifers as an emblematic symbol for the increasing commercialization of human dependency. Their perception of their opponents' gender identity as culturally male—sexual pleasure and individual ambition separated from procreation and nurturant social bonds—is set against their own identification of "true femininity" with the self-sacrificing traits our culture conflates with motherhood. The interpretation of gender that underpins pro-life arguments, however, is based not on a woman's possession of but in her *stance toward* her reproductive capacities. Nurturance is achieved rather than natural, as illustrated in the procreation stories in which the point of the narrative is to show that pregnancy and motherhood are accepted *despite* the ambivalent feelings they produce. In their view, a woman who endorses abortion stresses the other side of the ambivalence and thus is "like a man," regardless of the shape of her body. Conversely, pro-life men encourage and take on a nurturant stance culturally identified as female, often at the urging of their activist wives.

CONCLUSION

This paper examines how American concepts of gender are being redefined by female activists in life story narratives and collective movements. While the analysis is specific to the abortion controversy as it developed in one locale, it is part of two interrelated areas of research: the cultural and social meanings of gender, reproduction, and sexuality; and arenas of conflict in contemporary American culture.[10] The common theoretical assumption of such work (cf. Colen 1986; Harding 1981; Martin 1986; Rapp 1986; Vance 1986) is that understandings of gender and its attendant meanings in American culture are not unified but multiple, and most clearly visible in moments of social and cultural discord. Methodologically, those interested in such dialectical processes focus on contested domains in America in which the definitions and control of procreation, sexuality, family, and nurturance are in contention.

At such moments of reformulation of cultural definitions, models from other societies offer instructive (or deconstructive) counterpoints to our own arrangements. New Guinea and Australia provide notable cases in which a high valuation is placed on nurturance and reproduction, broadly defined, and the role of men as well as women in "growing up" the next generation. Writing on the Trobriand Islanders, Annette Weiner points out.

> all societies make commitments to the reproduction of their most valued resources, i.e. resources that encompass human reproduction as well as the regeneration of social, material, and cosmological phenomena. In our Western tradition, however, the cyclical process of the generation of elements is not of central concern. Even the value of biological reproduction remains a secondary order of events in terms of power and immortality achieved through male domains. Yet in other societies, reproduction, in its most inclusive form, may be a basic principle through which other major societal structures are linked [Weiner 1979].

Similarly, the abortion struggle demonstrates how reproduction, so frequently reified in American categorizations as a biological domain of activity, is always given meaning and value within a historically specific set of cultural conditions. Looked at in this way, the conflict over abortion, regardless of its particular substance, presents a paradox. The claims of opponents to each represent "the truth" about women are at odds with the fact of the controversy. The very existence

of the contest that they have created draws attention to reproduction as an "open" signifier in contemporary America. Yet, both pro-life and pro-choice women are trying, in their activism and procreation stories, to "naturalize" their proposed solutions to the problems created by the differential consequences of biological reproduction for men and women in American culture.

Activists, as narrators of their life stories, create symbolic continuity between discontinuous transitions in the female life cycle, particularly between motherhood and wage work, that, for larger reasons, are particularly problematic for specific cohorts in ways that mark them as "generations." In the procreation stories, abortion not only provides a framework for organizing "disorderly" life transitions and extending a newly articulated sense of self in both space and time, it also provides narrators a means of symbolically controlling their opposition. The narratives show how these activists require the "other" in order to exist. This is what gives these stories their dialectical quality; in them the two sides are, by definition, in dialogue with each other, and thus must address the position of their opposition in constituting their own identities.

The signification attached to abortion provides each position with opposed but interrelated paradigms which reconstitute and claim a possible vision of being female. Reformulated to mesh with different historical and biographical experiences, the authority of nurturance remains prominent in both positions. As historian Linda Gordon points out

> contemporary feminism, like feminism a century ago, contains an ambivalence between individualism and its critique. [Right-to-lifers] fear a completely individualized society with all services based on cash nexus relationships, without the influence of nurturing women counteracting the completely egoistic principles of the economy, and without any forms in which children can learn about lasting human commitments to other people. Many feminists have the same fear [1982:50–51].

Grassroots pro-life and pro-choice women alike envision their work as a full-scale social crusade to enhance rather than diminish women's position in American culture. While their solutions differ, both sides share a critique of a society that increasingly stresses materialism and self-enhancement while denying the value of dependents and those who care for them. These conditions are faced by all parties to the debate. Nonetheless, the abortion issue persists as a contested domain in which the struggle over the place and meaning of work, reproduction, and nurturance, and their relationship to the category female, are being reorganized in oppositional terms. By casting two possible interpretations of this situation in opposition, the abortion debate masks their common roots in, and circumvents effective resistance to, problematic conditions engendered by a central contradiction for women living in a system in which motherhood and wage labor are continually placed in conflict.

The procreation stories told by women on each side—spun from the uneven threads of women's daily experience and woven into life stories—give compelling shape to the reproductive experiences of different generations, which stress one side of the contradiction. It is not surprising that the abortion contest arouses such passion. Its effects, played out on women's bodies and lives in particular, are the evidence and substance on which activists draw. Their verbal and political performances are created to fix with irreversible meaning events in the female life course that are inherently contingent, variable, and liminal. Yet, the narrative and political actions of activists are intended to close off other possible interpretations, as each side claims to speak the truth regarding contemporary as well as past and future generations of American women.

NOTES

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1. There is considerable argument in the debate over abortion regarding the proper name for each position. Those advocating abortion rights prefer to call their opposition "anti-choice" while those opposed to legal abortion refer to their opponents as "pro-abortion." Following Malinowski's axiom that the anthropologist's task is, in part, to represent the world from the native's point of view, I have used the appellation each group chooses for itself.
2. For a description and analysis of the "social drama" that took place over the clinic opening, see Faye Ginsburg (1984), "The Body Politic: The Defense of Sexual Restriction by Anti-Abortion Activists," in *Pleasure and Danger*, C. Vance, ed.; and Part III of *Reconstructing Gender in America: Self-Definition and Social Action Among Abortion Activists* (1986).
3. I carried out research in Fargo during 1981–82, as a producer for WCCD-TV Minneapolis, for a documentary on the clinic conflict, "Prairie Storm," broadcast in 1982. I am grateful to Joan Arnow, the George Gund Foundation, Michael Meyer, and the Money for Women Fund for their financial assistance; and to Jan Olsen, Greg Pratt, and Mike Sullivan with whom I worked on that project. I returned for another eight months of participant observation fieldwork in 1983.
4. In a 1984 review article on life histories in the *Annual Review of Sociology*, Daniel Bertaux and Martin Kohli use the term "life story" to distinguish such oral autobiographical fragments from more comprehensive, fully developed narrative texts that would more properly be called life histories, such as Vincent Crapanzano's *Tuhami* (Chicago: University of Chicago Press, 1980); Sidney Mintz's *Worker in the Cane* (New York: Norton, 1974); or Marjorie Shostak's *Nisa* (New York: Vintage, 1983). See Daniel Bertaux and Martin Kohli, "The Life Story Approach: A Continental View." *Annual Review of Sociology* 10:215–237, 1984.
5. In order to better understand the connections activists made between their sense of personal identity and the engagement in a social movement, I asked them to work with me in creating "life stories." People were already well known to me. I interviewed them (using a tape recorder) for four to five hours, sometimes twice, at a location of their choice where we knew we would not be interrupted. Simply put, I asked people to tell me how they saw their lives in relation to their current activism on the abortion issue. I explained that my interests were to understand why women were so divided on the abortion issue, and to provide a more accurate portrayal of grassroots abortion activists since they tend to be overlooked or misrepresented in both popular and scholarly discussions of the issue. In general, the activists shared these concerns. I chose subjects who had taken during 1981–83, the period of my fieldwork, the most prominent roles in local activity and who reflected, in my estimation, the range of diversity encompassed in the active memberships of each group in terms of age, socioeconomic status, religious affiliation, household and marriage arrangements, style of activism, and the like. While most of these people continue to be active, each side continues to undergo rapid permutations both locally and nationally. Most of my interviews were with women since the membership of both groups is primarily female, as is the case throughout the country. The men I worked with were either husbands of activists or pro-life clergy. Altogether, I collected 21 life stories from right-to-life activists and 14 life stories from pro-choice activists. In the presentation of the data in the thesis I have changed names and obvious identifying features as I agreed to do at the time of the interview.
6. As Rayna Rapp notes in her essay "Family and Class in Contemporary America" (1982),

> If ever a concept carried a heavy weight of ideology, it is the concept of class in American social science. We have a huge and muddled literature that attempts to reconcile objective and subjective criteria, to sort people into lowers, uppers, and middles, to argue about the relation of consciousness to material reality. . . . "Social class" is a short-hand for a process, not a thing . . . by which different social relations to the means of production are inherited and reproduced under capitalism. . . . there are shifting frontiers which separate poverty, stable wage-earning, affluent salaries, and inherited wealth [170–171].

Recognizing this, as well as the complicated questions raised by the sticky question of the relationship of "class" to women's unpaid domestic labor, I use Rapp's definitions for middle-class families and households.

> Households among the middle class are obviously based on a stable resource base that allows for some amount of luxury and discretionary spending . . . Middle-class households probably are able to rely on commodity forms rather than kinship processes to ease both economic and geographic transitions.
>
> The families that organize such households are commonly thought to be characterized by egalitarian marriages [p. 181].

(For egalitarian marriages, see Schneider and Smith 1973.) This definition is consistent with those used in the studies I cite (see note 7) as evidence for the middle-class basis for the abortion movement as a whole. It offers a good general description of the households and families of activists I worked with in Fargo. I do not mean to dismiss class but rather want to underscore the point that the opposing positions on abortion are not isomorphic with distinctive groups of people situated differently in the social relations of production. I use the life histories in particular to show how much more complicated the process is, and the multiple settings from which identity is drawn.

