UNIVERSITY OF CALIFORNIA SAN DIEGO

" '¡Cuídate!' le dije yo"

Imagined Choices:

Models of Agency, Intentionality, and Responsibility in Adolescent Pregnancy

A Thesis submitted in partial satisfaction of the requirements

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by

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TABLE OF CONTENTS

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ABSTRACT OF THE THESIS

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Morgen Angela Chalmiers

Master of Arts in Anthropology

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Adolescent pregnancy has come to symbolize all that is antithetical to the ideals of modern motherhood and remains a site upon which debates surrounding agency, intentionality, and responsibility take place. The moral schemas that structure such debates evolve against the standard of the self-managing, rational actor and are increasingly informed by ideologies that are primarily neoliberal rather than religious. Yet the cohesive self articulated in such tidy theories of human action remains elusive, a figment of the policymaker’s imagination. An analysis of the conflicting interpretative

frameworks surrounding adolescent pregnancy in a small town on the U.S.-Mexico border complicates binary models of choice based on rational actor theory and illuminates the neoliberal grounds upon which the moral valence of intentionality rests.

Chapter 1: **Introduction**

Many Rocks in the Road: An Ethnographic Investigation of Barriers to Reproductive Healthcare in Baja, Mexico

"*Hay muchas piedras en el camino*," there are many rocks in the road, Manuela[1] explained to me during one of our earliest conversations about women's access to healthcare in her community. Her statement was metaphorical and alluded to the many obstacles that had prevented her from "saliendo adelante," or "getting ahead," in life. At the same time, the phrase offered a literal description of the environment in which she lived. The dirt road that led to the community center where I was conducting anthropological fieldwork was indeed full of rocks, potholes, deep puddles, and other obstacles that rendered it nearly impassable, especially when it rained.

Later that day, I asked Mauela's neighbor Andréa about the greatest obstacles to women's health in the community that I refer to here as La Colonia.[2] "Transportation," she responded immediately and went on to describe the difficulties of reaching health care facilities, difficulties that were only compounded by the fact that few residents owned cars. Once women arrived at clinics, they often waited in long lines and many were turned away after waiting for hours. Those who were seen by providers were frequently subjected to disrespectful and insensitive treatment (similar to that described

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[1] As per anthropological convention, all names used in this text are pseudonyms to protect the anonymity of my interlocutors.

[2] Similarly, I use the generic pseudonym "La Colonia," translated literally as "The Colony," to refer to the community in which the research informing this thesis was conducted.

by Singer 2016; Zacher Dixon 2015; Smith-Oka 2015) that prompted many to seek care in the more expensive private sector, despite financial hardship.

Since the early 1990s, there has been an enormous shift in global health rhetoric, funding, and focus towards women and children's health, specifically reproductive health. Discourses of human rights have been invoked to argue for humanitarian intervention and political reforms (Singer 2016). By some accounts, important gains are being made in the field of global maternal health; programs to decrease maternal mortality have had a modest impact on reducing perinatal and maternal mortality in several countries and more women are gaining access to contraceptives. Yet with the increase in institutional deliveries, public hospitals have also become sites where women encounter stark physical manifestations of the structural violence (Farmer et al. 2004) that pervades their daily lives. Similarly, women's increased access to contraceptives does not always equate with the ability to control their fertility. Family planning initiatives have, in many cases, employed coercive measures to persuade women to accept particular methods of contraception or led to the insertion of IUDs in post-partum patients who were unaware that the procedure was taking place (Castro 2004; Van Hollen 2003). Morgan and Roberts (2012) and Singer (2016) understand policies and programs designed to address women's health issues as part of a larger neoliberal process of "reproductive governance" that invests in the production of a particular type of responsibilized subject.

Over the last decade, the Mexican government's expansion of Seguro Popular—a national health insurance program that covers the full cost of many preventative services—has reduced some of the financial barriers to reproductive healthcare.

However, many women in poor or rural communities of Mexico, such as my fieldsite, still lack access to many basic reproductive health services; women arrive early in the morning to wait in line at overcrowded clinics with no guarantee of being seen by a provider. Furthermore, the quality of care women often receive--if they are seen--and the dismissive, condescending attitudes of providers discourage many from seeking care at all.

My preliminary fieldwork was largely consistent with the anthropological and global health literature on reproduction. This literature suggests that women marginalized due to socioeconomic class or indigenous status face the typical barriers to healthcare access experienced by persons living in the precarious circumstances of poverty, unstable employment, and everyday violence (see Muehlmann 2013). Though my research initially began as a broad examination of the obstacles to reproductive healthcare for women living in La Colonia, I realized early in my fieldwork that the issues I was identifying had been thoroughly examined by anthropologists, physicians, and policymakers. More importantly, as I began in-depth conversations with women about reproductive healthcare, I noticed that these issues of access to care were not their primary concern. Again and again, during focus groups and interviews, I found that participants redirected the conversation back to the topic of adolescent pregnancy.

Older women in the community lamented what they saw as a loss of opportunity for their daughters to "salir adelante," to get ahead in life, while the younger women I interviewed emphasized that they had intended to get pregnant and adamantly rejected narratives that frame adolescent pregnancy as the result of teenage carelessness, absence of preparation, or lack of knowledge. This preliminary data led me to reconceptualize my

research, which now focuses on the multiple meanings ascribed to teenage motherhood at my fieldsite in Baja, Mexico. Across diverse contexts, the pregnant adolescent remains a contested figure in contemporary discourses in development and health policy. As my research evolved, this contrast between mothers' and daughters' interpretive frameworks with regard to adolescent pregnancy illuminated what became an unexpected yet central question of my research: How do women across a diverse range of ages understand reproductive agency? If adolescent pregnancy is conceived of as a social pathology (as it was by nearly all of the middle aged women participating in focus groups), what explanatory models (Kleinman, Eisenberg, and Good 1978) are invoked to account for its prevalence? By comparing and contrasting the diverse moral schema through which adolescent pregnancy is interpreted in La Colonia, my research complicates conventional notions of women's agency and reproductive rights to reflect the tensions observed at my fieldsite.

In addition, the debates between women in La Colonia regarding adolescent pregnancy highlighted an important tension often present in participatory research. While participatory research aims to respond to the needs articulated by the target population, it presumes the existence of a cohesive, homogenous community. The methodology is predicated upon the researcher's ability to interact with this imagined community and glean knowledge that will inform sensitive, community-based health interventions. However, "communities" are messy, oftentimes bitterly divided and refuse the neat framework that participatory methodologies assume.

Ultimately, my project seeks to complicate the easy truths and assumptions that global health practitioners too often take for granted. I begin Chapter 2 by contextualizing

La Colonia and briefly considering the political economy of the U.S.-Mexico border region. I provide a cursory overview of essential work in the anthropology of reproduction, with specific attention to the literature on obstetric violence in Latin America and Mexico, in addition to a historical description of reproductive health services offered by the Mexican state. I discuss here as well my own positionality—how I came to know La Colonia and its residents and how my association with a monthly free clinic in the area affected the process of fieldwork. Chapter 3 takes as its subject the multiple meanings ascribed to adolescent pregnancy in La Colonia and the significance of the interpretive framework of "choice" in discourses surrounding reproduction. I then demonstrate how the circumstances structuring such "choices" complicate simplistic economic models of human behavior such as Rational Actor Theory. Chapter 4 builds upon this analysis using narratives from two women who experienced adolescent pregnancy themselves. Overall, these ethnographic inquiries problematize the false dichotomy created by discourses of choice and intentionality in discussions of reproduction. Chapter 5 ties these threads together to consider the larger implications of these conclusions for the study of moral action, agency, and the self.

Chapter 2

Contextualizing Reproductive "Choice:" Women's Health in the U.S.-Mexico Borderlands

I first traveled to La Colonia as a volunteer medical student at a monthly free clinic held in the community center. The clinic was run by undergraduate students from an American university who organized the set-up, coordinated scheduling, and recruited volunteer EMTs and physicians to see patients at the clinic on a rotating monthly basis. The clinic had originally been held in another location near central Tijuana. However, Graciela, the wife of La Colonia's pastor, had heard about the free clinic and traveled to central Tijuana several years ago to ask the organization to set up a similar clinic in La Colonia, a more rural location where residents lacked access to adequate healthcare.

The community of La Colonia is located east of Tijuana off of a major highway that leads to the city of Tecate. Though both the cities of Tijuana and Tecate are only twenty to thirty minutes away by car, the lack of transportation (most residents do not own cars) results in La Colonia's relative isolation from the resources available in urban centers. Women walk to the nearby supermarket chain to buy groceries for their families. Children can attend elementary and middle school in La Colonia but must travel an hour by bus to reach the nearest high school. The community was created as part of a government initiative to support low-income single and working mothers, who were offered free housing and land. A number of homes were also constructed by a nearby steel mill company to house migrant workers.

