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Unintended consequences: Exploring the tensions between development programs and indigenous women in Mexico in the context of reproductive health☆

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ABSTRACT

This article offers a case study of the politics of reproduction present between development programs, medical practitioners, and population policies in Mexico. It particularly explores how these policies have shaped indigenous women's family planning choices. It analyzes the unintended consequences that emerge from the interaction between indigenous women, medicine, and an economic development program—*Oportunidades*. The study was based on participant observation and in-depth interviews carried out between 2004 and 2007 with 53 women, as well as doctors and nurses, in northern Veracruz. Results show that the close association of government policies with medical practitioners serves to constrain women's reproductive decisions. Medical practitioners use this association to promote the state's concern for family planning, unintentionally disempowering their target population. This article uses a political economy of fertility framework to look at broader processes affecting women's choices beyond the personal or domestic level. Such a framework allows us to analyze these connections and place women's reproductive rights within a larger struggle for human rights and dignity.

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Introduction

Development is one of the most powerful forces of change in the late 20th and early 21st centuries, often irretrievably changing the lives of small-scale populations. In many cases the spatial, conceptual, and experiential gap between planning and implementing policies induces profound, fascinating, and sometimes devastating changes for entire societies, families, and individuals. These fractures in daily life play out along many facets, and gender is often one of the most profoundly affected areas. From microfinance projects in Bolivia causing greater debt (Brett, 2006) to the training of traditional birth attendants in Nepal that generalizes local culture and development itself (Pigg, 1997), the implementation of development projects is a bumpy process, where the "structure [enters] into the fluid set of possibilities that exist locally" (Pigg, 1997: 282).

Development programs in Mexico are no different in their local implementation. My research offers an extraordinary case study of the synergy between development programs, medical practitioners, and population policies. I show how population policies are reproduced and inscribed on women's bodies to turn them into good citizens (Laveaga, 2007) and good mothers (Molyneux, 2006). Building upon works by Browner (2000) and Maternowska (2006) I explore the institutional constraints and unintended consequences of population and development policies on women's reproduction. Because "women's reproductive activities are neither wholly free nor completely constrained" (Browner, 2000: 784) we must elicit the layered/scalar factors that interplay in women's choices and strategies—by focusing on women as agents within larger social processes and institutions.

Development programs have increasingly been the objects of critique by academics (Greenhalgh, 2003; Manderson & Whiteford, 2000; Molyneux, 2006; Singer & Castro, 2004) particularly because of the disconnection between planning and implementation and the unintended consequences on local arenas this entails. An important concern in this discourse is to study and assess the

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process of decision-making, the actions of and influences on decision-makers, and the impact of policies and development on human lives (Singer & Castro, 2004: xiii). Critics of development challenge the assumption of the level playing field by analyzing the consequences of development projects that fail to recognize local ethnic and national identities (Manderson & Whiteford, 2000). Many studies have shown the pitfalls of assuming the existence of a level playing field; for example, Castro and Marchand-Lucas's (2000) work on breastfeeding patterns in France illustrates the disconnection between WHO policies encouraging exclusive breastfeeding and the lack of information and support for mothers that leads to low breastfeeding rates.

In the larger politics of reproduction women's bodies are a battleground, where population and reproductive policies created in elegant city offices are executed in a blanket fashion on populations that are invisible, except for their "development" potential. Women's bodies become tools for government control. These policies inadvertently affect local populations because of unforeseeable issues at the local and regional levels created by the various actors involved.

There has been a significant amount of research in the social sciences regarding the control of women's reproduction through national and global health policies (Browner, 2000; Castro, 2004; Maternowska, 2006; Nazar, Zapata, & Vázquez, 2003), which discuss the oftentimes uneasy relationship between the local context and the larger policies and politics influencing it. Browner (2000: 775) suggests that we must understand how structural and cultural factors act together to influence the dynamics between women and their reproductive activities. These structural and cultural factors exert great influence on key aspects of the reproductive behavior of certain groups in society.

Ginsburg and Rapp (1995: 1–2) place reproduction within an analysis of politics and social theory wherein "cultures are produced (or contested) as people imagine and enable the creation of the next generation." Their analysis shows how global and national policies are framed within the discourse of "appropriate" and "modern" forms of reproduction. These policies attempt to standardize their target population's practices while privileging western ideas of the "appropriate" childbirth, pregnancy, or mothering. As they point out, many of these policies efface the centrality of women to reproduction, thus failing to acknowledge their effect on women's lives and communities. An important point they make is that reproductive rights are culturally and historically located, which should force us to reflect on the often-ethnocentric assumptions of social policy and the convictions of our "correctness."