7. See, for example, Daniel Granberg 1981; Harding 1981; and Tatalovich and Daynes 1981: 116–137. Granberg's random sample survey of members of the National Abortion Rights Action League (NARAL) and National Right to Life Committee (NRLC), which is the most thorough of all research to date, gives a breakdown of selected demographic and social status characteristics (see Granberg 1981, Table 1, p. 158).
8. In an article on new anthropological views of the family, authors Collier, Rosaldo, and Yanagisako write:

> One of the central notions in the modern American construct of The Family is that of nurturance . . . a relationship that entails affection and love, that is based on cooperation as opposed to competition, that is enduring rather than temporary, that is noncontingent rather than contingent upon performance, and that is governed by feeling and morality instead of law and contract. . . . a symbolic opposition to the market relations of capitalism [1982:34].

9. In assessing the way that abortion opponents view the world in relation to their ideology, authors Callahan and Callahan write:

> Both sides are prepared to argue that abortion is undesirable, a crude solution to problems that would better be solved by other means. The crucial difference, however is that those on the pro-choice side believe that the world must be acknowledged as it is and not just as it ought to be.
>
> By contrast, the pro-life group believes that a better future cannot be achieved . . . unless we are prepared to make present sacrifices toward future goals and unless aggression toward the fetus is denied, however high the individual cost of denying it. The dichotomies are experienced in our ordinary language when "idealists" are contrasted with "realists." [1984:221].

10. Several sessions at professional anthropology meetings in 1986 were indicative of this trend. A panel organized by the author and Linda Girdner entitled "Contested Domains of Reproduction, Sexuality, Family and Gender in America" was held at the American Ethnological Society meetings in April. At the December meetings of the American Anthropological Association, a session entitled "Speaking Women: Representations of Contemporary American Femininity" was organized by Joyce Canaan; at the same event, Susan Harding organized a panel on "Ethnographic America." Specific research presented at these sessions included Rayna Rapp's study of amniocentesis, Carole Vance's investigation of the pornography debates, Susan Harding's research on the Moral Majority, Shellee Colen's work on domestic childcare workers, Emily Martin's study of conflicting metaphors for birth and the female body, Joyce Canaan's work on adolescent sexuality in America, Linda Girdner's

study of contested child custody disputes, and Judy Modell's research on adoption.

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The Movement Against Clitoridectomy and Infibulation in Sudan: Public Health Policy and the Women's Movement

Ellen Gruenbaum

Sudan is one of the countries where the most severe form of female circumcision persists and is practiced widely among both Muslims and Coptic Christians, in both urban and rural communities. Only the largely non-Muslim Southern Region is free of the practice, except among people of northern origin.

The most common form of the operation is referred to as pharaonic circumcision, consisting of the removal of all external genitalia—the clitoris, the clitoral prepuce, the labia minora and all or part of the labia majora—and infibulation (stitching together of the opening), so as to occlude the vaginal opening and urethra. Only a tiny opening is left for the passage of urine and menses. A modified version, Sunna circumcision, is less common, and consists of excision of the prepuce of the clitoris, generally also with partial or total excision of the clitoris itself (clitoridectomy), but without infibulation.

The operations customarily are performed by traditional or government-trained midwives on girls in the 5–7 year age range; the girls, however, may be older or younger, since it is common to circumcise two or three sisters at the same time. These occasions are ones of celebration, with new dresses, bracelets, and gifts for the girls. An animal may be slaughtered and a special meal prepared for the many guests and well-wishers who are expected to drop in. In wealthy families, musical entertainment is often arranged for an evening party. The girls themselves, though they may be fearful of the operation, look forward to the first occasion at which they will be treated as important people.

The origin of the practice is unknown, though its existence in the ancient civilizations of the Nile Valley in Egypt and Sudan has been documented. The practice survived the spread of Christianity to the ruling groups of the Nile Valley kingdoms in Sudan in the 6th century. Waves of Arab migration, intermarriage with the indigenous people, and the influence of Islamic teachers resulted in Islam's becoming the dominant religion of northern Sudan by about 1500. Pharaonic circumcision, along with other non-Islamic beliefs such as veneration of ancestors or saints and spirit possession cults, was successfully incorporated into the Sudanese Islamic belief system. The practice is deeply embedded in Sudanese cultures; and it should be recognized that the symbolic significance and cultural concomitants of female circumcision undoubtedly play important roles in individual repetition of the custom, as the work of Janice Boddy (1979) has shown.

Still, to say that it is a "custom" is not a sufficient explanation for the persistence of this damaging practice. Numerous physically harmful effects have been documented in the medical literature (Verzin 1975, Cook 1976, Shandall 1967). At the time of circumcision, girls may suffer from hemorrhage, infections, septicemia, retention of urine, or shock; deaths may result from these complications. The infibulated state may also result in retention of menses or difficulties in urination (due to scar tissue), and may be related to an apparently high prevalence of urinary tract and

other chronic pelvic infections (Boddy 1979, Toubia 1981). At first intercourse, infibulation presents a barrier which is painfully torn unless cut open by husband, midwife, or doctor. Childbirth is complicated by the inelastic scar tissue of infibulation, which must be cut open by the birth attendant and restitched after delivery. Vasicovaginal fistulae, which can result from such obstructed labor, are by no means rare in Sudan. Such a fistula—a passage between the urinary bladder and the vagina created by damage to tissue between the two organs—results in a most embarrassing condition for the woman, who cannot retain her urine and therefore leaks constantly (Toubia 1981).

Why, then, in light of these physically harmful, even life-threatening, consequences, do women continue to perform these operations on their daughters? Much of the literature has gone no further than the observation that it is "customary," or as one Sudanese writer has put it, "the implicit and explicit message being that it is something we inherited from an untraceable past which has no rational meaning and lies within the realm of untouchable sensitivity of traditional people" (Toubia 1981:4).

Social scientists and feminists writing on the subject have pointed out that female circumcision forms part of a complex sociocultural arrangement of female subjugation in a strongly patrilineal, patriarchal society (*cf.*, Assaad 1980, Hayes 1975, El Saadawi 1980). The fact that it is women who carry out the practice, and who are its strongest defenders, must be analyzed in terms of their weaker social position.

Women in Sudan generally must derive their social status and economic security from their roles as wives and mothers. Among most cultural groups in northern Sudan, female virginity at marriage is considered so important that even rumors questioning a girl's morality may be enough to besmirch the family honor and to bar her from the possibility of marriage. In this context, clitoridectomy and infibulation serve as a guarantee of morality. Sudanese women hold that clitoridectomy helps to attenuate a girl's sexual desire so that she is less likely to seek premarital sex; infibulation presents a barrier to penetration. Any girl known to have been "properly" circumcised in the pharaonic manner can be assumed to be a virgin and therefore marriageable, while doubts can be raised about those who are not circumcised or have had only the modified Sunna circumcision.

Attempts to formulate policies against the practice have seldom recognized the significance of the linkage between the operations and the social goal of maintaining the reputations and marriageability of daughters in a strongly patriarchal society. In addition, the economic and social status of midwives, the group chiefly responsible for performing the operations, has seldom been seriously considered. Instead, government policies have tended to emphasize simple legal prohibitions; propaganda against the apparent ideological supports of the practice; spreading information on some of the physically harmful aspects of female circumcision; and tacit acceptance of a compromise policy of modification and "modernization" of the practice.

Some policies resulting from these emphases are undoubtedly useful. Certainly the recommendations of the 1979 Khartoum Conference (Seminar on Traditional Practices Affecting the Health of Women, sponsored by the Eastern Mediterranean Regional Office of the World Health Organization) are to be commended and supported. These recommendations included a call for clear national policies for the abolition of the practice in the countries where it persists; the passage of legislation in support of such policies; the intensification of general education on the dangers and undesirability of the practice; and intensification of educational programs for birth attendants and other practitioners to enlist their support. Because there is such strong social motivation for continuing the practice in Sudan, however, I would argue that the proposed public health education approach would have only a weak or slow effect. Policy on female circumcision requires rethinking.

In the following sections, I draw upon my experience in Sudan, where I carried out research on rural health services and lectured at the University of Khartoum. My goal here is twofold: to consider the reasons for failure of past anticircumcision policies, and to provide a critique of current policy efforts. In addition, I hope to provide insights into what is necessary for the development of viable policies.

ABOLITION EFFORTS IN SUDAN

The first efforts to eliminate the practice of clitoridectomy and infibulation in Sudan came during the British colonial period (1898–1956). When a British midwife was brought in to organize a midwifery training school in 1920, efforts were made to dissuade the traditional midwives enrolled in the training program from continuing the practice. But persuasion and example apparently had little effect.

In 1946, an edict was promulgated prohibiting pharaonic circumcision. This attempt to impose the colonialists' values on the culture of a subject people by force of law also failed completely, and was even met with violent resistance. Residents of the town of Rufa'a still talk about "our Revolution"—the day in 1946 when they tore the government prison to the ground to free a midwife who had been arrested for circumcising a girl. Government troops fired on the crowd, and injured some; yet even this failed to stem popular resistance to the British and to their attempts to outlaw the entrenched custom.

Resistance to the government ban did not require rebellion. Since the activity took place outside the purview of the foreign government, the practice simply continued as before. In fact, historically, the government seldom attempted the sort of enforcement that led to the Rufa'a "Revolution."

Another approach used by the British against the practice was propaganda. In 1945, the Sudan Medical Service issued and circulated a pamphlet, written in both English and Arabic, that condemned pharaonic circumcision and urged the Sudanese to abandon the practice. It was signed by the highest ranking British and Sudanese doctors, and was endorsed by Sudanese religious leaders. The Mufti of Sudan provided an authoritative Islamic legal opinion stating that female circumcision was not obligatory under Islam; and another endorsing religious leader advocated the substitution of Sunna circumcision (clitoridectomy). Thus, while the backing of the religious leaders was something less than total opposition to female circumcision, their opposition to the pharaonic form is important. (Few Sudanese queried in villages where I worked, however, were aware that the religious leaders had ever spoken against female circumcision.)