Political Economy of the U.S.-Mexico Borderlands in Brief

As in many communities located near the U.S.-Mexico border, most of La Colonia's male residents work in foreign-owned factories — maquiladoras — that multiplied along the border following the passing of the North American Free Trade Agreement (NAFTA). In brief, the agreement, discussed elsewhere in greater detail (see Bacon 2004), removed export tariffs on goods produced in Mexico and transported to the U.S. The large sector of the Mexican population living in relative poverty and willing to work for little pay, in combination with the lack of human rights protections (as well as the Mexican government's failure to enforce those that did exist), attracted investors hoping to maximize profit margins. Under the new regulations introduced by NAFTA they could now produce their goods with cheap labor in Mexico, move them across the border, and sell them at high prices in the more affluent U.S. market. A worker in Tijuana typically makes less in a day than an undocumented worker just a few miles north in San Diego makes in an hour (Bacon 2004:44). The availability of cheap labor in Mexico along with neoliberal market reforms mandated by the International Monetary Fund and the removal of export tariffs produced a financial environment favorable to foreign investors who could capitalize on the massive number of laborers willing to work for little pay, while the "ability of people to buy what they produce…[was] sacrificed" (Bacon 2004:45).

The vast majority of my interlocutors had not been born in Tijuana or even in the state of Baja but had migrated from other parts of Mexico in search of employment in the industrial economy of the border zone. Residents had come from states like Guerrero, Sonora, Sinaloa, and even as far as Chiapas, in search of gainful employment, or had

followed a relative who had moved to Tijuana. Several had also spent time living on the U.S. side of the border, working in the garment industry or participating in the informal economy. Rosa and her mother, for example, spent years living in Imperial Beach, where they prepared and sold tamales every day. Rosa was born in Acapulco and traveled to Tijuana for the first time at age eighteen. She and several friends paid a *coyote* the equivalent of four hundred U.S. dollars to cross the border to San Diego. A few years later, she returned to Acapulco to bring her mother back to San Diego, where they made a living for nearly two decades selling their tamales. In those days, she explained, it was much easier to cross between the U.S. and Mexico outside of official entry points. Now, she surmised, one might pay up to $5,000 U.S. dollars to cross through the desert and at least $10,000 to be smuggled across in an automobile.

In addition to the smuggling of migrants, another defining feature of the border economy is, of course, the expansive trade in illegal narcotics and the state's attempts to prevent trafficking through a militarized war on drugs (Muehlmann 2013). This illicit economy grew in no small part due to the heavy demand maintained by Mexico's more affluent neighbor to the North. In her compelling ethnography, *When I Wear My Alligator Boots: Narco-Culture in the U.S.-Mexico Borderlands*, anthropologist Sarah Muehlmann traces the historical developments that created the economic conditions in which the drug trade began to flourish. In the 1980s, the United States' Drug Enforcement Agency cracked down on smugglers bringing narcotics from Columbia into the U.S. by airplane (Muehlmann 2013:11). Subsequently, the Mexican cartels benefited from the now-unmet demand for drugs in the U.S. due to the DEA suppression of shipments from Columbia. Several years later, in 1994, with the introduction of NAFTA,

Mexico's markets were flooded with "cheap agribusiness-produced corn," which put many rural farmers and agricultural workers out of business (Muehlmann 2013:11). Involvement in the rapidly expanding drug trade offered this now-unemployed population of mostly young and middle-aged men a lucrative means to continue providing for their families in dire economic circumstances (Muehlmann 2013:11). Following the militarization of the war on drugs in 2006, violence associated with the drug trade has dramatically increased, particularly in the areas within one hundred miles of the U.S.-Mexico border (Muehlmann 2013). While "official government discourses and the mainstream media" attribute this drastic increase in violence as "resulting from rivalries among cartels," others, including Muehlmann, argue that this violence escalated, at least in part, due to the militarization of the war on drugs itself (Muehlmann 2013:14).

Muehlmann's work highlights the ways in which the drug trade and war on drugs affect women living on the Mexican side of the U.S.-Mexico border. As husbands, sons, and brothers are imprisoned or killed, essential sources of income and financial support are lost, not to mention the emotional toll associated with the loss of a loved one through incarceration or death and the corresponding impact on one's mental health. Similar comments were made by Abril Saldaña-Tejada, a Mexican sociologist conducting research on adolescent motherhood in Guadalajara. She emphasizes that "any study that looks at youth in Mexico needs to be seen in the light of a context of rampant violence, governmental oppression and widespread poverty. The experiences of young men and women in the country are marked by the normalization of violence and fear. Thus, to be young in Mexico is in itself a practice of resilience" (Saldaña-Tejeda 2015:38).

As these authors suggest, the drug trafficking economy has a profound effect on young women living near the border. The women I met during my fieldwork in La Colonia were no exception. Ernesta, for example, described the fear she had felt one day in November when her boyfriend had called from a nearby factory where he worked as a security guard to warn her not to leave the house. At a nearby supermarket, located only a few blocks away from the small home they shared, a group of *narcos* and *federales* were shooting at each other. Though I avoided asking questions directly about the drug economy and its associated violence, I nevertheless came to see its impact on the women I interviewed as they described their husbands' struggles with addiction and incidents such as the supermarket shooting.

Neoliberalism and the Mexican Healthcare System

Shortly after the end of the Mexican revolution in 1920, the new government initiated efforts to construct a "unified and modern state, engaged in a steady and successful process of centralization that relegated federalism to symbolic status" (Homedes and Ugalde 2006). At that time, emphasizing public health was considered an essential strategy for consolidating the nation as a unified polity (Agostoni 2016). An important aspect of this approach was a centralized, government-sponsored healthcare system that aimed to address the health needs of the population nationally (though the success of these attempts was certainly limited). This system remained in place until 1983, when the Mexican economy underwent a massive recession and devaluation crisis and the state was consequently unable to make payments on its national debt (Homedes and Ugalde 2009). Like many other developing nations during this time period, Mexico

was offered loans by the World Bank and International Monetary Fund. These loans were, of course, accompanied by a number of policy stipulations as part of a neoliberal international development strategy now referred to as structural adjustment.

In general, structural adjustment policies mandated that state welfare services such as nationalized healthcare be decentralized and privatized in order to reduce overall government expenditure. The presence of a substantial population—the urban poor, the indigenous, or rural populations—that lacked access to essential health services led to the creation of the National Health Service, which was ostensibly founded to address the needs of these marginalized groups (Schneider 2010). However, the NHS has been criticized by a number of scholars, such as Asa Cristina Laurell, who argued that the NHS was nothing more than "an ideological pretext to justify the state's disregard of its constitutional obligation to guarantee the social rights of all Mexicans" (Laurell 1991:462).

Following a second peso devaluation crisis in 1994, additional reforms were introduced, including user fees at public health facilities as part of a second IMF-sponsored bailout. These compounded the already significant barriers to care faced by marginalized populations, who did not receive health insurance through their employers and were often unable to afford the increasing cost of care in the public sector. However, beginning in 2003, the nationalized health insurance program known as Seguro Popular was introduced to provide coverage for the uninsured. Since that time, an increasing percentage of the population has had access to healthcare—at least officially—and enrollment in Seguro Popular continues to grow today. Nevertheless, even individuals ostensibly covered through Seguro Popular continue to face significant barriers to care

including long wait times, lack of transportation to primary or tertiary care facilities, as well as discrimination and disrespectful treatment that deters many from seeking non-emergency health services. This dynamic has been discussed in particular with regard to reproductive healthcare access.

History of Reproductive Healthcare in Mexico

While the history of women's reproductive healthcare since Mexico's colonization is discussed in great detail elsewhere (see Sanders 2009; Schneider 2010; Smith-Oka 2013; Jaffary 2016), here I provide a very brief review of recent scholarship and essential aspects of Mexican history. While the colonial state restricted its intervention in the realm of reproduction to the elite class of Spanish women responsible for birthing heirs, the period immediately following independence was characterized by intense state interest in motherhood and reproduction, which was seen as "central to their project of developing, in Anne-Emanuelle Birn and Raúl Necochea López's terms, 'a healthy yet docile citizenry'" (Jaffary 2016:2). Although the post-revolutionary state from 1917 onwards is often described as pronatalist, Gutmann argues that a more accurate depiction would be one that reflected the "scant attention paid to demographic trends by the Mexican state" until the 1970s (Gutmann 2007:108). Rather than concentrating on birth rates, the state's interest in reproduction was manifest in public health and educational initiatives that sought to reshape maternal practices to reflect modern ideas about sanitation, hygiene, and the body.

Beginning in the 1960s, growing international anxiety about population growth led to the initiation of family planning programs across the globe, disproportionately

concentrated in post-colonial nations and communities of color. Feminist analyses (Roberts 2014) of these often-coercive health interventions have offered detailed accounts of the ways in which the "unfettered fertility" (Sanger 1920) of women of color in developed nations and the Global South was perceived as threatening not only to the economic growth of individual nations but to the human race as a whole, in the context of increasingly scarce natural resources. This fear led to massive, coordinated efforts to curb the reproduction of such women across the globe (Castro 2004; Van Hollen 2003; Oparah and Bonaparte 2015). Through this process of "reproductive othering" certain populations laid "claim to a whiter, worthier status than racialized Others on the basis of their purported reproductive practices" (Braff 2013:121). These family planning campaigns are a striking example of the phenomenon Ginsburg and Rapp (1995) refer to as stratified reproduction, defined as the "power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered."

The Neo-Malthusian logic employed at the time suggested that the relationship between high fertility rates and poverty was of a causative nature. According to this view, the ostensibly developing nations of the world could only achieve economic growth when their respective fertility rates decreased. Many countries adopted aggressive population control policies based on this reasoning in their efforts to escape the poverty trap and foster national economic development.