A political economy of fertility framework is rooted in anthropology and moves demography from a static discipline of statistics and quantitative patterns to a significantly more dynamic one that incorporates the nuanced processes affected by culture, history, gender, and power (Maternowska, 2006: 38). While individuals' decisions are taken into account in reproduction, it is the role of institutions—such as population and development programs—that becomes central to understanding how those individuals frame and choose certain reproductive pathways. Maternowska (2006: 38) argues that this framework provides "a much-needed, vital, and dynamic view of how fertility patterns, behavior, and trends [can] be explained by both micro and macro forces over time". Such a framework allows us to look at broader processes affecting individuals', and in this case women's, choices beyond the personal or domestic level.

Greenhalgh (2003: 197) uses the term "social categories" to refer to quantitative data that are embedded in governmental technologies for population surveillance, management, and restriction in order to effect direct interventions in the domain of the social. Such efforts frequently are blind to the local level problems and realities. Though, as Green (1989) reminds us, it is important to distinguish between the *intent* and the *effects* of development programs. This observation becomes even more relevant in the face of the many evaluations of development programs operationalized in a top-down manner by external evaluators not familiar with local concerns (Skoufias, 2005). I focus on one such program implemented in Mexico, *Oportunidades*, which unintentionally constricts women's reproductive choices. *Oportunidades* (Opportunities) is a form of social welfare that has been readily hailed by people in the development field as a success story. Because of this success, it has been used as a model for other development programs around the world (Medlin & de Walque, 2008) to create change in people's behaviors through potentially coercive conditionalities. In a paradoxical manner, *Oportunidades* was created as a tool of empowerment, yet in its local implementation it often disempowers the very population it seeks to empower.

Oportunidades is a conditional cash transfer program aimed at alleviating the poverty of participating women by focusing on health, nutrition, and education. It provides women with bimonthly cash grants for their family's benefit. As part of its conditionality, women and their families must receive regular medical check-ups and their children must attend school. If these conditions are unmet the women are removed from the program (Skoufias, 2005; Smith, 2006).

Childbearing is a legal right in Mexico, which is coupled with the right to family planning (Braff, 2008; IIJ, 2008). The Mexican government uses the official discourse of family planning to promote women's rights, as per the 1994 Cairo Conference. In recent years this rhetoric has been accompanied by an increase of family planning programs among the most marginalized populations. This policy is viewed as a strategy to fight poverty (Nazar et al., 2003: 6). The Mexican government has had deep-seated fears of underdevelopment and overpopulation of the poor. It has identified contraception as the ideal means to modernize Mexico and move away from "stereotypical" behaviors, including having too many children. But, as Laveaga (2007: 29) expertly informs us, the massive campaigns emerging from this fear reinforced racial and class divisions; they created the concept of an ideal, modern citizen by building on the notion of eugenics, either through education or through selective health policies.

Oportunidades places no official reproductive conditions on participating women. One of its main conditions, however, is for women to attend medical clinics as patients, particularly regarding *autocuidado*—looking after one's health by following medical orders. The doctors, who are the enforcers of women's fulfillment of *Oportunidades's* conditions, have conflated compliance with *Oportunidades* with a compliance with their medical orders (which include family planning). In short, because the women have come to depend upon the regular cash stipends as guaranteed supplementary income, they are unable to oppose the supervisory medical staff, specifically when the latter use the conditions to promote the overarching family planning plans of the Mexican National Population Council.

In this article I explore the politics of reproduction of indigenous Mexican women by using a political economy of fertility framework (Maternowska, 2006: 10) to explore how seemingly innocuous programs, such as cash transfer policies, shape women's reproductive choices. I also offer a critique of development regarding "technical fixes that evade deeply political questions." Specifically, my purpose includes the following: (a) to examine the clash between women's perceptions of *forcible* interactions and the medical staff's use of *insistence* and a *joking relationship* to implement policies; (b) to show how the implementation of

development programs often goes awry on the ground; and (c) to illustrate the intersections between medicine, economic development, and the state on women's reproductive freedom. Though men play a very important role in women's reproductive decisions, in this paper I have moved beyond an analysis of gender relations, focusing instead on the larger structural processes that interact to constrain women's reproduction.