During this same period, the mid-1940s, several educated Sudanese women—teachers and midwives—undertook speaking tours in the provinces to publicize the bad effects of pharaonic circumcision. An Arabic poster used during the campaign declared that the Sunna circumcision came from the Prophet Mohammed, and should therefore replace the pharaonic form, ascribed to "Pharaoh the enemy of God" (Hall and Ismail 1981:93–95).

Today, after three decades of illegality, pharaonic circumcision of girls continues to be widely performed in both rural and urban areas. It is openly celebrated, with feasting and gift-giving. Midwives speak freely of their participation in the perpetuation of the practice. To my knowledge there have been no government efforts in recent years to enforce the legal prohibition.

There has, however, been some change in the methods used in performing the operations, although this has not been uniform. The dangerously unhygienic traditional methods, such as performing the operation over a hole in the ground, using knives for cutting, thorns and leg binding for infibulation, and plain water for cleansing, have been supplanted by the availability of better equipment and knowledge of more hygienic methods. The government-trained village midwife whose practice I observed did the operations on a wood and rope bed covered with a plastic sheet. She used xylocaine injections for local anesthesia, new razor blades, suture needles, dissolving sutures when available, and prophylactic antibiotic powder. Her equipment

was sterilized with boiling water before use. After this initial use, however, she returned the instruments to the same bowl of previously boiled water, and did not resterilize them before using them in a second girl's operation. The midwife purchases most of the necessary supplies and medications out of her earnings; some of the basic equipment necessary for childbirth attendance is provided by the government, however, and some supplies are obtained informally through the local government health center.

CURRENT POLICY EFFORTS

In more recent years, opponents—ordinarily resorting to medical and psychological arguments against pharaonic circumcision—have recognized that complete eradication of the practice is an unrealistic short-term objective. While continuing to advocate eventual eradication, policymakers have tended to attempt to mitigate the effects by substituting the less drastic Sunna form of circumcision. This opinion, held unofficially by the government health service's leaders and many medical doctors with whom I spoke in the late 1970s, has meant that many doctors are willing to perform such operations themselves. They assume that, in terms of medical safety, it is better for them to perform clitoridectomies in their offices.[1]

As policy positions, both the eradication goal and the "modification" compromise are problematic. The view that the practice should or could be "eradicated," as if it were a disease, is a particularly medical view. While it is reasonable that arguments against circumcision stress physical risks, the problem nevertheless is one that is not necessarily amenable to medical solutions. The medical view implies not only that the practice is "pathological," but that its solution might lie in some sort of campaign-style attack on the problem. Social customs, however, are not "pathologies"; and such a view is a poor starting point for change, since it is not one necessarily shared by the people whose customs are under attack. While these people may be open to the view that a practice such as this may be harmful in some ways, to approach it as an evil or pathological situation is to insult those who believe strongly in it and consider it a means of promoting cleanliness and purity, and is unlikely to foster consideration of change. Furthermore, the decades of emphasis on medical reasons for discontinuing the practice have not in fact resulted in its abandonment. For example, in a study of medical records of 2526 women in Khartoum and Wad Medani, Mudawi (1977a) found only seven to be uncircumcised; 12 had been clitoridectomised only, and the remainder had been infibulated.[2] A questionnaire sample survey of about 10,000 women in Sudan found that 82% were infibulated (El Dareer 1979).

Another problem with the strategy of promoting a modified form of circumcision as a transitional program relates to the unfortunate ideological linkage of the modified type. Among Sudanese who practice pharaonic circumcision, it is widely believed that the practice is commanded by Islam. While this interpretation is disavowed by many Islamic scholars, the belief that both male and female circumcision were commanded by the Prophet Mohammed persists.[3] This widespread belief serves as strong ideological support for a practice known to predate Islam (Diaz and Mudawi 1977) and which is perpetuated largely because of its important social functions.

The use of the term "Sunna circumcision" for the less drastic operation, which many reformers are encouraging as the most feasible short-term alternative, has unfortunately reinforced the ideological linkage with Islam. To describe a practice as "Sunna" is to consider it religious law.[4] Since Sudanese Muslims are adherents of the Sunni branch of Islam (i.e., "those who follow the Sunna"), they do not want to say their practice is incongruent with Sunni tradition. The linguistic root of the words Sunni and Sunna is the same, and although "Sunna circumcision" does not literally imply linkage to Sunni Islam, they are commonly associated. Indeed, the ideological linkage between the term

"Sunna circumcision" and the religion has been reinforced even by an eminent Sudanese gynecologist, Dr. Suliman Mudawi, who writes that, "The Sunna circumcision, or clitoridectomy, is the legal operation recommended by Islam, consisting of the excision of the glans clitoris and sometimes a small portion of the clitoris itself" (Mudawi 1977b).

Thus, now that the term "Sunna circumcision" is widely known, many people profess to practice it—since they wish to be regarded as faithful Sunnites—even when the operation is performed as before with infibulation after removal of clitoris and labia. Reform efforts advocating a modified operation, therefore, may have resulted in a change in nomenclature, rather than widespread change in the operations. Thus, reports that pharaonic circumcision with infibulation is gradually being abandoned in Sudan, which are based on questionnaire interviews or anecdotal material (e.g., Clark and Diaz 1977, Cook 1976), may be misleading, since some of those who say they have adopted the Sunna form simply may have begun calling pharaonic circumcision by another name.

In spite of the importance of ideological supports, it would not be sufficient to attack the presumed religious reasons. Change efforts must take into consideration the socioeconomic relations in which Sudanese women are enmeshed, and the social dilemmas to which families that try to change the practice would be exposed. After all, where a most significant aspect of marriage is control of female reproductive capacity, and where circumcision has come to be the mechanism for guaranteeing the perfect condition of that capacity, to dispense with circumcision is to violate a basic condition of an essential social relation. Thus, a religious scholar's testimony that female circumcision is not necessary for religious reasons would not be sufficient for a mother to risk her daughter's marriageability. Similarly, awareness of medical and psychological[5] hazards may be only weakly deterrent; a daughter's marriageability would scarcely be risked because of a psychological notion that she may suffer bad dreams or never experience orgasm. Marriage and children are more vital, closer to the meaning of life and to a woman's economic survival, than transitory emotional feelings.

While most women are economically active, either in subsistence production, wage employment, trade, or production of commodities, economic well-being—indeed, survival in many of the harsher rural areas—requires large family production units. A husband and children are necessary to a woman's economic security; not only do children contribute their labor at an early age to the family's economic production—especially in rural areas—but also they are security for old age. Commonly, women are to some degree dependent on their husbands for access to land or domestic animals, their labors, and/or their wages. A husband dissatisfied with his wife—either personally or because of reproductive inadequacy—is considered more likely to take a second wife. Although polygyny frequently enhances the prestige and wealth of the husband, it commonly weakens the individual woman's economic position and, if the other wife or wives bear children, lessens her own children's inheritance. Under Islamic law,[6] a divorced woman has no right to child custody after the age of seven for boys and the age of nine for girls, regardless of the reasons for divorce or on whose initiative the marriage was ended. Men have the right to unilateral divorce, but women do not. With these constraints it is not surprising that most women put considerable effort into pleasing their husbands and protecting their reputations, so as to safeguard their marriages.

Efforts to please husbands and safeguard virtue take many forms. Beautification methods, while pleasurable for a woman herself and usually done in pleasant camaraderie with other women, are primarily directed toward husbands, with the most sensuous techniques being reserved for married women. Even poor rural women spend considerable time and effort on the arts of decorative henna staining of hands and feet, removal of body hair, sauna-like incensing of the body, careful selection of clothing and ornaments, and decorative hair plaiting. They also pre-

pare special scented substances for massaging their husbands.

Beyond these, the enhancement of a woman's ability to please her husband is considered to be most importantly achieved by clitoridectomy and infibulation. One midwife I spoke with claimed that clitoridectomy allowed for longer intercourse, pleasing to the man. This belief presupposes that a woman experiencing more sexual stimulation would be less patient, and can hardly be credited as a major factor in perpetuating clitoridectomy. On the other hand, the attenuation of *inappropriate* sexual desire, before marriage and extramaritally, should be considered one of the major goals of the practice.

It is infibulation, and especially reinfibulation, that is alleged to contribute most significantly to the sexual pleasure of men. Following childbirth, the midwife restitches the long incision made for the delivery of the baby. A tighter reinfibulation is expected to result in greater pleasure for the husband when intercourse is resumed following the customary 40-day postpartum recovery period. One reinfibulation I witnessed, performed by a government-trained midwife following a woman's thirteenth childbirth, left a completely smooth vulva, the urethral opening completely concealed, and only a pin-sized opening to the vagina. A number of women told me that such tight reinfibulation gives husbands greater sexual pleasure, the tightness lasting approximately three months after resumption of sexual intercourse. They claimed that husbands were more generous in their gifts (clothes, jewelry, perfumes) when the reinfibulation is very tight. It was clear, too, that such marital sexual satisfaction is considered important in avoiding the possibility of the husband exercising his legally guaranteed rights to unilateral divorce or polygynous marriage.

The attitudes of women toward the practice of clitoridectomy and infibulation are often contradictory. Occasionally, I encountered Sudanese women who were surprised to learn that American and European women are not circumcised. Others realized that Europeans did not circumcise women, but believed that all Muslims did. Although they found it hard to believe that Saudi Arabian women are not circumcised, such information did nothing to undermine their faith in the importance of the practice. To my comment that American women are left "natural," they replied, "But circumcision *is* natural for us."

There was, however, recurrent ambivalence expressed in many of the conversations I had on this topic. Without questioning the necessity of circumcision, a woman might sigh and say, "Isn't it difficult?" When discussing repeated reinfibulation with one small group of urban women (which included a new mother who had just been reinfibulated a few days before), I was urged, "Be sure and put all this in your report, about how difficult it is for us."