International organizations like the World Bank and USAID promoted the agenda of population control for different reasons. The prevalent discourse on the "population bomb" framed the issue not only as an impediment to the prosperity of individual nations but as a serious threat to global welfare as well (Ehrlich 1968). The problem of

overpopulation was thus rendered significant not only to individual nations but to all actors with an interest in the future ability of the human race to thrive, unencumbered by the serious shortages of ecological resources anticipated by economists, environmentalists, and development officials alike. The increasing anxiety surrounding the perceived population problem created new imperatives to control population growth. The onus, of course, was placed on women who "had to be convinced it was their responsibility to 'protect themselves' by using birth control" (Gutmann 2007:116). In this way, the problem of high fertility was transformed, as reproductive rights advocate Dr. Ravindran suggests, into "the problem of 'women having too many children'" (Ravindran 1993:29).

In Mexico, specifically, the National Population Council attempted to reduce fertility rates by establishing national numerical goals for contraceptive use. Clinics and hospitals were expected to convince a certain number of women annually to "accept" contraception (Gutmann 2007:120). This policy led to the frequent insertion of IUDs immediately post-partum, often without the patient's knowledge or consent as well as forced sterilization (Castro 2004; Gutmann 2007). As Gutmann explains, "each health center was assigned a goal for enlisting new birth control users…clinics suffered penalties, at least indirectly through loss of prestige and clout in the health system, if they consistently fell short of the federally established goals. Conversely, clinics could expect extra resources if their numbers were significantly over target. What is more, the target-quota system of promoting contraception [was part of a larger program] that compelled all medical personnel to encourage birth control use every time they met with women for any other reason" (Gutmann 2007:120–1).

Obstetric Violence and the Anthropology of Reproduction

The practice of inserting IUDs or even performing sterilizations without patient consent has been internationally recognized as a human rights violation and such "target-centered" approaches to the provision of contraceptives have now been mostly abandoned. Nevertheless, through initiatives such as the Oferta Sistemática, which mandates that health providers offer all female patients of reproductive age contraceptive services—no matter their original reason for seeking care—the idea that women have a responsibility to regulate their reproduction in accordance with norms promoted by the state continues to permeate the national health system and provider mentalities (Gutmann 2007). Women whose reproductive "choices" were seen as irresponsible in the context of national family planning agendas promoting smaller families were frequently subjected to verbal abuse and occasionally physical violence as has been described by Singer (2016), Zacher Dixon (2015), Smith-Oka (2015), Smith-Oka (2013b), and Savage and Castro (2017).

I use the term "choice" here in quotations to reflect providers' conviction that pregnancy was the result of individual choices that were subsequently assigned moral value. This mentality was deeply informed by the tenets of neoliberalism such as self-responsibility that rely on the notion of the individual as a rational actor. The term remains in quotes, however, in recognition of the large body of work critiquing the emphasis on the role of individual "choice" rather than structural factors in contexts of scarcity with regard to health outcomes. Paul Farmer, for example criticizes the ways in which this emphasis perpetuates a "victim-blaming model" in development ideology that

blames “the poor themselves…[claiming that] these people are backward and reject the technological fruits of modernity” (Farmer 2004:155).

The verbal abuse and physical violence in reproductive healthcare settings observed by anthropologists such as Singer (2016), Zacher Dixon (2015), Smith-Oka (2015), and Savage and Castro (2017) has been referred to as obstetric violence. The concept is informed the work of Davis Floyd (2004) and Martin (1987), pioneers in the anthropology of reproduction, who analyze the ways in which the rituals of medicalized birth reflect patriarchal norms and capitalist ideology. Many definitions of obstetric violence highlight the inherently dehumanizing nature of medicalized birth. These definitions refer to a variety of coercive practices observed in labor wards across the globe including compulsory cervical examinations (Smith-Oka 2013b), the routine insertion of IUDs immediately postpartum without patient consent as discussed above (Castro 2004), the overuse of uterotonic medications in order to expedite labor (Van Hollen 2003; Davis-Floyd 2004), as well as deliberate acts of violence against women in labor (Smith-Oka 2015; Van Hollen 2003; Savage and Castro 2017). Much of the literature on obstetric violence has been based on fieldwork conducted throughout Latin America, including Mexico (Castro 2004; Singer 2016; Smith-Oka 2013b; Zacher Dixon 2015).

Methodology

It was in this context in which I initially began my fieldwork, interested in questions of access to reproductive healthcare among marginalized communities in the U.S.-Mexico borderlands. In order to address my original research question—What are

the barriers to reproductive health for women in La Colonia? —I worked with the previously mentioned NGO to conduct a needs assessment among the community, specifically focusing on reproductive health.[3]

I trained several undergraduates in the use of ethnographic methods in understanding community health (see training documents in Appendix 1). I saw patients as a third year medical student, supervised by an attending physician, at the monthly clinic and conducted weekly focus groups for a period of three months at the community center. In addition, I conducted multiple person-centered (Levy and Hollan 1998), semi-structured interviews in Spanish with a number of key informants whom I met through the focus groups or at the monthly clinic. Sample questions from semi-structured interviews and focus groups are available (in Spanish) in Appendices 2 and 3 respectively. I spent time in women's homes as they cooked, cared for their children, and socialized with friends.

My association with the clinic and positionality as a medical student meant that I was trusted easily with sensitive information of a very personal nature. At the same time, I was careful to distinguish my role as a researcher from that of a student clinician. I often found this distinction challenging to maintain in practice in the sense that my anthropological experience informed how I took and interpreted patient histories while, my medical training and association with the NGO may have affected my relationships with friends and participants. No matter how clear I tried to be that my research was separate from the NGO's actions in the community, I worried that participants might be under the false assumption that contributing to the project might afford them special

[3] Approval for this ethnographic study was obtained from the University of California, San Diego Institutional Review Board (Project # 170298).

treatment or benefits later, despite my insistence that this was not the case. As physician-anthropologist Carolyn Sufrin suggests in her illuminating article, " 'Doctor, Why Didn't You Adopt My Baby' Observant Participation, Care, and the Simultaneous Practice of Medicine and Anthropology," the complications of this dynamic are inescapable and must be carefully attended to in the process of fieldwork given that "our divided selves influence our expectations of our patients and informants, and theirs of us" (Sufrin 2015:617).

As part of my fieldwork, I also accompanied my friend Rosa to her job at the middle school cafeteria, where we prepared lunch for the students along with several other female employees. Participant observation at the cafeteria allowed me to witness many conversations among Rosa and her coworkers about adolescence, education, and their aspirations for their children, among many other topics that informed my ethnographic research. On one occasion, I accompanied Rosa, who was active in local politics, to city hall in Tijuana, where she was applying for several permits. This offered me the opportunity to observe the ways in which the small community where I worked was integrated into larger development initiatives sponsored at the county, state, and national level. Over time, as mentioned in the introduction, I came to focus my research on the topic of adolescent pregnancy, given the importance this topic was awarded by my interlocutors and the dearth of anthropological investigations in this area.

Chapter 3

"Tu Quisiste Tener Una Hija:" Models of Personhood, Agency, and Action Invoked in Explanations of Adolescent Pregnancy

Walking up the bumpy dirt road that leads to La Colonia, I saw a crowd of women gathered outside of the secundaria[4]. During the forty-five minute drive to La Colonia from the Otay Mesa border, I frequently noticed that almost every pedestrian I saw was, in fact, male. Public space, at least along the roadside of the highway connecting the urban centers of Tijuana and Tecate, was occupied nearly exclusively by men. However, on this early November morning, a crowd of at least twenty women was gathered outside of the secundaria, arguing loudly with a man whom I later learned served as the school's principal.

"*Como van a salir adelante los niños si no les enseñan?*" How will the children get ahead [in life] if they don't teach them? The question was posed by the group's apparent leader, who was referring to a recent controversy in the community regarding three of the six teachers employed at the town's middle school. The three teachers allegedly spent the majority of the school day outside of the classroom—texting, talking on the phone, or otherwise engaged in non-didactic activities. Students' mothers had organized a protest and petition, demanding that these teachers be fired and replaced by instructors who would not take the responsibility of educating their children so lightly.

Verónica, a mother of three, cried out angrily from the crowd—"you're denying our children their right to education." Others joined in, decrying the injustice of teachers

[4] "Secundarias" are roughly equivalent to middle schools and serve children from ages eleven to fifteen.

collecting monthly salaries while failing to attend to their duties of educating the children of La Colonia. Tears began to stream down Verónica's cheeks and I wondered if I had missed something essential in her story. Later I asked Rosa, my closest friend in La Colonia, why Verónica was crying—what had triggered her intense emotional response? "*La impotencia*," Rosa replied. "Powerlessness. She's crying out of frustration at our powerlessness."

Saliendo Adelante and the Ideal of Modern Mexican Womanhood

Throughout the focus groups and interviews that I conducted, women used the Spanish phrase "salir adelante" again and again to describe the hope that their daughters would someday escape the cycle of early pregnancy, marriage, and motherhood that they felt had weighed so heavily on their own lives.[5] At the Secundaria that day I witnessed the intensity of that drive, of these mothers' hope that their children might "salir adelante," that they might "come out on top" or "get ahead in life," despite the obstacles stacked against them, and go on to achieve the goals to which their mothers had aspired but, ultimately, failed to reach.[6] These goals are informed by notions of what it means to

[5] See also (Jenkins 2015, 210) discussion of the use of this phrase among Salvadoran women immigrants to describe their "deeply held desire to simply carry on and go forward" after escaping the violence of the civil war in the homeland (Jenkins 2015, 213).