I would like to make it clear that my analysis of the data as well as my conclusions do not stem from an overly romantic, pronatalist viewpoint that eschews family planning and contraception options for women. Nor do I mean to imply that indigenous women have no agency at all; instead I suggest that despite local negotiations, indigenous women of Mexico still live within a system that implies that they cannot, or will not, control their own reproduction and thus the state (or another authority) needs to do it for them (Maternowska, 2006). As Paul Farmer (2006: xiii) states, "It is important that those seeking to improve services to the poor understand how class works in a society traversed by such steep grades of inequality."

Methodology

The indigenous populations of Mexico have been historically marginalized, both physically and socially. As a group, they have the lowest access to resources, education, health services, or agency in the country (Ruvalcaba, 1998). The majority of Mexico's indigenous population is either rural or part of the urban poor, with only a handful having political or social presence in the country. Mexico has slightly over 10 million indigenous people, about 10 percent of the population (CNDPI, 2006). The Nahua are the largest indigenous group, with approximately 1.5 million speakers spread over several states. Veracruz has about 340,000 people who speak Nahuatl, which is slightly over 50 percent of the state's indigenous population (INEGI, 2001). Northern Veracruz has one of the highest densities of indigenous populations in the state (Ruvalcaba, 1998).

Amatlán (a pseudonym) is a 600-person Nahua village in the municipality of Ixhuatlán de Madero (Fig. 1) where I carried out ethnographic research during 2004, 2005, and 2007. The people primarily make their living by maize agriculture and small-scale cattle ranching. A single, unpaved road leads into the village from the main highway that connects the municipal head of Ixhuatlán de Madero with Llano de Enmedio, a small town with a new public hospital.

During the 13 months I spent in Amatlán I lived in the home of Esperanza and her family, which gave me the opportunity to participate in people's lives more intimately and to establish the much-needed rapport to broach the delicate topic of reproduction. I explored this topic through participant observation and semi-structured/unstructured interviews with 53 women of reproductive and post-reproductive age. We discussed a variety of topics, including contraception and family planning, pregnancy and birth, and the medical health care received at the local clinics. I also spoke with the five village midwives about their practices and the effect of change on their activities.

I also conducted over 70 hours of observations and/or semi-structured interviews with doctors ($n = 3$), nurses ($n = 5$), and patients ($n = 58$) at two clinics (in Tepatepec and Ixhuatlán de Madero) and one hospital (in Llano de Enmedio). I carried out the interviews in the clinic setting—in the waiting areas, examining rooms, and doctor's offices. Informed consent was obtained from all adult participants. I analyzed the data using pile sorts and focused coding. The research was carried out under the auspices of the Institutional Review Boards of the University of Illinois at Chicago and the University of Notre Dame, USA.

Over the past few decades the two changes with the greatest impact on the women's health have been the introduction of medicine in the form of public clinics and hospitals as well as their enrollment in *Oportunidades* in 2000. In the region of Ixhuatlán de Madero, the clinic and hospital are considered to be the authority regarding reproductive health and as such the most "modern" choice. The women in Amatlán receive on average $800 pesos (around $70 dollars) per month under *Oportunidades*, which frequently comprises more than 50% of the family's income and is thus of great necessity for people who are inexorably moving toward being part of the market economy and the globalizing world (Smith-Oka, 2008; Smith, 2006).

Results

Several key themes continually emerged in my interviews and observations: (a) women's responses to their interactions with medical staff and their perceptions of the forcible nature of medical procedures, (b) the nurses' use of strong language and insistence to highlight ethnic differences and obtain women's compliance with the procedures, and (c) the doctors' (mis)use of humor and bonhomie that eroded women's beliefs and resolve.

Women's concerns with coercive procedures: "At the clinic they force a lot"

Much of the lack of reproductive freedom for these women takes the form of coercion. Research on the control of people's health usually focuses on ideas of hegemony or domination. But for the women in this study it is about who controls their body politic, a process over which they have no choice. I refer to this process as coercive, because within coercion is embedded the idea that any resistance expressed by the women will have significant negative consequences. Coercion also includes manipulation and implied threat, as Esperanza told me, "They forcibly sent [that woman] to be sterilized because she has too many children… The doctor says we should only have two children."

Over 30% of the women I spoke with stated that they—and their acquaintances—felt forced in their personal interactions with the medical staff. Without fail all the women felt that the medical staff compelled their patients to follow their directives and procedures. The women described their interactions with the doctors and nurses using phrases such as "*a la fuerza*" (through force or coercion) or "*nos obligan*" (they obligate/compel us). These words were not limited to describing reproductive health; instead all interactions with the medical staff had forcible tones embedded in them.