DEVELOPING VIABLE POLICY ALTERNATIVES

That women perpetuate practices painful and dangerous to themselves and their daughters and that inhibit their own sexual gratification must be understood in the context of their social and economic vulnerability in a strongly patriarchal society. Public health policymakers must allow for the fact that the circumcision of girls is a deeply rooted social custom. Even among urban-dwelling, educated families, there are those who would take their daughters back to the relatives in a rural village for circumcision, to ensure a traditional, thorough operation.

Although harmful sequelae have brought female circumcision to the attention of medical professionals, it is argued here that medical opinion can have little relevance in changing the situation. While more research into the psychological and medical hazards of circumcision could be useful for convincing influential educated people to back efforts toward change, the medical model and the efforts of the medical services system are limited in terms of policy development. Effective change can only come in the context of a women's movement oriented toward the basic social problems affecting women, particularly

their economic dependency, educational disadvantages, and obstacles to employment (e.g., the dearth of child day-care facilities for urban workers). To improve women's social and economic security, marital customs must be challenged, and new civil laws are needed to offer additional protection to married and divorced women concerning child custody, rights in marital property, and financial support, going beyond the present provisions of Islamic and customary law. Further, general health conditions are very poor and must be improved. With an infant mortality rate conservatively estimated at 140 per 1000 (Sudan, Ministry of Health, 1975:6), and with a high prevalence of numerous disabling and life-threatening illnesses, especially dangerous to children, it is not surprising that Sudanese women—particularly in rural areas—seek to give birth to large numbers of children. The crude birth rate is approximately 49 per 1000 (Sudan, Ministry of Health 1975:5). Thus, basic health issues are important concerns of women.

The implications of reducing women's dependency through improvement of their economic opportunities are far-reaching. Any policy that would threaten the form or importance of the family and its functions would obviously excite widespread reaction. At the same time, Sudan's current laws and social values already offer some advantages to women in promising productive roles. Educated women are expected to hold full-time jobs and to have the right to the same pay and benefits as men in comparable jobs, although there are social barriers to women's participation in certain occupations. While many struggles remain to be fought on this front, the fact that wide networks of people benefit from each person employed in a stable job means that families generally back the educated woman who wants to work. Frequently, child care can be provided by relatives during working hours, and there is a general acceptance of the principle of equal pay for equal work. In addition, the government (the largest employer of the educated) gives eight weeks' paid maternity leave, often additional unpaid leave with position held, and makes special allowances for the needs of nursing mothers.

While these offer a good basis for developing women's position, many problems prevent women from taking full advantage of the opportunities that do exist. Working women complain (or, more often, do not complain, but simply carry on) that they must still perform all the usual housework after coming home, and are still expected to make time for all the traditional visiting and hospitality. Women college students find their neighbors and relatives consider them snobbish if they do not take the time for such visiting, regardless of the demands of their studies. This is especially hard on women medical students who must keep odd hours, and often spend the night at the hospital during their clinical training.

The family continues to be an extremely important factor, however, in the lives of even the most advantaged, educated, employed women. Since childbearing is expected to begin immediately after marriage, the employed woman most commonly depends on her mother or another female relative to provide child care. Family members become dependent on her income, and she may find herself locked into the necessity of working even when other social obligations make it difficult. Should her marriage falter and her husband divorce her, she may not only lose his support but custody of her children as well. Clearly, additional social services would help overcome these problems. For example, while government-sponsored child care centers presently exist in some towns, many women workers find them unavailable or too costly. Some form of social security benefits could reduce women's vulnerability to divorce and loss of support and child custody. But state subsidy of such services outside the family currently is neither a feasible nor a desired alternative in Sudan, where government policy favors investment in economic development over expansion of social service expenditures.

A full discussion of development strategies and their implications for women's position in the society would be outside the scope of

this paper. It is important to realize, however, that while women share in the desire for economic development in their poor country, just as they desire increased incomes for their families and themselves, current development policies offer little to women. Sudan's development has been of the peripheral capitalist pattern of uneven development (O'Brien 1980). Investment has gravitated toward the center of the country in the most highly productive centers of primary products for export or import substitution. All too frequently, foreign investments have been self-serving, emphasizing high technology that the developed countries want to sell, or the production of products that the investors want to import. The high technology emphasis, which appeals to scheme managers and government officials seeking to "modernize," results in jobs for men rather than women, and sometimes even undercuts existing productive roles of women (see Sørbø 1977).

Sudanese and other Middle Eastern women have demonstrated their interest in changing their lot by the formation of women's organizations such as the Sudanese Women's Union. The Union has a history of militant action, as when Sudanese women took to the streets in the popular uprising that overthrew the military regime in 1964. While the issues such women's groups have chosen to address have long included modifying or abolishing circumcision, they have addressed themselves more urgently to other problems. In the 1950s and 1960s for example, the women's organization in Sudan was concerned with nationalist issues: the achievement of national independence, avoidance of control by U.S. imperialist interests, and the development of democratic government. In the early 1970s, the women's union was restructured under the ruling party (under Nimeiri's government, which came to power in a coup d'etat in 1969), and most of the communist and other politically radical women were purged or barred from leadership. Since then, the thrust of the organization has also changed somewhat. In the urban and "modern" sector rural areas (such as the Gezira Irrigation Scheme), the primary activities of the Union as they touch the lives of the ordinary women center on cultural and educational activities—embroidery classes, crafts shows, and the like and support for the ruling party; eradication of circumcision has not been a high priority.

The majority of women in the country, who live outside the towns and agricultural schemes or in the poor neighborhoods and rural villages in those areas, have not by and large been recruited into such organizations. Yet these women, too, have a number of very basic concerns: improved incomes, education for their children, clean water, and basic health services. Organizing these rural women, however, has proven difficult. In a prosperous village in the Gezira Irrigated Scheme, for example, the membership of the local branch of the Women's Union has not met in two years. One divorced woman, a Union member, tried to organize women in that village to take an active part in improving village sanitation. She was unable to mobilize support, however, even though a fully staffed health center (which should share responsibility for public health) is located in the village. Further, though this woman is part of the mandated one-third female membership of the village People's Council, she and the other women members are not ordinarily informed of meetings. Her participation as an individual in development is also blocked. Although she is literate, she is not highly enough educated to qualify for a white-collar job; and her brother has opposed her working in agriculture, a position that would threaten the prestige of the family.

This is not to say that women's organizations and programs are everywhere ineffective. In fact there is much enthusiasm in Gezira villages for the literacy campaigns and home economics courses offered by the Gezira Scheme's Social Development Department. But if the woman just mentioned must face such obstacles even in a relatively well off village that has resources to devote to local projects, the problems of the more remote and poorer villages, where literacy campaigns

and women's organizations have not penetrated at all, are far greater.

Since, as history demonstrates, circumcisions can continue with or without governmental sanction, it is impossible to conceive of any efforts to change the custom having an effect unless they are supported by women themselves. These changes will come only as the result of many other societal changes, especially those that enable women to be less economically dependent on men and thus less oriented toward pleasing husbands.

POLICY CONTRIBUTIONS

To assert that changes in female circumcision must come from the women themselves and their social movement is not to say that policymakers have nothing to contribute. Indeed, there are several key areas where public policy and specifically health policy could contribute significantly.

First, further research is appropriate. Much of the writing thus far has been based on case studies, anecdotal material, or haphazard sampling (e.g., Assaad 1980, Hayes 1975). It would be useful to relate the place of circumcision and its celebration to the social position of women in societies where the practice is common. Studies should focus particularly on the significance of marriage, the importance of virginity and its relation to the maintenance of family "honor" (e.g., segregation of sexes, chaperoning, infibulation, manner of dress), and the economic participation of women and form of economic organization (especially whether the organization of production continues to emphasize family production units). Whether more clinical medical articles, describing the operations and their sequelae, would add anything to arguments against the practice is uncertain, although more information on the treatment of complications could be useful. Epidemiological studies of the apparently high rates of urinary and vaginal infections associated with circumcision also would be in order. Although I am aware of no data on a relationship between the operations and infertility or low fertility, such a relationship has nevertheless been suggested (*cf.*, Hosken 1980; Hayes 1975); Hayes (1975), in fact, considered lowered fertility a "latent function" of female circumcision. Certainly infertility might be expected in cases of obstructed intercourse (Sudan Medical Service 1945), and in association with the medical complications of circumcision. The existence of a demonstrable relationship between circumcision and infertility could provide a powerful argument against the operations in countries such as Sudan with strong pronatalist values.

Second, policies that promote the opportunities of women in education and employment could be beneficial in two ways. First, reducing women's dependence on marriage and motherhood as the only economically viable social roles could separate circumcision from basic economic survival and thus weaken support for it. Second, education and employment could be expected to enhance women's ability to act as a group by enabling them to become more involved in shaping their own destiny through access to political and economic power and greater opportunities for organizing themselves. Women then would be better able to influence and implement policies according to their own priorities. The realization of such opportunities may require not only that additional social security and other support services be provided but, in addition, that economic development policies be challenged. The high technology strategies which have so often resulted in skilled jobs for men while undermining women's traditional productive roles and ignoring the possibility of their involvement in new areas, may need to be revised.

The Role of Midwives

A particularly important locus of policy concerns should be the role of midwives, since they are the principal practitioners of circumcision. It is not enough to recommend that they be educated as to its harmful effects; it must also be recognized that fees, together

with gifts such as soap, perfume, meat from the celebration slaughter and other foods, constitute important elements of a midwife's income. Government-trained midwives, if they are paid at all, receive only a very small monthly retainer fee from the local government. This is not paid in all areas and is too small to be considered even a meager salary. Untrained, traditional midwives receive no benefits from the government at all; even basic equipment for childbirth attendance is supplied only to the trained midwives, and both groups must purchase their own drugs and supplies, unless acquired informally through local health services facilities of the government. The fee-for-service payment system means that the midwife's income is directly dependent on the number of births attended and circumcision performed.