[6] At the same time, I am wary of contributing to universalizing narratives that assign a particular subjectivity to *all* mothers and, in many cases, reinforce and romanticize the notion of a natural maternal instinct. Specifically, in the case of Latin America, the assertion of "motherhood as a political identity" negates the multiple and intersecting

be an upwardly mobile, "modern" Mexican woman—specifically to delay childbearing, attend university, and, more than anything, establish economic security, which my interlocutors defined as the ability to provide for one's children. In her book chapter "Modernizing Patriarchy," Mary Kay Vaughan explores the ways in which the post-Revolutionary Mexican state of the 1930s attempted to reshape traditional gender roles through the institution of policies that "sought to 'update' motherhood through training mothers in proper home-care and childrearing techniques…to create 'modern' families for a 'modern' era" (Sanders 2009:1545, citing Vaughan 2000).

Ideals of modern motherhood are both invoked and reinforced by state and NGO-sponsored family planning campaigns. Catchy slogans such as "la familia pequeña vive mejor"—the smaller family lives better—presuppose a distinctly modern, aspirational subjectivity; it is not enough simply *to live*, one must always strive to *live better.* It was this urgent sense of aspiration that had led Verónica, Rosa, and other mothers to gather outside the school that day. This same sense of aspiration fueled my interlocutors' concerns that pregnancy at a young age would impede their daughters' upward social mobility.

In the context of a "national post-revolutionary project that confers upon women the responsibility to birth citizens of a modern and mestizo Mexico" (Saldaña Tejeda, Aguilera, and Davids 2016:16, translation my own), the image of the pregnant adolescent comes to symbolize all that is stigmatized as unmodern and backwards. Embedded in this

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identities of women activists organizing against the state, who may differ from each other in significant ways i.e. along lines of indigeneity, ethnicity, and social class (Tejeda, Aguilera, and Davids 2016:20).

aspirational subjectivity is a drive towards supposed progress, that is, progress as it is defined by teleological notions of a society evolving from "backward, rural, and poor" to "modern, urban, and middle class" (Gutmann 2007:123). Through this paradigm of aspiration, the switch from natural methods of contraception to "métodos modernos" (Gutmann 2007:123) comes to serve as an essential symbol of the modernizing nation's progress.

Simultaneously present alongside the hope that one's own children would *salir adelante* was the conviction that daughters who failed to *cuidarse* (a Spanish word that literally means to take care of oneself but colloquially translates to "to use contraception") had made a deliberate choice in becoming pregnant and should have to face the consequences. Gloria, a mother of three, described a heated interaction with her daughter Luisa, who had married and had a child as a teenager: "If she was a single mother—and she had the need—then, yes I'd have to support her. But she has her husband and yet she showed up in my house [saying]: 'Mamí, take care of my daughter because I want to go to work.' And I said to her, 'Why?' [My daughter responded:] 'Because you're the grandmother.' That doesn't matter—I told her—Did I want to be a grandmother? '*Tu quisistes tener una hija*—you wanted to have a child—I told you to think about it before you…I already raised you, I already raised all of you. From the moment you bring her to my house, she becomes my responsibility. I'll have to make her breakfast, wash her clothes, and then it will be easier for you to go and get pregnant a second time.'" Gloria's assertion that Luisa "wanted to have a child" is representative of the language frequently used by my interlocutors when discussing adolescent pregnancy.

For example, Rosa recalled a conversation she'd had with her sister Guadalupe after Guadalupe's daughter became pregnant at 16: "We were sitting outside and my sister Guadalupe was crying—saying to me 'I always talked with her. If you have a boyfriend, *cuídate*, take care of yourself, I told her. I trusted her and, in the end, she still got pregnant.' But I said to my sister, 'Why are you crying? You talked to her and you trusted her—it wasn't your fault. You put everything there on the table for her, she didn't want to take it, *pues ya es su responsibilidad*—so now it's her responsibility.'"

These two examples demonstrate a conviction shared among most of my interlocutors that adolescents who became pregnant had consciously—almost defiantly—chosen to do so. Guadalupe's daughter, for instance, is portrayed as refusing to take the advice her mother has laid out for her "on the table." While discourses among health professionals often attribute adolescent pregnancy to an impaired ability to plan ahead and make "responsible choices" (to use the moralizing language of policymakers) due to an underdeveloped frontal lobe and the resulting deficits in impulse control, my interlocutors seemed to imply that getting pregnant was a calculated decision by adolescents for which they must be held accountable. As Eva, a mother of three, joked, "they plan for everything—they go up into the hills, plan a time, a meeting place—they plan for everything except *that* [i.e. a method of contraception]." Pregnancy, then, is implicitly constructed as a result of individual choices, choices that, as my interlocutors were quick to point out, come with consequences.

Discourses of Choice and the Rational Actor Model

Such a conviction reflects a broader understanding of personhood, agency, and action consistent with the principles of voluntarism as discussed by Strauss (2007). Specifically, she defines voluntarism as "a cultural model of persons as free to choose their actions with a focus on the proximate actor…rather than more distal agents" (Strauss et al. 2007:812). Similar ideologies are, of course, present in neoliberal economic models, specifically rational choice theory, and continue to inform interventions in the field of health and development throughout the Global South. My interlocutors invoked voluntaristic models of reproductive decision-making not only when criticizing young women's purported choice to become pregnant but also in direct reference to their own experiences. As Paula explained to me, "As a woman, one decides how many children you'll have because men just wash their hands and leave. *Soy yo que les voy a sacar adelante*—It's me that's going to bring them up." Therefore, Paula implied, it was solely her decision how many children she would have and when she would attempt pregnancy. Rather than reflecting the reality of most women in La Colonia, I see this statement as an assertion of reproductive agency, an attempt to make a claim on a distinctly modern identity Paula aspired towards—that of the independent, self-managing woman who made her own choices freely and rationally.

This orientation towards the reproducing individual as a rational actor contrasts with interpretations traditionally informed by Catholicism that claim "children are a gift from the lord" (Psalms 127:3-5), thus framing pregnancy as an act of God, outside of human control. As Gutmann (2007:111) suggests, Catholic religious doctrine has been interpreted and adopted with great flexibility throughout Mexican history. Mexican

women, in particular, he argues, "are neither submissive nor passive, but are active individuals who mediate Catholic teachings…based on their personal subjectivities" (González-López 2005:244 cited in Gutmann 2007:128). In their willingness to embrace biomedical contraceptives in order to space and limit their children, Mexican women showed little concern for religious prohibitions regarding contraception and instead demonstrated a deep commitment to "providing their fewer children with more educational opportunities and material privilege" (Gutmann 2007:112) so that these children might someday *salir adelante*. Though religious conservatism is often considered a potential barrier to accessing contraception and reproductive healthcare in general, this did not appear to be the case at my fieldsite in La Colonia. As Maria-Rosa, mother of three, explained, "I laughed at her when I was washing her clothes and I found condoms [in her pockets]. I didn't get scared. To the contrary, I gave them back and left them in her purse so that she wouldn't forget them. I prefer prevention. I didn't get scared because now it's not like before—now sexuality is very open."

While much of the literature on reproductive health among Mexican and Mexican-American women has suggested that traditional gender norms rooted in Catholic religious doctrine and the cultural ideal of *marianismo*[7] among these populations emphasize female purity, modesty, a lack of knowledge about sex, and frame sex as "more a duty than a pleasure" (Erickson 2010:28), I found that most of the middle-aged women who participated in focus groups were more than comfortable discussing their

[7] *Marianismo,* often described as "the opposite face of *machismo"* is a term coined by Evelyn Stevens (1973) in reference to the value assigned to sexual purity, passivity, and other traditionally "feminine virtues (Stevens 1973).

enjoyment of sex. Many seemed to take pleasure in comparing their preferences and experiences, joking about the "scent of a man…¡*Sin bañarse que ricos son!* How delicious they are when they don't bathe! You fill yourself up with that smell…Mmmm…but ask another question because this is making me…" She left her sentence unfinished, but the group laughed at her innuendo--one woman fanning herself playfully.

Early on in my fieldwork, I greeted Eva and asked her how her weekend had been. "Very good, *Morgana*, very good," she replied in a mischievous tone, raising her eyebrows suggestively. Oblivious at first to the meaning of her statement, I inquired further: "Great! What all did you do?" Eva, laughing at my naïveté, responded with a wink, adding "*Cosas, Morgana…cosas*...Just things, Morgen…things." Rather than a taboo topic to be avoided, sexuality was clearly a source of pleasure as were these suggestive performances of desire, at least within the exclusively female environment of the focus groups. At the same time, Carrillo draws attention to the ways in which social norms that render discussions of sex taboo create an environment in which the only acceptable manner to address the topic is through joking, especially through *albures,* double entendres, which "on the one hand...make the topic of sex a common one in everyday interactions…[while] on the other hand, they also contribute to a perception that it is shameful to address sex openly or seriously" (Carrillo 2002:153).