When asked why the medical staff forced or compelled them, most women referred to ideas of inconvenience or laziness: they thought that the doctors/nurses felt inconvenienced by having so many people at the medical centers or that the medical staff wanted to work less and so preferred a smaller client base. For the women these ideas frequently resulted in them feeling coerced to have smaller families and undergo certain procedures, such as sterilizations or insertion of an intra-uterine device. In the women's minds these procedures were solely to benefit the medical staff and make their lives easier; the women did not see much benefit to their own lives.

Even though many of the women have resisted the pressure from the medical staff, they perceive that there is a culture of force in the medical settings. This perception arises from their interactions with the doctors/nurses, consisting of almost endless haranguing urging them to be compliant: "Yes, they do it forcibly… The [staff] at the clinic tell us and tell us not to have more children… They tried to convince me three times to be operated [on]. But I did not want it. But they forcibly send other [women] to be

Fig. 1. Map of northern Veracruz showing the location of Amatlán.

operated [on].'' So even if a woman feels she has managed to resist (''I tell the doctor not to force the women to be operated on''), she knows that for others such resistance has not been effective. They know that it is only a matter of time before they have to undergo something they do not truly want, simply because of a wearing down of their resistance.

The medical staff is very aware of this coercive interaction and uses it to their advantage. Doctora Felipa said to me, ''The women are forced to come in [because of *Oportunidades*]…'' Once they are in the medical setting other factors help the staff to make a patient compliant, such as refusing them treatment if they do not allow the staff to give them a check-up.

Nurses' insistence: ethnicity plays a role

Ethnicity—indigenous or *mestizo*—plays an important role in determining women's decisions. *Mestizo* can either refer to someone who is of mixed ancestry (indigenous and European) or, most frequently, as someone who has lost or eschewed indigenous cultural traits for the mainstream Mexican ethos. In this definition, even someone who has indigenous ancestry but no longer identifies with that ethnicity is a *mestizo*. Without fail all of the doctors at the clinics and hospital are *mestizo*, they do not speak an indigenous language and they emphasize through their language and actions the cultural and class divide between them and their indigenous patients. Though several of the nurses were born in indigenous villages they consider themselves *mestizas* by the sheer fact of education and cultural distance from their patients. A *mestizo* is considered to be more educated and ''enlightened,'' and hence with greater authority and power.

> ''We tell them that the condom exists. They do not accept it because they are ignorant. They hear stories from other people; [they say] that they bleed with the IUD, or that their husband does not let them. [But we tell them that] they do not need to ask permission; [that] it is their body. But these are just excuses, and then a while later they appear with more children…''.

Brenda, a nurse from Llano de Enmedio, said this to me when we discussed the reasons for the reticence to use family planning among her female patients. Though she is local and speaks Nahuatl, she distances herself culturally from her patients—she identifies herself as *mestiza* while they are indigenous.

All the medical practitioners are unequivocally concerned with women's high fertility and the effects this can have on their lifestyle. Consequently they implement the Mexican national family planning program with great zeal every time a woman comes in, even if her health issue during those visits is unrelated to reproduction. Frequently a woman agrees to accept family planning, yet this choice happens within the confines of limited choice. As one of the nurses stated:

> "We have the duty to inform them about contraception every time they come in…because the greatest benefit [of contraception] is to have a better quality of life. […] We do not force them [to contracept] because it is a free decision. We simply insist again, until the woman finally wishes to [use it]."

The women's ability to make choices about their reproductive bodies is constrained by the link between *Oportunidades* and medicine. Fig. 2 shows how the nurses, as medical practitioners who monitor the women's compliance with *Oportunidades*, use their authority to persuade the patients to follow birth control and sterilization. As Matilde pointed out to me as she prepared lunch for her children, "The doctor gets angry and tells the [women] to be sterilized, that we shouldn't have more children. The nurse gets very angry and she even shouts. She doesn't like so many [people at the clinic]." Esperanza told me later,

> "If one does not go to the appointment they take away [*Oportunidades*] […] that is why you see those women who have lots of children going every day [to the clinic…] The women have to go or they take away their [*Oportunidades*]. Their file would be unsigned (they have to sign to indicate their attendance) and then if someone checks and it is empty they take away her [*Oportunidades*]."