The current drive for the development of Primary Health Care for the achievement of WHO's goal of "Health for All by the Year 2000" could very usefully seek out midwives to be Community Health Workers. The additional training would benefit their midwifery practices, and whatever status individual midwives already have achieved as respected community members concerned with health could enhance their influence as health care providers. Further, since barriers to the effective health care of women by male health care providers now prevent women from receiving needed care, more female providers would fill a real need.[7]

Providing midwives with a wider role and some other income might help them heed educational efforts against circumcision by reducing the conflicts of interest with respect to income. Difficulties inherent in the training of midwives (involving a full year's study away from family, especially hard for married women and mothers) have been overcome. The same could be expected for Community Health Workers, whose training period is shorter. Such a strategy could help to achieve primary health care goals while improving midwifery at less cost than training and supporting two separate specialized individuals. Since midwives, as women, have access to women and children even in the most traditional communities, they could be expected to be very effective in promoting maternal and child health goals.

PERSPECTIVES ON INTERNATIONAL POLICYMAKING

Such recommendations should be considered in the context of the social dynamics of an underdeveloped country. The dependency relations between a country such as Sudan and the more powerful capitalist financial centers has surely played as much a part in molding priorities in social and health policy as have religion and cultural tradition.

Social scientists who seek to design rational, sensible, and culturally sensitive public health policies, must ask themselves several questions. What would be necessary to ensure the adoption of their proposals? What are the interests of the social classes with access to the most political power in a country? What image of their country do the relevant national ministries, organizations, and occupational groups wish to portray? What sort of research or program priorities might they want to block? Which would they prefer to support?

Similarly, international organizations and the aid missions of developed countries are limited by their own hidden agendas.[8] For example, USAID projects ordinarily must be demonstrated to have some beneficial effect on U.S. trade, U.S. geopolitical strategies, or other U.S. interests; beneficial effects on the people or the economies of the developing countries are desirable, but secondary. To suppose that an aid mission might withhold support from such programs as primary health care until serious work against female circumcision is undertaken is to pretend that aid missions are moral entities instead of international political and economic tools. For aid to be accepted by the host government, its terms ordinarily must be beneficial to the interests of ruling groups or to governmental stability. Aid must not, therefore, make the nation or the government appear backward, discriminatory, or as having anything less than the best interests of the entire populace at heart.

While international bodies such as the United Nations organizations are less likely to have such strongly political agendas, and can be assumed to be genuinely oriented to abstract goals such as peace and health, they, too, suffer from an inability to be critical of host governments. Programs must be invited and collaborative, although these organizations' apparently neutral political position gives them somewhat more leeway to provide guidance without seeming offensively imperialistic.

I believe it is a mistake to insist, as some outspoken critics do, that aid missions, international organizations, and even nongovernmental and church groups take firm stands "to prevent the operations" (Hosken 1980). Such agencies and organizations would have no political interest in taking such a controversial stand except where host governments might ask them to do so as part of an indigenous movement against the practice. But even if the necessary forces could be mobilized in the developed countries to force the adoption of such a policy and such agencies and organizations *did* adopt this stance, a "backlash" phenomenon would all too likely follow. Heavy-handedness on the part of the developed countries is generally unwelcome in fiercely nationalistic underdeveloped countries such as Sudan. Thus, while its external relationships may be those of dependency and its economic system capitalist (including some state-capitalist structures and some use of "socialist" ideology), there is no loyalty to a particular power which extends beyond national interests or economic constraints. Even Saudi Arabia, with its stranglehold control of the supply of much of Sudan's energy and investment capital and its influential role in religious leadership of the Islamic countries, has thus far been able to impose only temporary or partial social programs—such as the crackdown on prostitution in Khartoum in 1976–77. The Nimeiri government, however, has stalled on such issues as the abolition of alcohol or imposition of an Islamic constitution, which might prove either widely unpopular or which might jeopardize the government's control over the largely non-Muslim south.

Policy research must be placed in this context. It is clear that the movement against clitoridectomy and infibulation must receive its primary momentum for national movements in which women themselves play a leading role. Thus, policy researchers should keep in mind that it is not appropriate merely to expose practices and make recommendations to outside organizations. Wherever possible, indigenous women and women's organizations should be involved in all stages of the research, from formulation of the problem to development of policy. Only in this way will such indigenous movements be sure to benefit from the research.

NOTES

1. In support of this point, one Sudanese doctor recently stated that before the Khartoum Conference in 1979, the medical profession's official policy "was not total abolition of female circumcision, but the promotion of clitoridectomy under more hygienic circumstances as a substitute for infibulation" (Toubia 1981).
2. It is ironic that this same author, a senior Sudanese gynecologist, has said, "Although the habit is still practised in some parts of the Sudan it is gratifying to note that it is gradually dying out." He is further quoted as saying. "The most effective line of attack was a medical one" (quoted in Toubia 1981:3).
3. The sayings attributed to the Prophet Mohammed on this subject do not, however, endorse infibulation. "Reduce but do not destroy," is often quoted by reformers. Another saying, handed down by Um Attiya, is, "Circumcise but do not go deep, this is more illuminating to the face and more enjoyable to the husband" (Sudanese Medical Service 1945, in Foreword by the Mufti of the Sudan).
4. While "Sunna" may be translated as "rule" or "tradition," the Islamic ideology asserts that Islam is not simply a religion, but a "way of life." Hence, it is not uncommon for Sudanese Muslims to assume linkages between cultural traditions and religious beliefs, and to assume that their shared beliefs and practices are

rooted in formal Islamic doctrine. In his statement against pharaonic circumcision in 1945, the Mufti of Sudan cited a religious authority who believed that "male circumcision was a Sunna and female circumcision was merely preferable" (Sudanese Medical Service 1945). This usage implies a greater obligation for that which is termed "Sunna." Therefore, to attach the term "Sunna" to female circumcision is to imply that *some* form of circumcision is expected by religious law.

5. The psychological effects of female circumcision have only recently received any systematic attention in Sudan (*see*, e.g., Baashar et al. 1979).
6. All matters concerning marriage, divorce, custody and inheritance in Sudan are governed by customary rather than civil law. A system of *shari'a* courts exists for the administration of Islamic law for cases where the individuals involved are Muslims.
7. It is interesting to note that in Sudan, where the great majority of primary health care workers at all levels are male, government statistics show males outnumbering females in 89 out of the 93 categories of treated illnesses that are not female-specific conditions (Sudan, Ministry of Health 1975a).
8. Dr. Nawal el Saadawi, an Egyptian physician and novelist who has written extensively on women in Arab societies, has criticized the "'them' helping 'us'" approach of some foreign groups: "That kind of help, which they think of as solidarity, is another type of colonialism in disguise. So we must deal with female circumcision ourselves. It is our culture, we understand it, when to fight against it and how, because this is the process of liberation" (El Saadawi 1980a).

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Female Infanticide and Child Neglect in Rural North India

Barbara D. Miller

INTRODUCTION

> Sitting in the hospital canteen for lunch every day, I can see families bringing their children into the hospital. So far, after watching for five days, I have seen only boys being carried in for treatment, no girls (author's field notes, Ludhiana Christian Medical College, November 1983).
>
> When the hospital was built, equal-sized words for boys and girls were constructed. The boys' ward is always full but the girls' ward is underutilized (comment of a hospital administrator, Ludhiana Christian Medical College, November 1983).
>
> In one village, I went into the house to examine a young girl and I found that she had an advanced case of tuberculosis. I asked the mother why she hadn't done something sooner about the girl's condition because now, at this stage, the treatment would be very expensive. The mother replied, "then let her die, I have another daughter." At the time, the two daughters sat nearby listening, one with tears streaming down her face (report by a public health physician, Ludhiana Christian Medical College, November 1983).
>
> When a third, fourth, or fifth daughter is born to a family, no matter what its economic status, we increase our home visits because that child is at high risk (statement made by a public health physician, Ludhiana Christian Medical College, November 1983).

From Nancy Scheper-Hughes (ed.), *Child Survival* (Dordrecth: D. Reidel Publishing Co., 1987), pp. 95–112. Reprinted by permission of Kluwer Academic Publishers.

These quotations, taken from field notes made during a 1983 trip to Ludhiana, the Punjab, India are indicative of the nature and degree of sex-selectivity in health care of children there. Ethnographic evidence gleaned from the work of other anthropologists corroborates that intrahousehold discrimination against girls is a fact of life in much of the northern plains region of India (Miller 1981: 83–106). The strong preference for sons compared to daughters is marked from the moment of birth. Celebration at the birth of a son, particularly a first son, has been documented repeatedly in the ethnographic literature (Lewis 1965: 49; Freed and Freed 1976: 123, 206; Jacobson 1970: 307–309; Madan 1965: 63; and Aggarwal 1971: 114). But when a daughter is born, the event goes unheralded and anthropologists have documented the unconcealed disappointment in families which already have a daughter or two (Luschinsky 1962: 82; Madan 1965: 77–78; Minturn and Hitchcock 1966: 101–102). The extreme disappointment of a mother who greatly desires a son, but bears a daughter in-

stead, could affect her ability to breastfeed successfully; "bonding" certainly would not be automatically assured between the mother and the child; and the mother's disappointed in-laws would be far less supportive than if the newborn were a son (Miller, 1986).

A thorough review of the ethnographic literature provides diverse but strongly suggestive evidence of preferential feeding of boys in North Indian villages (Miller 1981: 93–94), as well as preferential allocation of medical care to boys. Sex ratios of admissions to northern hospitals are often two or more boys to every one girl. This imbalance is not due to more frequent illness of boys, rather to sex-selective parental investment patterns.

The practice of sex-selective child care in northern India confronts us with a particularly disturbing dilemma that involves the incongruity between Western values that insist on equal life chances for all, even in the face of our universal failure to achieve that goal, versus North Indian culture which places strong value on the survival of sons rather than daughters. Public health programs in North India operate under the guidance of the national goal of "equal health care for all by the year 2000" which was declared by many developing nations at the Alma Ata conference in 1978. Yet the families with whom they are concerned operate with a different set of goals less concerned with the survival of any one individual than with the survival of the family. In rural North India the economic survival of the family, for sociocultural reasons, is dependent on the reproduction of strong sons and the control of the number of daughters who are financial burdens in many ways.