Strikingly absent from all of my interviews on the topic of adolescent pregnancy was the moralizing language of shame, embarrassment, or disgrace of the family that one might expect in a culture frequently described as conservative, family-oriented, and religious. Just as historian Nichole Sanders suggests that the "notion that Catholicism [is]

the root of women's subjugation" in Mexico is "a persistent myth," in my own fieldwork, I found that religiously-based objections to adolescent pregnancy seemed irrelevant to my interlocutors (Sanders 2009, 1546). For example, the fact that adolescent pregnancy almost always resulted from premarital sex—traditionally stigmatized as sinful in Catholic religious doctrine—was never once referenced by my interlocutors. Instead, judgments of adolescent pregnancy were nearly exclusively couched in neoliberal terms. As Eva emphasized, "*es tu propia responsabilidad de cuidarte,* it's your own responsibility to take care of yourself [to use contraception]. Because now there are many contraceptive methods, now you can't say '*ay, se me chispoteó*,' oops I screwed up. If you teach your child what it means to be responsible—the consequence of what they are going to do—they're going to think about it twice, three times. But if you don't teach them [about] the consequence that it's going to have [i.e. the consequences of having sexual relations], then they're going to do it and not just one—two, three pregnancies [will occur]."

Adolescents are portrayed as rational agents who, when provided with the relevant information (that sexual intercourse can result in pregnancy), are expected to act accordingly and take the necessary precautions to avoid pregnancy. It is this view that informs sex education initiatives internationally, in Mexico[8], and in the United States as well. However, while such education is undoubtedly important, in most cases education alone does not reduce pregnancy rates among teenage women, who often get pregnant

[8] Sex education was introduced to the Mexican public school curriculum in 1974 and began to focus on STI and pregnancy prevention through condom use in 1982 (Gutiérrez and Saldaña).

"because they *aren't* being rational actors who put self first—they may have sex to please a man, and they may fail to use contraception because the man either actively objects or makes it difficult by complaining that a condom reduces his pleasure" (Luker 1997:5). As Maternowska (2006) suggests, family planning interventions that rely on the rational actor model's assumptions of a liberal subject acting out of individual self-interest are destined to fail, because they presume "a fluid, mutually respected discourse of equality and opportunity between actors within and among institutions that function at both micro and macro levels" (Maternowska 2006:31).

On a larger scale, the example of teenage pregnancy reveals significant limitations of rational actor theory as a tool for analyzing reproductive and health-related behavior (Luker 1997). Such theories remain analytically alluring in part due to their elegant reductionism. The intricate and opposing forces that motivate human behavior are disentangled and distilled down to their most basic form as represented in economic models of the marketplace. Orientations towards others that fall outside the explanatory scope of self-interest come to be seen as nothing more than "externalities" or "revealed preferences" and, in this way, are "reduced to the status of utilities" while "the rational actor of neoclassical economics is not an *individual* in the generic sense of the word, but rather a *male individual:* the concepts of 'work' and 'family' [upon which the rational actor model is predicated] have assumptions about gender deeply embedded within them (Luker 1997:4).

In addition to "irrational" emotions such as passion or love, these "externalities" also include the larger, structural context in which adolescents begin to make sense of their lives, not strictly as *individuals*, but as part of a complex web of interdependent

relations. For example, as Muehlmann observes in her ethnographic study of Narco-Culture in the U.S.-Mexico Borderlands, an individual's decision to enter the drug trade cannot be understood outside of the precarious political, social, and economic contexts in which he or she exists. She argues that the choice to engage in the illicit drug economy is, in fact, a calculated one. These calculations do not take place in a "social vacuum guided by pure economic considerations about potential gains in relation to the risk of a jail sentence or even death" (Muehlmann 2013:156). Rather, individuals evaluate risks against debts owed to friends and loved ones, personal safety, "the fact that their families may not have food to eat every day, and their sense self-worth" (Muehlmann 2013:156). Like the individuals Muehlmann describes, adolescents who become pregnant—whether by "choice," accident, or something in between—do not do so in a "social vacuum."

The constraining effect of structural factors on reproductive agency in the Mexican context is illustrated by the work of Gutmann (2007), who began his fieldwork intending to examine the process of decision-making regarding contraceptive use among heterosexual couples in Oaxaca but ultimately discovered that "much of the decision-making [that he had hoped to study]…takes place in the boardrooms of pharmaceutical companies located in Basel, Switzerland and New Jersey" (Gutmann 2007:14). Though sex education continues to be emphasized as a solution to unwanted pregnancies, such educational initiatives fail to disrupt the social hierarchies that continue to structure gendered power relations of race, class, and indigeneity (Gutmann 2007). Under these conditions of structural violence (Farmer 2004), education alone can do little to address the multiple barriers that prevent poor, rural, and indigenous Mexicans from accessing quality healthcare (Gutmann 2007; Singer 2016; Smith-Oka 2015; Zacher Dixon 2015).

These structural factors complicate our understanding of the possibility of choice and the concept of intentionality with regard to adolescent pregnancy. These structural factors complicate our understanding of the possibility of choice and the concept of intentionality with regard to adolescent pregnancy.

Chapter 4

Unwanted Pregnancy or Adaptive Practice: Complicating the Binary of Intentionality

Of course, what remains glaringly absent from this analysis thus far is the account of a pregnant adolescent herself. When I began fieldwork, the majority of my data was collected in focus groups that I held weekly at La Colonia's community center. Attendees, I later discovered, were disproportionately those with social connections to the community center directors, Eva and Rosa. Consequently, most of the participants belonged to the same age group—mid-thirties to mid-forties—and shared many of the same beliefs with regard to adolescent pregnancy. It was more difficult to recruit younger participants, who rarely frequented the community center. However, I was able to speak to several young mothers in their late teens and early twenties who became pregnant during their teenage years, two of whom I continued to visit frequently throughout my fieldwork: Ernesta (mentioned in Chapter 2) and Carmina.

Ernesta, now twenty-two years old, first became pregnant at age seventeen. She married the child's father and together they migrated from Chiapas to Tijuana in search of employment and economic opportunity. Her first husband had been violent and physically abusive since she moved in with him at the age of fourteen. Nevertheless, she remained in the marriage for five years, leaving only after he had stopped providing financially for Ernesta and their daughter. "When I was with him," she told me, "I didn't carry money in my purse. I didn't even carry a purse because I had nothing to put in it. We lacked a lot. I had to work to be able to buy things for my daughter." Eight months prior to our first meeting, Ernesta left the house with her daughter during a heated

argument that had become violent and moved in with her neighbor Francisca, an older woman who lived alone. Shortly after this, Ernesta met Francisca's nephew Miguel, an older man in his forties whose first wife lived with his children in Ecuador. Ernesta and Miguel fell in love, she became pregnant again, and they subsequently moved in together. In telling her story, Ernesta portrays herself as very much the agent of her own destiny and not a victim of circumstance. Although she had not intended to get pregnant so soon with Miguel, she was happy about the pregnancy. When asked how she had felt upon first realizing that she was pregnant, she replied, "Well, it's his first child with me," highlighting the importance of the pregnancy in cementing her relationship with Miguel. She was happy to be pregnant for many reasons, to be sure, however, the significance of the security a pregnancy with this new partner afforded her cannot be denied.

Within the moral schema that structure the lives of La Colonia's residents, a man (or boy) who impregnates a woman is expected to provide for her and the child financially, a principle that was repeatedly emphasized by focus group participants. Of course, not all men fulfill this expectation as Paula implied in her comment above, that men wash their hands and leave after having children. Nevertheless, shirking what is understood to be a man's duty to provide for his children and their mother is seen by the community as highly disgraceful, even morally abhorrent behavior.[9] Many adolescents (and older women) who intentionally become pregnant do so under the assumption that the social relations cemented by the pregnancy will obligate the child's father to support her financially. However, it would be a mistake to interpret this phenomenon through the

[9] Surprisingly, given the prevalence of Catholicism, marrying the mother of one's child was not considered a part of this ethical duty.

simplistic lens of Rational Choice Theory, which, at its extreme, might lead us to imagine a scheming woman callously trapping her sexual partners into economic obligations by neglecting to use the many methods of contraception available for free at Centros de Salud throughout the country. This is certainly not the case. Furthermore, the complex influences that affect women's use of contraception, the timing of intercourse, and even the desire to have a child cannot be reduced to simple risk factors that can be neatly incorporated into predictive models. Rather these influences must be understood as intersecting and compounding in complex, messy ways that defy definitive interpretation.

On one level, structural inequalities and patriarchal social norms render adolescent girls more vulnerable to what are referred to in the public health literature as "unwanted" or "unintentional" pregnancies. As Luker (1997) points out, the social norms that define respectable sexual behavior for a woman require her to display relative sexual inexperience, which may be demonstrated by a lack of preparation for a sexual encounter. These values are internalized long before sexual activity begins. Nice girls, after all, don't carry condoms. The cultural ideals of modesty, deference to male pleasure, and passiveness that are so valued in women are impediments to the effective use of contraception (Luker 1997, 146). Though her research focused on adolescent pregnancy in the United States, my fieldwork suggests that there are similar social pressures and phenomena at work in La Colonia. As Saldaña (2015) noted during her fieldwork in Guadalajara, Mexico, the social pressure to avoid appearing "easy" deters many young women from using any type of contraception. Women constantly struggle to establish a balance between maintaining their status as eligible for marriage (i.e. avoiding being

perceived as “loose” or promiscuous) and fulfilling their own sexual desires, which were openly acknowledged during interviews (Carrillo 2002:102).