In these settings, the nurses are in charge of executing the conditionality of *Oportunidades* and are therefore capable and authorized to influence and even make decisions about the women's bodies. As Juana stated, "And one has to go because if one doesn't get to the appointment one is scolded at the clinic… Yes, they just scold us, they scold us a lot." Since the medical centers in this region are firmly tied to *Oportunidades* and the staff has the authority to report any woman who is not complying with these conditions, the women have to follow the treatment options for fear of losing their monetary aid. This is an unintended consequence of *Oportunidades*.

I observed this same attitude in one of the nurses during her interaction with patients who had missed a previous appointment. She scolded them saying, "I tell you the requirements so don't you complain if they take away your [monetary] support. Remember that you are the ones that take away your own support." On another occasion she explained to me her role in managing women's health and attendance:

> "I do mark them as absent. They thus are forced to keep on coming, if not they would not come. I tell them that I will mark them as absent, and I follow through. Those who have more than two or three absences are automatically removed from [*Oportunidades*]. It is noted in their file. I always let them know so it does not come as a surprise. Though it is not my obligation I do let them know."

This example indicates that the use of *Oportunidades* as a tool to obtain women's compliance is not malicious, but is rather an added convenience for the medical personnel to treat the health conditions of their patients and obtain their compliance.

Doctors' jokes: taken as truth

Some of the medical personnel—particularly the doctors—have established a joking relationship with their patients. Though on most occasions their interactions with the patients were professional and formal, there were instances where they would relax and tease and joke with their patients. These jokes were a variant on the insistence present in all the medical interactions with patients. I observed several occasions where they would tease the patients about a variety of things, including their weight, dietary habits, or following *autocuidado*—all aimed at obtaining patient compliance. The statement "You are just lazy, nothing is actually

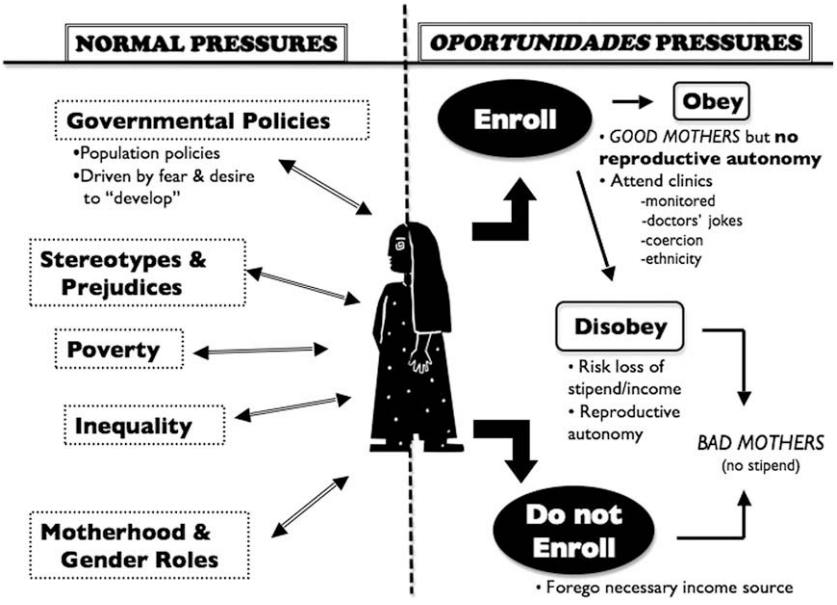

Fig. 2. Factors shaping women's reproduction and mothering.

hurting you" was not an uncommon joke. Female patients were not immune to this teasing, and would be the recipients of jokes about their money from *Oportunidades* being withdrawn, the number of children they had, the sorts of procedures they might need, or the consequences of not following orders.

The joking relationship was strictly one-sided and flowed from the doctor to the patient. The women tended to have a good sense of humor about the treatment they received at the medical center—often recounting difficult encounters or poor treatment with many laughs. However, this laughter was confined to other women in the village and was not shared with the medical staff. Laughter also served as a means of resistance—however mild—and as a venting mechanism. In the medical setting the women rarely relaxed; instead they would often be very stiff, barely speaking, and very compliant. They took the word of the medical staff to be the truth and thus when the doctors told them that they would carry out certain procedures it was not received as idle joking but as grim reality.

Dulce's case is probably the most poignant example of this; she is in her late 20s and has five children. She is also developmentally challenged. The villagers' attitude toward her is indulgent and concerned, tinged with criticism for being different. Her seeming stubbornness regarding contraception was a source of annoyance to the staff at the clinic. During one visit, one of the male doctors jokingly chided her for having too many children and always being pregnant; he said to her, "I will forcibly operate on you, even if it is right here and with a knife." Though his intention was to joke and tease her, it was a very chilling example of the power that rests in the doctors' hands.