The chapter examines a variety of data and information sources on the dimensions and social context of female infanticide and daughter neglect in rural North India, an area where gender preferences regarding offspring are particularly strong. I review what is known about outright female infanticide in earlier centuries and discuss the situation in North India today, examining the empirical evidence and current theoretical approaches to the understanding of son preference and daughter disfavor. The next section considers the role of a public health program in the Punjab. In conclusion I address the issue of humanist values concerning equal life chances for all versus North Indian patriarchal values promoting better life chances for boys than girls, and the challenge to anthropological research of finding an appropriate theoretical approach to the study of children's health and survival.

INFANTICIDE: BACKGROUND

I consider infanticide to fall under the general category of child abuse and neglect which encompasses a range of behaviors. As I have written elsewhere:

> . . . it is helpful to distinguish forms of neglect from those of abuse . . . abuse is more "active" in the way it is inflicted; it is abuse when something is actually *done* to harm the child. In the case of neglect, harm comes to the child because something is *not done* which should have been. Thus, sexual molestation of a child is abusive, whereas depriving a child of adequate food and exercise is neglectful. One similarity between abuse and neglect is that both, if carried far enough, can be fatal (Miller 1981: 44–45).

Infanticide, most strictly defined, is the killing of a child under one year of age. Infanticide would be placed at one extreme of the continuum of effects of child abuse and neglect—it is fatal. At the opposite end of the continuum are forms of child abuse that result in delayed learning, slowed physical growth and development patterns, and disturbed social adjustment. Outright infanticide can be distinguished from indirect or "passive" infanticide (Harris 1977); in the former the means, such as a fatal beating, are direct and immediate, while in the latter, the means, such as sustained nutritional deprivation, are indirect.

Infanticide is further delineated with respect to the ages of the children involved. Most broadly defined, infanticide applies to the killing of children under the age of twelve months (deaths after that age would generally be classified as child *homicide,* although the definition and, hence, duration of childhood is culturally variable). *Neonaticide* usually pertains to the killing of a newborn up to twenty-four hours after birth and is sometimes given a separate analysis (Wilkey *et al.* 1982). The induced *abortion* of a fetus is sometimes categorized as a pre-natal form of infanticide that has been termed *"feticide"* in the literature.[1]

The discussion in this chapter encompasses both infanticide and child homicide, that is non-accidental deaths to minors from the time of birth up to the age of about fifteen or sixteen when they would become adults in the rural Indian context. For convenience, I will use the term infanticide to apply to the entire age range.

I have asserted (1981: 44) that where infanticide is systematically sex-selective, it will be selective against females rather than males. There are few cases of systematic male-selective infanticide in the literature that I reviewed. Some more recent work on the subject, however, has begun to reveal a variety of patterns. For example, a study conducted on several villages in a delta region of Japan using data from the Tokugawa era (1600–1868) reveals the existence of systematic infanticide which was sex-selective, but selective against males almost as frequently as females, depending on the particular household composition and dynamics (Skinner 1984).

Obviously all household strategies concerning the survival of offspring are not based solely on gender considerations, and it is doubtful that we can ever come close to a good estimation of just "how much" gender-based selective differential in the treatment of children exists, and how much of this is biased against females. Nevertheless, one part of the world where female-selective infanticide is particularly apparent is in North India, and across India's northwestern border through Pakistan . . . to the Near East, and perhaps in a diminished form also in North Africa. Looking toward the East from India, it seems that Southeast Asia is largely free of the son preference/daughter disfavor syndrome, as opposed to China where one result of the one-child policy. . . was the death of thousands of female infants.

FEMALE INFANTICIDE IN PRE-TWENTIETH CENTURY INDIA

The British discovery of infanticide in India occurred in 1789 among a clan of Rajputs in the eastern part of Uttar Pradesh, a northern state.[2] All of the infanticide reported by British district officers and other observers was direct female infanticide. A lengthy quotation from a mid-nineteenth century description by a British magistrate in the Northwest Provinces of India demonstrates how open was the knowledge of the practice of female infanticide at that time:

> There is at Mynpoorie an old fortress, which looks far over the valley of the Eesun river. This has been for centuries the stronghold of the Rajahs of Mynpoorie, Chohans whose ancient blood, descending from the great Pirthee Raj and the regal stem of Neem-rana, represents *la crème de la crème* of Rajpoot aristocracy. Here when a son, a nephew, a grandson, was born to the reigning chief, the event was announced to the neighboring city by the loud discharge of wall-pieces and matchlocks; but centuries had passed away, and no infant daughter had been known to smile within those walls.
>
> In 1845, however, thanks to the vigilance of Mr. Unwin [the district collector], a little granddaughter was preserved by the Rajah of that day. The fact was duly notified to the Government, and a letter of congratulations and a dress of honour were at once dispatched from head-quarters to the Rajah.
>
> We have called this incident, the giving of a robe of honour to a man because he did not destroy his grand-daughter a *grotesque* one; but it is very far from being a ridiculous incident. When the people see that the highest authorities in the land take an interest in their social or domestic reforms, those reforms can give an impetus which no lesser influences can give them. The very next year after the investiture of the Rajah, the number of female infants pre-

served in the district was *trebled!* Fifty-seven had been saved in 1845; in 1846, one hundred and eighty were preserved; and the number has gone on steadily increasing ever since (Raikes 1852: 20–21).

A review of the secondary literature on female infanticide in British India reveals its practice mainly in the Northwest, and among upper castes and tribes. Not all groups practiced female infanticide, but there are grim reports that a few entire villages in the northwestern plains had never raised one daughter.[3] On the basis of juvenile (under ten years of age) sex ratios for districts in the Northwest Provinces, 1871, I have estimated crudely that for nineteenth-century Northwest India it would not be unreasonable to assume that one-fourth of the population preserved only half the daughters born to them, while the other three-fourths of the population had balanced sex ratios among their offspring (Miller 1981: 62). This assumption yields a juvenile sex ratio of 118 (males per 100 females) in the model population, which is comparable to current juvenile sex ratios in several districts of northwestern Indian and Pakistan (Miller 1981, 1984). It seems clear that female infanticide in British India was widespread in the Northwest rather than of limited occurrence.

The British investigated the extent and causes of female infanticide, and in 1870 passed a law against its practice. Other policy measures, based on their assessment of the causes of the practice, included subsidizing the dowries of daughters that were "preserved" by prominent families, and organizing conferences in order to enlighten local leaders and their followers about the need to prevent infanticide (Cave Browne 1857).

There are two areas of ignorance about the wider context of the historic practice of female infanticide in India. First, we know little about the apparent and gradual transition from direct to indirect infanticide. It appears that either deep-seated social change and/or British policy against the practice of female infanticide succeeded in bringing about the near-end of direct female infanticide by the beginning of this century. In the twentieth century we hear little about female infanticide in census reports, district gazetteers, or anthropological descriptions of rural life. What is needed is a careful tracing of the situation from roughly 1870 when the practice was outlawed to the present time in order to plot the dynamics of change from outright to indirect infanticide. Second, we need to know much more about the sociocultural determinants of female infanticide in British India. The British pointed to two causal factors—"pride and purse." The pride of upper castes and tribes is said to have pushed them to murder female infants rather than give them away as tribute to a more dominant group, or even as brides which is viewed as demeaning in rural North India today. By "purse" is meant dowry, and most groups that practiced infanticide did have the custom of giving large dowries with daughters.[4] But there is some contradictory evidence. In the undivided Punjab, it has been documented for the early twentieth century that dowry was not widely given among the rural Jats, a caste which nonetheless exhibited very high sex ratios (i.e., males over females) among its juvenile population. In fact, the Jats, a landed peasant caste, often secured brides through brideprice, which should have provided an economic incentive for parents to preserve daughters (Darling 1929; see also the discussion in Miller 1984). Further exploration of archival materials for the nineteenth century would help illuminate this matter.

FEMALE INFANTICIDE AND NEGLECT: THE CURRENT CONTEXT

It is beyond doubt that systematic indirect female infanticide exists today in North India. It is possible that outright infanticide of neonates is also practiced, though nearly impossible to document due to the extreme privacy of the birth event and the great ease with which a neonate's life may be terminated.[5] This section of the paper is concerned with indirect female infanticide, which is accomplished by nutritional and health-care deprivation of children, and which results in higher mortality rates of daughters than sons.[6]

There is a strong preference for sons in rural North India and there are several strong sociocultural reasons for this preference. Sons are economic assets: they are needed for farming, and for income through remittances if they leave the village. Sons play important roles in local power struggles over rights to land and water. Sons stay with the family after their marriage and thus maintain the parents in their old age; daughters marry out and cannot contribute to the maintenance of their natal households. Sons bring in dowries with their brides; daughters drain family wealth with their required dowries and the constant flow of gifts to their family of marriage after the wedding. Sons, among Hindus, are also needed to perform rituals which protect the family after the death of the father; daughters cannot perform such rituals.

Elsewhere I have argued that extreme son preference is more prevalent in North India than in the South and East, and that it is more prevalent among upper castes and classes than lower castes and classes (Miller 1981). By extension, daughter neglect would follow the same pattern. Some of the key research questions include: how extensive is daughter disfavor in different regions and among various social strata in India? How serious are its consequences in terms of mortality and in health status of the survivors (not to mention more difficult to diagnose conditions such as emotional and cognitive development)? Are these patterns changing through time? At this point, scattered studies help illuminate some aspects of these questions, but there is no study that addresses them all systematically either for one locale or for India as a whole.