Structural Constraints on Adolescents’ Reproductive Agency

There are also practical, structural constraints that prevent women who wish to avoid pregnancy from doing so. For example, though in theory women insured through Seguro Popular, Mexico’s government-sponsored healthcare initiative for low-income individuals, are entitled, free of charge, to various contraceptive methods including intrauterine devices, oral contraceptives, and Depo-Provera injections, my interlocutors emphasized the difficulty of obtaining care at health centers. Women must make appointments in advance or spend all day waiting at the clinic with no guarantee of being seen by a provider. Very few families in La Colonia own cars, which makes it inconvenient to reach the nearest health center, a thirty minute walk from La Colonia. The clinic’s hours prevent women who must attend school or work from being able to receive care there at all.

In La Colonia and marginalized communities across the globe, structural constraints and social pressures intersect to increase the likelihood of pregnancy among adolescent girls. The majority of teenage pregnancy prevention programs remain ineffective because they treat teen pregnancy as “an individual problem that can be treated outside the social and culture context of young mothers’ lives” (Erickson 2010:18). Of course, many young women choose to become pregnant because having a child is the next most logical step—what Geronimus (2003:881) refers to as an “adaptive practice”—given the socioeconomic constraints under which they live For example, as

Luker (1996) observed, when women become pregnant as teenagers, their child's infancy, arguably one of the most time-intensive stages of its life, coincides with a period of time in which they are typically not working full-time and can rely upon relatives, with whom they may share a residence, for economic and social support. These advantages are especially important for women living in the situations of precarity (Jenkins 2015) produced by poverty and social exclusion. Similarly, despite their mothers' hopes that they will *salir adelante*, the reality is that most adolescent girls in La Colonia will not attend high school, given that the closest school is over an hour away by bus. With few other opportunities available, starting a family is considered by many to be the next step in life.

Carmina, for example, reported that she began trying to get pregnant at age sixteen and feared she might be infertile when she did not. After two years, she had her first child and, eight months later, became pregnant again, assuaging her fears. She lives with her boyfriend, who works in a furniture factory and supports Carmina and their children. This lifestyle—remaining at home with the children while a male partner worked to provide income—was what many young girls in the community aspired towards. The employment opportunities available for women who have not graduated high school include working as a cashier, waiting tables, or performing demanding physical labor in a maquiladora. With these as their primary career choices, it is unsurprising that many women's highest aspiration is to housewifery. After all, traditional Mexican gender roles afford women a large degree of power within the domestic domain as long as they fulfill the gendered expectations of modern motherhood (Christie 2008, 243).

Reproductive intentionality cannot be understood as a binary variable but is more accurately described as a spectrum, characterized by "various degrees of intent" (Greil and McQuillan 2010:137). Fordyce (2012) describes the questions used by public health surveys that measure "wantedness" or "intendedness" of a pregnancy and the subsequent critiques of these methodologies while Luker points out how the concept of wantedness itself assumes "that people perceive clear choices and that they feel empowered to act on them" (Luker 1997:152). Similarly, Helmy (2017) draws our attention to the ways in which the intended-unintended dichotomy masks other inequalities. As she states, the concept of "reproductive intentionality privileges individuals for whom particular reproductive choices are possible. Specifically, as a disproportionate number of those who experience unintended pregnancies are women of color, poor or low-income women, and/or young women, intention may actually be measuring social or material disadvantage…Intendedness renders this political economic and social context invisible and the ability to have an intended or planned pregnancy is seen as residing entirely within the individual" (Helmy 2017:5). At the same time, it would be inaccurate to portray Carmina and Ernesta as simply victims of their social circumstances by minimizing or denying the agency they exert in their reproductive lives.

During my conversations with Carmina, I often wondered if she was, perhaps, retroactively overemphasizing her desire to become pregnant at age sixteen. Is it possible that, looking back, she now imagines her younger self as desiring pregnancy to a greater extent than she did? Is her assertion that she was trying to get pregnant a way of coping with or rationalizing her current situation? While she now describes her actions and intentions as part of a conscious effort to become pregnant, could she be assigning this

meaning retrospectively as a way of asserting reproductive agency in a social context where teenage pregnancy and adolescent motherhood continue to be stigmatized? Perhaps she had, at one point, imagined herself *saliendo adelante,* then been forced to give up on this aspiration when she found herself pregnant, as the older women in the community seemed to suggest. At the same time, it's equally possible that this suggestion originated more from prejudiced beliefs held by the older women about adolescent pregnancy rather than reflecting reality.

This epistemological uncertainty highlights the impossibility of conceptualizing Carmina's pregnancy as falling into one of the binary categories: wanted or unwanted. Could it have been both? Such ambiguity calls to mind Katherine Ewing's theory of multiple, shifting, and inconsistent selves as well as the distinction she (citing Hartmann 1958) makes between the self and self-representation (Ewing 1990). Like Ewing's informant Shamim, might Carmina's representations of her past actions and motivations shift depending on the context? My own uncertainty in interpreting Carmina's description of her efforts to get pregnant at sixteen is reminiscent of Sarah Pinto's attention to "the tension between the openness of narrative and the enclosure of meaning as a story becomes an explanation," through which she constructs a "hermeneutics of discord" (Pinto 2012:134). She draws our attention to the gendered power relations that remain inseparable from the process of diagnosis and inform the distinction made between the normative and pathological. Though her focus is on psychiatric diagnosis, I suggest that this same dynamic is also present in the designation of adolescent pregnancy as social pathology. It is apparent that the moral frameworks through which it is interpreted as such have been historically informed by a particular set of gendered, Judeo-Christian

values that define acceptable motherhood, even if women in La Colonia today do not directly reference religious ideology in their denunciation of adolescent pregnancy as a societal ill.

Stories like Carmina's call into question the construction of adolescent pregnancy as a social pathology or even as a problem at all. It is, after all, only in the last fifty years or so that the practice of delayed childbearing began to take on the social and moral significance it is accorded today. Teenage mothers are stigmatized in the United States and Mexico partially based on the assumption that adolescent pregnancy limits opportunities for young women as well as their offspring. However, Saldaña, Sisson, and Luker all show that the association of poor educational and health outcomes with young mothers and their children disappears after controlling for socioeconomic factors (Saldaña-Tejeda 2015; Luker 1997; Sisson 2012). Teenage mothers may indeed be more likely to be poor or to obtain a lower level of education, but this occurs because adolescent mothers come disproportionately from disadvantaged socioeconomic backgrounds (Luker 1997; Sisson 2012). This association demonstrates that "poverty and its correlates of low-level education and high unemployment all make adolescents significantly more likely to become parents" (Sisson 2012: 59). In this way, the stigmatization of adolescent mothers can be understood as a form of "stratified reproduction," as discussed in Chapter 2 (Ginsburg and Rapp 1995).

Saldaña Tejada (2015) examines the social roots of stigma against pregnant adolescents and teenage mothers. She invokes Mary Douglass's classic work on the concepts of purity, pollution, and danger (1966) to make a nuanced argument about the ways in which pregnancy's interruption of the transitional state of adolescence evokes a

unique kind of moral outrage. Like Douglas's "matter out of place," pregnant adolescents, Saldaña suggests, are seen as "bodies out of time," a term originally coined by Graham and Low (2008) to refer to women whose "reproductive firsts" such as puberty or menstruation occur outside of the developmental age range deemed normal by biomedical professionals. The perception of young motherhood as transgression necessarily relies on the relatively new concept of adolescence as a distinct developmental stage "bridging childhood and adulthood" (Bliss and Blum 2007, 166). Teenage pregnancy represents a transgression precisely because the rituals associated with adulthood, such as marriage, have been ignored, yet the corporeal embodiment of pregnancy clearly marks the adolescent as no longer a child (Saldaña-Tejeda 2015:39). Though motherhood is idealized in Mexico as a "holy state" (Saldaña-Tejeda 2015, 39), the history of sexual relations that the pregnant body betrays renders the unmarried, pregnant adolescent an almost blasphemous spectacle.

At the same time, the pregnant adolescent threatens the ideals of appropriate motherhood promoted by the Mexican state. In this sense, campaigns that "empower" adolescent girls by providing contraceptives are reminiscent of other efforts to define and enforce the gendered parameters of proper female sexuality. Such initiatives can be understood as part of a larger project that Morgan and Roberts (2012) refer to as "reproductive governance," through which new subject positions--i.e. responsible mothers--are generated and certain forms of reproduction become marked as normal and desirable while others are stigmatized as morally deviant (Braff 2013:124).

Chapter 5: Conclusion

Reproductive Agency and the Moral Valence of Intentionality

These examples illustrate the contradictions present in interpretative frameworks grounded in neoliberal notions of the responsible, self-managing individual as represented in Rational Actor Theory and the meaning adolescents themselves create in their reproductive lives. When pregnancy occurs, it is often not purely the result of "choice" but arises out of a nuanced set of circumstances that complicate definitions of intendedness. As Farmer (2004) illustrates, the importance of structural factors in understanding health outcomes is frequently underemphasized in biomedical models that focus on the individual rather than the social networks and political economy in which she is enmeshed. For pregnant adolescents in La Colonia, these structural factors include the limited availability of higher education, a lack of access to comprehensive women's healthcare, poverty and unemployment, as well as the need to cement social relations and establish their accompanying financial obligations.

These conclusions complicate the ethics and assumptions that inform adolescent pregnancy prevention programs. If a pregnancy is neither fully wanted nor unwanted, how does this trouble ideas in bioethics about patient autonomy and the purported right to choose? Activists in the field of reproductive justice have emphasized how the focus on choice in the abortion rights movement masks the fact that certain choices are accessible to particular groups of women while others remain excluded. Thus, these scholars have advocated for a shift from the language of reproductive choice to reproductive justice in recognition of the multiple, intersecting systems that oppress the reproductive freedom of some women while simultaneously rendering this same freedom more accessible to

others. Similarly, I follow Helmy (2017) in problematizing the emphasis on pregnancy intendedness in public health and propose instead an examination of reproductive agency. This discursive shift to reproductive agency highlights the complex social context and intricate networks in which reproductive lives evolve. The notion of reproductive agency situates the individual within a broader structural context that cannot be dissected into measurable variables and risk factors but often refuses definitive interpretation and extends beyond the boundaries presupposed by the rational actor model.

These ethnographic threads, woven together, speak to larger anthropological questions surrounding the self. Following Csordas (1994), who defines self as "an indeterminate capacity to engage or become oriented in the world" (5), we may come to understand these concepts of intentionality, agency, and responsibility as orientational processes (Csordas 1994) through which the self is objectified and moral experience is made. For example, through Carmina's assertion that she intended to become pregnant, her actions are afforded a degree of moral legitimacy that is often denied the pregnant teenager, who "plans for everything except *that* [contraception]," (see Chapter 3) and is imagined as careless, ignorant, and, above all, irresponsible. Her claim of intentionality counters this stereotype through its postulation of a rational, responsible, distinctly modern self whose life is a product of calculated choices. Responsibility, as defined by my interlocutors, is predicated on intentionality and thus presupposes an ability to exercise agency in the manner supposed by Rational Choice Theory. These conceptual interdependencies illuminate the neoliberal grounds upon which the moral valence of intentionality rests. Yet the cohesive self articulated in such tidy theories of human action remains elusive, a figment of the policymaker's imagination.

At the same time, from its position in the neoliberal imaginary, this ideal of the self exerts enormous influence on experience, shaping aspirations and subjectivities. Moral worlds evolve against the standard of the self-managing, responsible actor. The interpretive frameworks employed by my interlocutors are deeply embedded in such worlds and reflect a differential valuation of particular modes of being. In the post-Enlightenment era, actions that can be portrayed as a product of a Weberian rationality, of a process of "coming to know" (Taylor 1999) through secular reasoning, are granted a kind of moral superiority over behaviors motivated by such "externalities" (Luker 1997) as emotion, religion, or impulse.

Ultimately, this brief ethnographic inquiry not only complicates the binary of intentionality upon which debates regarding adolescent pregnancy rest but also demonstrates how notions of intendedness intersect with moral schema structured by ideologies that are primarily neoliberal rather than religious. Adolescent pregnancy prevention programs both rely on and reinforce this neoliberal moral climate in which the Rational Actor is privileged as an ideal to be aspired towards. Despite such aspirations, the life narratives of pregnant adolescents themselves continue to reveal the ways in which theories of human behavior that treat emotion, experience, and relations between persons as variables, albeit complex ones, remain inadequate.

Appendix 1:
Community Needs Assessment Guide

Interviewing Basics

The best interviews feel like conversations. Use the questions below as a guide for your conversations rather than a script. Rather than trying to go through every question in order, allow the interviewee to direct the conversation and circle back to questions as they come up in conversation. Topics may emerge naturally in your interviews that are not addressed here—if they seem relevant to our overarching goal of understanding women's life experiences in the broadest sense, pursue them!

Be mindful of your location. The interview ideally should take place in a quiet area where the conversation cannot be overheard by other members of the household. This may be impossible in some situations; follow your interviewee's lead—ask where she would feel most comfortable.

Begin with casual questions regarding family background and slowly transition to more sensitive topics as you feel it is appropriate. Before delving into the questions that specifically address reproductive health, it is appropriate to directly ask the interviewee if they feel comfortable discussing these topics with you. For example, you might say something like: "Ahora, me gustaría hablar de temas un poco sensibles: la salud sexual, el parto, y los anticonceptivos. Como dijimos antes, si se siente incomoda o prefiere no hablar de cualquier cosa, avísame y podemos cambiar de tema o terminar la entrevista. ¿Quiere continuar?"

Remember that in discussing women's health, we are asking about issues that are very sensitive and very personal. It's important to be attuned throughout the interview to the possibility that interviewees may become uncomfortable. If this occurs, change the subject and remember that the interviewee may choose to terminate the interview at any time.

At the same time, be sensitive to how your reactions may affect the tone and quality of the interview. Be aware of the possibility that in asking about the most intimate domains of life (childbirth, pregnancy, sexuality etc.), unanticipated and extremely sensitive subjects may arise including sexual assault, abortion, infant death, and infidelity. Remember that you as an interviewer may actually feel more uncomfortable than the interviewee in these situations, especially if she has brought the topic up on her own.

Hollan and Levy elaborate further on this point in their work on person-centered interviewing:

> "Interviewers sometimes, however, avoid topics of importance that they *inappropriately* fear are too sensitive. For many, this is a matter of an exaggerated fear of the fragility of the respondent in regard to emotionally loaded material that might stir up feelings of anxiety, anger, or sadness…Clearly, interviewers can be insensitive. More likely, though,

> they will be much too cautious, and in so being (and by avoiding certain topics and by signaling back their anxiety to the interviewee, covertly entreating him or her to change the subject) close off the discussion of critically informative feelings, evaluations, concerns, and experiences" (348-9)

If you have concerns about any topics discussed in an interview, please contact the lead physician, another organizational leader, or Morgen.

Introductions and Consent

When we introduce ourselves to community members, it's important to be clear about the purposes of our conversations. Here is a sample script one might use to explain the project and obtain consent for interviewing and audio recording. Please feel free to customize it and make it more conversational as you translate it into Spanish.

"We are conducting research on women's experiences of reproductive health. We are interviewing community members to understand their perspectives on a variety of issues in women's health including: childbirth, prenatal care, pregnancy, contraception, gynecologic cancers, and breast cancer. The goal of this needs assessment is to increase our understanding of the barriers to health faced by women in the community and to design future health programs for women here. Please stop me at any time if you don't understand something I'm saying or if you have a question."

"If you would like to participate in the needs assessment, we will discuss these issues for approximately thirty to sixty minutes. You may terminate the interview at any time for any reason. You may also decline to answer any question asked by the researcher. In order to maintain participant confidentiality, all data collected during the interviews will be stored on a password-protected computer and de-identified, meaning that your name will not be associated with any of your statements. At any time following the interview, you may decline participation and the data collected during your interview will be deleted."

"I am audio recording my interviews so that I can refer back to our conversations and remember your opinions and perspectives as accurately as possible. Any time audio is recorded, there is always the potential for a loss of confidentiality. To minimize this risk, the audio files will be stored on a password-protected computer. Only this researcher will have access to these audio files. You may request that the recording be stopped or that audio files be deleted at any time. You may still participate in the project if you decline audio recording."

Key Informants

During the needs assessment, you will encounter a variety of interviewees. Some may be reserved at first but after time become quite enthusiastic about the interviewing process. Other might respond politely to your questions but may not be terribly interested in discussing issues of gender, health, and reproduction at length. Part of our goal is to

identify particularly effusive individuals in the community who enjoy engaging with these topics and might be willing to participate in several interview sessions over the course of several months to continue discussions about women's health in the community. These are referred to as *key informants.* They may be community leaders, community health workers, grandmothers, or young women.

Ideally as part of your participation in the women's health project, you will have the opportunity to develop a relationship with one key informant. As you transcribe your first interview, you may notice topics or stories that merit further explanation or ideas requiring additional clarification. Take note of these and bring follow-up questions to your next visit.

Historical Background

Interventions in the areas of reproductive health and family planning have a long and checkered history in nations around the world, including Mexico. For many women, hospitals and clinics are not places of healing but sites of violence, where women may be verbally or physically abused, shamed for being sexually active, and reprimanded for having too many children by providers. These practices—known as obstetric violence—continue to take place across Mexico and in countries around the world (Zacher Dixon 2015; Smith-Oka 2013, 2015; Castro 2004).

Approaches to family planning by the Mexican state as well as some NGOs are often coercive and motivated by anxieties about population growth rather than a recognition of women's right to control their own fertility. For example, Arachu Castro (2004) has documented the frequent insertion of IUDs immediately post-partum without obtaining consent from the patient or even informing her that the insertion was taking place. It's important to avoid the ethnocentric error of framing this phenomenon as a "Mexican" or "Third World" problem—involuntary sterilization of immigrant and disabled women has taken place here in the United States throughout the 20th century and USAID has funded family planning programs and sterilization campaigns now regarded as coercive (Reilly 1987; Stern 2005).