First, let us consider the question of the extent of the practice in India. In a recent publication, Lipton (1983) suggests that fatal discrimination against daughters in India is a very localized, and thus minor, problem. But my all-India analysis (1981), using juvenile sex ratios as a surrogate measure of child mortality, shows that while the most afflicted area encompasses only two or three states of India, there are seriously unbalanced sex ratios among children in one-third of India's 326 rural districts, an area spanning the entire northwestern plains.[7] Simmons *et al.* (1982) provide results from survey data on 2064 couples in the Kanpur region of Uttar Pradesh (a state in northern India) which reveal that reported infant and child mortality rates for girls aged one month up to three years of age are much higher than the rates for boys. This finding is similar to, though less astonishing than, Cowan and Dhanoa's (1983) report that in a large sub-population carefully monitored in Ludhiana district, the Punjab, 85 percent of all deaths to children aged 7–36 months were female. Another dependable database that has been carefully analyzed by Behrman (1984) and Behrman and Deolalikar (1985) concerns an area of India where juvenile sex ratios are not notably unbalanced, south-central India in the area between Andhra Pradesh and Maharashtra. The authors have found that there is a noticeable nutrient bias in favor of boys in the intrahousehold allocation of food. This unequal distribution has a seasonal dimension: in the lean season boys are more favored over girls in the distribution of food in the family, while in the surplus season distribution appears quite equal.

Class/caste variations in juvenile sex ratios are also important. Simmons *et al.* (1982) unfortunately do not present findings on class or caste patterns. They mention that education of the parents is a positive influence on child survival in the first year of life, less so in the second and third. If parental education can be used as a crude indicator of class status, then it would seem that survival for both boys and girls would be more assured in better-off families. Demographic data from the Ludhiana area of Punjab state have been analyzed for class differences by Cowan and Dhanoa (1983). Among upper class, landed families (termed "privileged" by Cowan and Dhanoa), there is a large disparity between survival rates for male and female children and also in the nutritional status of those surviving (Table 1). These disparities are mirrored, though less severe, in the lower class, landless population. Cowan and Dhanoa found that

TABLE 1. Prevalence of 2nd/3rd Degree Malnutrition in 911 Children in Second and Third Year of Life, Ludhiana, the Punjab

	Number	*Sex Ratio*[a]	*With 2nd/3rd Degree Malnutrition*[b]	*Ratio of male to Female Malnourished*
Privileged males	231	111.0	2	1:6.5
Privileged females	208		13	
Under-privileged males	244	102.5	11	1:2.6
Under-privileged females	228		29	
TOTAL	911	106.5	55	1:3.2

[a]Sex ratio refers to the number of males per hundred females.

[b]The numbers in this column were read from a graph and may be off by a small margin

Source: Cowan and Dhanoa (1983: 352).

birth order strongly affects the survival and status of daughters. Second-born and third-born daughters are classified by health care personnel as "high risk" infants, as are high birth order children of both sexes born to very large families, regardless of socioeconomic status. The extent of fatal daughter disfavor in this relatively affluent state of India is severe, and it contributes to Punjab's having infant (up to one year of age) mortality rates higher that those of poorer states where daughter discrimination is less severe (Miller 1985).

Caldwell's data on a cluster of villages in Karnataka (southern-central-India), with a total population of more than 5000, revealed "surprisingly small" differences in infant and child mortality by economic status, father's occupation and religion (1983:197). (This area of the country is characterized by balanced juvenile sex ratios at the district level.) The authors do not mention whether there are any sex differentials in child survival and health. Infant mortality rates are, however, much lower in households with an educated mother than those where the mother has little education. Girls tend to receive less food than boys, and family variables are mentioned as being involved in this matter.

Another report from a region with balanced juvenile sex ratios, a two-village study in West Bengal reported on by Sen and Sengupta (1983), produced some provocative findings. The authors did not look at mortality but rather at levels of undernourishment in children below five years of age according to caste and land ownership status of the household. Results were surprising: the village with a more vigorous land redistribution program had a greater nutritional sex bias, even among children in families who had benefited from the redistribution. In the second village, children in poor families had higher nutritional standards and a lower male-female differential than their counterparts in the first village.

Rosenzweig and Schultz (1982) used a subsample of rural households in India, presumably nationwide, and found that boys have significantly higher survival rates relative to girls in landless rather than in landed households. Horowitz and Keshwar report that survey data from a Punjab village (northern India) demonstrate more pronounced son preference among the propertied peasant castes, although the phenomenon is "nearly" as strong among agricultural laborers (1982: 12); they do not provide health or survival statistics, but use data on stated preferences of parents.

The above review indicates that, while we do not possess an ideal picture of the extent and nature of daughter disfavor, there is evidence that its practice does exist widely in India and does tend to exhibit class/caste patterns—though the exact nature of these is in dispute. We know very little about the question of change through time since few good sources of longitudinal data exist, and those that do exist have not been examined for sex disparity information as yet.

SEX-SELECTIVE ABORTION

> Several years ago a Jain woman in her sixth month of pregnancy came to Ludhiana Christian Medical Hospital for an amniocentesis test. The results of the test showed that genetic defects such as Down's syndrome or spina bifida were not present in the fetus. The test indicated that the fetus was female. The woman requested an abortion and was refused. She went to a clinic in Amritsar, another major city in the Punjab, and had the abortion done (report by a physician, Ludhiana, November 1983).

This anecdote was told to me at Ludhiana Christian Medical College as an explanation why Ludhiana CMC no longer performs amniocentesis. There were so many requests for abortion of female fetuses following amniocentesis that the hospital made a policy decision not to provide such services.[8] Today a person with intent to abort a female fetus in Ludhiana must take the train about 90 miles to Amritsar where the service is available. An especially poignant aspect of the anecdote is the information that the woman was a Jain. Jainism supports nonviolence toward all life forms. Orthodox Jains sometimes wear cloths over their mouths so as not to swallow a fly, and Jains do not plow the earth for fear of inadvertently cutting in half a worm. But the Jain woman in the anecdote was willing to abort a female fetus in the sixth month of gestation, so strong was the cultural disfavor toward the birth of daughters.

At this time I do not have access to data on the number of female fetuses aborted each year in India, nor to data on the social characteristics of those people who seek to abort their female fetuses. Nonetheless, several considerations are important: how can we estimate the extent of the practice? What are the social and economic characteristics of those families seeking to abort female fetuses? What are the demographic characteristics of the families seeking sex-selective abortion? There are some clues.

In 1980 an article published in *Social Science and Medicine* provided some evidence of the extent of the phenomenon based on clinic records in a large city of western India (Ramanamma and Bambawale 1980). In one hospital, from June 1976 to June 1977, 700 individuals sought prenatal sex determination. Of these fetuses, 250 were determined to be male and 450 were female.[9] While all of the male fetuses were kept to term, fully 430 of the 450 female fetuses were terminated. This figure is even more disturbing in light of the fact that western India is characterized by a less extreme son preference than the Northwest.

There is an eager market in India for sex-selective abortion, although the cost of the service may make it prohibitive for the poorest villagers. A report in *Manushi* (1982) states that the service is available in Chandigarh, the Punjab, for only 500 rupees.[10] Another report mentions that the charge was 600 rupees at a clinic in Amritsar, the Punjab (*Washington Post* 1982). A recent visitor to Ahmedabad, Gujarat, reports a charge of only 50 rupees in a clinic there (Everett 1984). Whether the charge is 50 rupees or 500 rupees, the cost is minor compared to the benefits reaped from the possibility of having a son conceived at the next pregnancy, or compared to the money that would have been needed to provide a dowry for the girl were she to survive.

DETERMINANTS OF SON PREFERENCE AND DAUGHTER DISFAVOR

Why does son preference exist, and why does it often exist in tandem with the practices of sex-selective abortion, female infanticide, and female neglect? Anthropologists have proposed "explanations" for the practice of female infanticide in simple societies, but less work has been done for complex civilizations. Recent problems in China, provoked by the one-child policy, have attracted attention to the subject, but little scholarly thinking, with few exceptions. . . . A range of hypothesized

causal factors has been suggested to account for female infanticide in the past few years. They can be divided into ecologic/economic determinants, social structural determinants and sociobiological determinants.

From the broadest population ecology perspective, Harris (1977) proposes that female infanticide, and by extension sex-selective abortion, will most likely occur when a society has reached a crisis level in its population/resources ratio, or right after that crisis when the society has moved into a necessarily expendable portion of the population in relation to resources. This theory has explanatory power for some cases, but we might bear in mind that infanticide is only one of many possible strategies for ameliorating a high population/resources ratio. Other options include migration, and the reduction of natural population growth through delayed marriage, abstinence, abortion, and other forms of birth control both traditional and modern.

My interpretation, based on the case of North India, gives more emphasis to economic demand factors. I have hypothesized that labor requirements for males versus females (themselves ecologically, agriculturally and culturally defined) are key in determining households' desires regarding number and sex of offspring (Miller 1981, 1984). Although I take the sexual division of labor as primary, I view it as creating a secondary and very powerful determinant in the domestic marriage economy. In the case of India, the contrast between dowry marriages and bridewealth marriages illustrates the "mirroring" of the sexual division of labor in marriage costs: generally where few females are employed in the agricultural sector, large dowries prevail, but where female labor is in high demand, smaller dowries or even bridewealth are the main form of marriage transfers.

Other more orthodox economic approaches stress rational decision-making on the part of the family based on perceived "market opportunities" of offspring (Rosenzweig and Schultz 1982) or intrafamily resource allocation systems (Simmons *et al.* 1982). Sen and Sengupta propose that land distribution patterns are an important determinant of sex differentials in children's nutritional status (1983).

The major exponents of a social structural theory are Dyson and Moore (1983). They identify the patriarchal nature of North Indian society as the basis for the neglect of daughters and other manifestations of low female status. They do not seek to explain why society in North India is strongly patriarchal—that is simply a given.

Dickemann, who studied female infanticide cross-culturally and particularly in stratified societies such as traditional northern India and China, provides a sociobiological interpretation for female infanticide (1979, 1984). Her early observation of the connection between hypergynous marriage systems and female infanticide was a particularly important contribution (1979). Dickemann views sex ratio manipulation among offspring as one reproductive strategy that will, under alternate resource conditions, result in maximum reproductive success for the family. She has recently stated that:

> Like other acts of reproductive management, infanticide-pedicide seems to be best understood at present, in all species, as one parameter of interindividual and interfamilial competition for the proportional increase in genes in the next generation . . . (1984: 436).