It is important to be aware of this dynamic, as it certainly has affected how the women we are interviewing think about contraception in a fundamental way. Furthermore, it is important to understand this history so that we can actively structure our program as an alternative that explicitly values women's autonomy and control over their own fertility by offering access to contraceptives in a respectful, woman-centered environment. Awareness of this larger context also reminds us to think carefully about the way we frame our questions during the interview—for instance if a woman mentions that she's trying to have a 4th, 5th, or 6th child—an incredulous response of "What? Why??" by the interviewer would not be appropriate. It's important to be conscious of the context in which our responses may be heard and be careful not to perpetuate discourses that shame women for having many children.

Cultural humility

"Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon and Murray-García 2010)

Approaching our interviewees from the perspective of cultural humility means acknowledging the limitations of our own knowledge. Our needs assessment is the first step in a participatory research project focused on women's health. Implicit in the notion of participatory research is the recognition that it is women themselves—not the researchers—who are experts in their lives, whose knowledge is valuable and must be at the center of program design and implementation. Participatory research rejects the paternalistic notion that engagement with vulnerable populations is a one-way transfer of knowledge from the expert researcher to less knowledgeable recipients. "Instead," suggests Patricia Maguire, "participatory research offers a partnership: We both know some things; neither of us knows everything. Working together we will both know more…Participatory research assumes that both parties come to the research process with knowledge and experience to contribute" (Maguire 1987).

Appendix 2:
Sample Semi-structured Interview Questions (Spanish)

Preguntas de Entrevista

Historia de la Familia

¿Cuando se mudó a Girasoles/Tijuana Progreso? Por qué?

¿Dónde nació? ¿Dónde pasó su niñez?

¿En qué trabajaban sus padres?

¿Tiene hermanos? Cuantos? Algunos viven en Tijuana Progreso/Girasoles también?

¿Cuál lenguaje hablan sus padres? ¿Fue el español el primer lenguaje de sus padres? ¿De usted? ¿De sus abuelos?

Situación de Vida

¿Con quien vive usted?

¿Está casada? ¿Cuando se casó?

¿En qué trabaja su esposo?

¿Cuantos hijos tiene?

¿Trabaja usted? ¿En qué trabaja?

¿Cuánto ganan al mes?

¿En qué gasta la mayor parte de su sueldo?

El Futuro

¿Qué tu gustaría hacer en la vida?

¿Cuáles son sus metas en la vida? ¿Qué le falta para realizar?

¿Cómo sus metas han cambiado desde la niñez?

Dieta y Nutrición

¿Qué tipos de comida come/prepara normalmente para su familia?

¿Dónde compra la comida para su familia?

¿Tiene usted diabetes? ¿Hipertensión? Si lo tiene: ¿Qué hace usted para tratar esta enfermedad?

¿Hace ejercicio? ¿Qué tipo? ¿Por cuánto tiempo (minutos/ horas)?

Papanicolaou

¿Á donde van las mujeres aquí por un Papanicolaou? ¿Es difícil recibir esta prueba? ¿Por qué?

¿Alguna vez en su vida ha recibido un Papanicolaou? ¿Cuántas veces?

El embarazo

¿A dónde van las mujeres para las citas prenatales? ¿Cuántas citas obtiene una mujer normalmente durante los nueve meses del embarazo?

¿Puede describir como es una visita prenatal? ¿Qué hacen las enfermeras y los médicos durante su cita?

¿Cuáles son algunos obstáculos en conseguir servicios prenatales?

El parto

¿Cuántas veces ha estado embarazada?

¿Ha tenido un aborto espontáneo? (miscarriage)

¿Cuántos partos ha tenido usted? Fueron partos vaginales o cesáreos?

¿Dónde dio a luz y como fue? Por ejemplo, cómo se sentía sobre la calidad del cuidado que recibió? ¿Cómo eran sus interacciones con los doctores y las enfermeras en el hospital? (Eran amables, groseros, impacientes, le explicaban las cosas que le estaban pasando usted, etc.)

¿Le gustaría tener más hijos? Cuantos?

Planificación Familiar

¿Qué hacen las mujeres para prevenir el embarazo?

¿Cuáles son los anticonceptivos preferidos? ¿Por qué? ¿Hay anticonceptivos que las mujeres no prefieren? ¿Por qué?

¿Usa usted un anticonceptivo? ¿Para usted, cuáles son las ventajas y las desventajas de este método?

¿Ha usado otros métodos en el pasado? ¿Cuáles fueron las ventajas y las desventajas de cada uno?

¿Cuándo elige usted un anticonceptivo, con quién habla antes de tomar una decisión? ¿Sus hermanas, sus amigas, su novio, su esposo?

¿Qué tipos de cosas afectan la decisión de usar un anticonceptivo?

¿Qué piensa su esposo sobre la tema de planificación familiar y anticonceptivos?

¿Qué piensan los hombres en general sobre la planificación familiar aquí en Tijuana Progreso/Girasoles?

Enfermedades Transmitidas Sexualmente

¿Cuáles son las problemas de la salud sexual aquí? ¿Por ejemplo infecciones transmitidas sexualmente?

¿Hace algo para prevenir ese tipo de enfermedades?

¿Ha sufrido de alguna enfermedad transmitida sexualmente? ¿Cuándo? ¿Qué hizo para tratarla?

¿Cree que las infecciones transmitidas sexualmente son comunes aquí?

¿Cuales las razones por las que una muchacha de 13 a 15 años tendría relaciones?

¿Usted piensa que las muchachas de esta edad tienen la habilidad de decirle “no” a un chico?

Embarazo de Adolescentes

¿Le parece que el embarazo de adolescentes es un problema en la comunidad?

¿En su opinión, cuáles son algunos factores que contribuyen a esta problema? ¿Siempre fue así o algo cambió recientemente?

¿En su opinión, cuáles son algunas soluciones al problema del embarazo en adolescentes?

El Cáncer de Mama

¿Conoce alguien que ha recibido una mamografía?

¿Es común que las mujeres aquí vayan por mamografías? ¿Por qué sí/Por qué no?

¿Es un servicio cubierto por el Seguro Popular?

Grupos de Discusión "Grupo de Salud Para La Mujer"

Nos gustaría organizar un grupo de mujeres de la comunidad en los que se puede hablar más de estos temas. Este grupo se llamará "Grupo de Salud Para La Mujer." Las discusiones duraran aproximadamente una hora y serán en el centro comunitario, donde se organiza la clínica cada mes.

¿Le gustaría participar en el grupo de salud para la mujer? ¿Por qué sí/por qué no?

¿Cuáles son las temas más importantes para este grupo? ¿En cuales temas debería concentrarse/enfocarse el grupo?

Appendix 3:
Sample Focus Group Questions

1. **La Salud de La Mujer en General**

   Como saben ustedes, la meta de este grupo es hablar de los obstáculos a la salud de la mujer y de que son las necesidades de las mujeres en la comunidad. ¿En general, cuales asuntos les parecen los más importantes para considerar en este grupo?

2. **El Futuro y La Autoestima**

   ¿Qué tu gustaría hacer en la vida?

   ¿Cuáles son sus metas en la vida? ¿Qué le falta para realizar?

   ¿Cómo sus metas han cambiado desde la niñez?

3. **Preguntas de Seguimiento**

   La ultima semana, algunas de nosotras han hablado del machismo y los obstáculos que crea por la salud de la mujer. Cuales son algunos ejemplos de ese machismo? Hay eventos o ejemplos en particular que les parecen importantes o demostrativos?

   La ultima semana Rosa ha mencionado que muchas personas son reluctantes a venir a las platicas ofrecidas en el centro comunitario. Ha mencionado que a veces sienten aburridas o que les daba vergüenza…Hay ejemplos de platicas que se recuerdan como especialmente efectivas que tuvo un impacto positivo por la comunidad? Como las platicas podrían ser más accesibles/útiles/ y/o atractivas para la comunidad? Hay ejemplos de platicas particularmente inefectivas en las cuales la gente sentía insatisfechas, aburridas? ¿Por qué?

   La ultima semana hemos hablado de las adolescentes que salen embarazadas y los asuntos asociados. Es que les parece un fenómeno nuevo aquí en la comunidad? Cuando empezó? Siempre algunas muchachas de ese edad han salido embarazadas o es que ha aumentado ese fenómeno? Si ha aumentado recientemente, por qué?

   ¿Hay un estigma asociado con el uso de anticonceptivos? Por ejemplo, si una adolescente tiene condones con ella, es que ella tiene miedo que pueda estar percibida mal como muy experimentada o algo así?

¿Les parece que algunas de las adolescentes embarazadas querían tener un hijo? ¿Por qué quisiera una adolescente tener un hijo? ¿La mayoría de embarazos adolescentes son intencionales o por accidente?

¿Como son los actitudes de los médicos y las enfermeras hacia las adolescentes que van al centro de salud para citas prenatales o para obtener anticonceptivos?

¿Cuál sería la edad ideal para una mujer tener hijos? (¿Cuantos años tenían ustedes?)

¿Cuándo es que una mujer sea lista para tener un hijo? ¿Es solamente una cuestión de edad o de otras cosas también?

¿Cuales tipos de aseguranza de salud son comunes aquí? ¿Hay servicios de la salud reproductiva que no son cubiertas por el Seguro Popular? ¿Cuáles son los servicios más exigentes, servicios que la gente necesita pero que no son muy accesibles?

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