In terms of the explanatory power of evolutionary models with respect to the cause of violent mistreatment of human offspring, however, Hrdy and Hausfater (1984: xxxi) agree with Lenington (1981) that "only a portion of such cases" will be thus explained.

PUBLIC HEALTH AND PATRIARCHY

Ten years ago when I began my research on fatal neglect of daughters in rural India the problem was not widely accepted by scholars in the West or in India as a serious one.[11] Today the practice of fatal daughter disfavor is more widely recognized by scholars as a serious social issue. Current concern in India about the growing recourse to sex-selective abortion, using information on sex of the fetus derived from amniocentesis, adds a new and important dimension to problems of female survival and the ethics of abortion (Ramanamma and Bambawale 1980; Kumar 1983).

Operating within such a patriarchal system, could any health care program seeking to provide equal health care for all have any success? There is controversy concerning the impact of health care programs in alleviating sex differences in child survival in patriarchal cultures, particularly North India. Some writers suggest that a simple increase in health care services will improve the situation for girls (Minturn 1984). Others have found evidence that increased services will be diverted to priority children, most often boys, and that only secondarily will low priority children, most often girls, benefit.[12] Finally, the introduction of new medical technologies—such as amniocentesis—can be manipulated to advance patriarchal priorities (Miller 1986).

Focus on the Punjab

The Punjab, India's wealthiest state, is located in the northwestern plains region adjacent to Pakistan. Its economy is agricultural with wheat the major food crop, but there is a well-developed industrial sector also. Within the Punjab, Ludhiana district is usually recognized as the most "developed" district. Ludhiana district also stands out because it houses one of the best medical colleges and community health programs in India, Ludhiana Christian Medical College. Ludhiana, and the Punjab district, are squarely in the area in northwestern India where juvenile sex ratios are the most masculine and excess female child mortality the greatest (Miller 1985).

Since the early 1970s, Ludhiana CMC has been monitoring the reproductive and health status of the surrounding population—first as a pilot project in three rural locations and one urban location, and later in the entire block of Sahnewal (an administrative subdivision of the district), with a population of about 85,000. The monitoring is part of a decentralized, comprehensive basic health care program that focuses on the welfare of mothers and children and includes both health care delivery at village centers and home-based educational programs. For each of the nearly 14,000 families in Sahnewal block, the CMC Ludhiana program maintains family folders containing information on all family members and their health status. Mortalities are carefully recorded in each folder and also in Master Registers kept in 49 village centers throughout the block. Some analysis of these data has been performed (Cowan and Dhanoa 1983) which provides startling figures on sex differentials of mortality for children aged 7–36 months in which female deaths constituted 85 percent of the total (1983: 341).

Cowan and Dhanoa note that one important result of their intensive home-based visiting approach in the rural Punjab is a reduction in the percentage of female child deaths (1983: 354). There is no doubt that their approach can be effective for saving the lives of high-risk children, though it requires great effort and entails much surveillance of private life. Two questions arise from this finding: a related result of increased survival for girls is an increase in the percentage of malnourished girls—girls' lives have been saved, but the quality of those lives may not be at all equal to that of males. Would even more intensive home visiting help alleviate this problem? Furthermore, some would argue that the death of unwanted children might be preferable to their extended mistreatment and suffering (Kumar 1983. . .).

We have not estimated the unit health care costs by sex and priority of the child, but the cost of saving the life of a low priority female child must far outweigh the cost of saving and improving the life of a high priority male. It is not unthinkable that the time will arrive when, with fiscal stringency the watchword of the day, the cost of intensive health care and survival monitoring for girls becomes a barrier to programs such as the one at Ludhiana CMC. Two arguments can be developed to counter policies which would limit special ef-

forts to equalize life chances between boys and girls. First, one might look to the broader social costs of a society in which the sex ratio is seriously unbalanced. It cannot be proven that unbalanced sex ratios invariably lead to social disturbances, but there is much cross-cultural evidence to support this (Divale and Harris 1976). A balanced sex ratio does not guarantee social tranquility, but it could minimize some sources of social tension. Second, in a strongly son-preferential culture, women bear many children in the attempt to produce several sons. The pattern of selective care which promotes son survival to the detriment of daughter survival is built on "over-reproduction" and much child wastage. Mothers bear a physical burden in this system. The Ludhiana program seeks to keep children alive and wanted, and to promote family planning after a certain number and sex composition of children have been born in a household; this goal should reduce the physical burden on mothers created by extended childbearing.

HUMANISTIC VALUES, PATRIARCHAL VALUES AND ANTHROPOLOGY

This chapter discusses an extreme form of sex-selective child care, one which is not universally found throughout the world though it is not limited to rural North India. Strong preference for sons which results in life-endangering deprivation of daughters is "culturally" acceptable in much of rural North India with its patriarchal foundation. It is not acceptable from a Western humanistic or altruistic perspective . . . nor from that of an emergent, international feminist "world view." But, how can anthropological research, with its commitment to nonethnocentric reporting of cultural behavior, contribute to an amelioration of the "worldview conflicts" that create inappropriate public health programs targeted at high-risk children, that sometimes only prolong the suffering of these disvalued ones?

. . . [P]erhaps positivistic anthropology and Western altruism can work together. First, let me hasten to soften the hard edges of the "conflict" in world views that Cassidy has constructed: there is no such thing as purely objective and nonethnocentric anthropological research and there is, increasingly, less and less culturally uninformed altruism being foisted on the Third World. All anthropologists, as Schneider so clearly states (1984), have their own unavoidable, culturally-influenced presuppositions and biases through which they choose subjects for research and through which they analyze their data. The best an anthropologist can do is state the nature of his/her presuppositions at the outset: mine, influenced by my white, middle class, American upbringing, are based on the precept that human life, its duration and quality, is something to which all persons should have equal access, although I am fully aware of the fact that scarcity (real or culturally defined) results in priorities about the quality of life that certain groups will receive. Thus I define female infanticide and skewed sex ratios as a social "problem." As an applied anthropologist I believe that socio-behavioral data can provide the key to successful public programs which seek to ameliorate the "problem."

My experience, though too brief, in working with Dr. Betty Cowan and Dr. Jasbir Dhanoa (two "altruists") in Ludhiana convinced me that there is hope for a realistic solution to the conflict between altruism and, in this case, extreme patriarchy, in the sensitive applications of social science knowledge and research. The public health program at Ludhiana is perhaps never going to dilute the force of Indian patriarchy, but knowledge about the patriarchal culture can help promote more effective health care. For instance, the Ludhiana hospital built equal-sized wards for boys and girls, on the Western model. But families bring their boys in for health care in much greater numbers than their girls; the girls' ward is relatively empty while the boys' ward is overflowing. Health care practitioners thus realized the need for very decentralized health care rather than only hospital-based services, including frequent home visiting, if health care was to reach girls.

Anthropologists can provide important information to health care intervenors which will allow those intervenors to be more effective in delivering their services. The most important issue in the Ludhiana area still to be resolved is the impact of class and caste stratification on female survival. Health care practitioners see daughter disfavor largely as a result of poverty. My own research would question poverty as the principal determinant in Ludhiana because there is a marked disparity in survival of boys and girls in the propertied class as well as in the unpropertied class. Although the larger picture is unclear because of lack of data across North India, it is obvious that policy implications differ greatly depending on class/caste dimensions of village life. If health care programs are to be targeted to "high-risk" groups, anthropologists can help by providing data on the nature of these groups and the potential implications of intervention in their lives.

NOTES

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1. A discussion of abortion and infanticide from a Western philosophical view is provided in Tooley (1983); compare his presentation with Potter's description of the Chinese view (this volume).
2. We know very little about the practice of female infanticide in India before the British era. The discussion that follows is extracted in large part from Miller (1981: 49–67).
3. Critics are quick to point out that without daughters, villages will not "survive." But in the case of North India, marriage is village exogamous, particularly for Hindus; that is, brides must come from a village other than the groom's. Villages without daughters would "survive" because they would bring in daughters-in-law. More anecdotally, the Community Health Program at Ludhiana CMC was started by a woman physician who was the third daughter of the Grewal lineage to be preserved; even without daughters, the Grewal lineage has "survived" for centuries.
4. Another effect, largely urban and upper-class, of the dowry system in North India is the murder of young wives by their in-laws in order to procure a second bride with her dowry (Sharma 1983).
5. Knowledgeable physicians who have worked with the community health care program in the rural areas surrounding Ludhiana, the Punjab, know that there is a preponderance of female neonatal deaths as compared to those of males. They are averse to labelling this as due to infanticide since an autopsy may well not reveal an intentional death as opposed to a stillbirth or an unintentional death. The physicians do know that neonatal deaths constitute a serious problem, and one that is the hardest for them to deal with due to the secrecy surrounding births in rural India.
6. A detailed discussion of the dynamics of son preference in India can be found in Miller (1981), and a comparison between Pakistan and Bangladesh in Miller (1984).
7. This pattern in Northwest India extends over the Indian border into Pakistan . . . .
8. The central government of India has banned prenatal sex determination tests in government hospitals throughout the country for the same reason.
9. The preponderance of females in the sample is probably due to sheer accident.
10. In 1984–85, one dollar equalled approximately twelve rupees.
11. There are some notable exceptions to this generalization (Bardhan 1974; Chandrasekhar 1972; Dandekar 1975; Visaria 1961), although none of these scholars emphasized the major role of sex-differential survival of children in creating the preponderance of males over females.
12. Srilatha (1983) reports that in a large study

area in Tamil Nadu, South India, infant and child mortality rates have declined significantly in the last ten years, but the decline was dramatic for boys and only slight for girls. The implication is that improved health services may be differentially allocated to boys and girls in this area of India.

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