What is often evident in the clinics and hospitals is the asymmetrical relationship between a *mestizo* doctor and an indigenous woman. In most of these encounters the women have no choice but to accept the comments leveled at them, which reflect and replicate the dominant structures present throughout Mexican society (Maternowska, 2006: 78; see also Nazar et al., 2003).

Discussion: the unintentional effects of government policies

Fig. 2 shows the interaction between the various factors that interplay to constrict women's reproductive freedom and the possible outcomes for the women. On the left side of the image are the normal pressures on the women's lives. These pressures include the government population policies (which are driven by fear and the desire to "develop"), many stereotypes and prejudices (which work against the women and categorize them as indigenous and poor, and thus ignorant), poverty, inequality, motherhood, and gender roles. Each of these shape women's decisions, the women responding to them in particular ways.

The right side of the figure shows the intensification of the normal pressures once *Oportunidades* is introduced. If the women choose not to enroll they forego the necessary income source and are classified as "bad mothers." If they do enroll they are monitored and subject to doctors' jokes and coercion, which are compounded by ethnic differences. By obeying they become "good mothers" by both national policies and local perceptions but cede reproductive autonomy to state policies. If they disobey they risk losing the necessary stipend and once again are classified as "bad mothers" for risking their children's welfare (Molyneux, 2006). These coercive development policies are attempting to standardize women's mothering practices by privileging western ideas of what is "correct" mothering and eliminating alternative meanings of motherhood. As Tsing (1990: 283) discusses, the state's primary concern is with the "vulnerable infant, endangered by its maternal environment" that must be "rescued by altruistic outsiders" by resocializing women into being good mothers. *Oportunidades* becomes the tool for this resocialization.

The interplay between the various actors and institutions I have described can best be understood through multiscaling. I find this a better term than multilevel as levels tend to imply simply one echelon/plane over another with little information about size. Scale has a great notion of size (and power/authority) embedded in it. There are interactions between agency and structure at multiple scales: the individual women and the medical staff, the medical centers and government policy makers, the *Oportunidades* policy makers, and the population policy makers. Each of these scales feeds into the others, and agency, authority, and power move ever upwards; the lowermost scale, i.e., the women, upon whom all the policies are enacted and inscribed, become the most disempowered. By disempowering women the state also makes them increasingly vulnerable to all forms of violence.

By providing money to mothers, *Oportunidades* unambiguously rests on normative assumptions regarding women's roles, with childcare naturalized as something that mothers do. In effect the money transfers are conditional on good motherhood (Molyneux, 2006: 438). Molyneux (2006: 440) doubts that women have been empowered (as opposed to Skoufias, 2005) because the program's success has been dependent on "fortifying and normalizing the responsibilities of motherhood as a way to secure programme goals." Consequently the state re-traditionalizes, and essentializes, gender roles and identities. In doing so it confirms mothering as women's primary social role and does not provide a means to sustainable livelihoods, putting them at risk for remaining poor for the rest of their lives. The women continue to exist within a patriarchal system that tells them what to do and expects them to behave in the proper maternal way. The women's rights appear to be sacrificed—and the women themselves are expected to be self-sacrificing—to the greater human capital development of their children, and ultimately the country. Thus, when we consider the relationship between social organization and political discourse, we can "clearly see the impact of ethnocentric assumptions" on women's lives (Ginsburg & Rapp, 1995: 13).

For the women in this study, the term *forcible* carries a particular connotation where they do not have to be physically threatened to consider certain medical procedures forced. The process is much more insidious than simply through use of overt coercion. These women interact on a regular basis with medical personnel in clinics and hospitals where their knowledge about health and their bodies carry less weight than the knowledge of the medical personnel. In these contexts their knowledge becomes discredited and devalued in light of the authoritative knowledge of doctors and nurses (Maternowska, 2006). Specifically, given the supervisory role granted to the medical personnel by *Oportunidades*, including the authority to report a woman who is not complying with the conditions, most women feel coerced to follow the orders at the clinic, even if the conditions of *Oportunidades* are not being violated. There are powerful sanctions (perceived or actual) at play here if a patient does not comply with the directives of the clinic. Consequently, when a doctor or nurse tells them that they should undergo certain medical procedures, the women would consider these directives coercive because the idea that they had real choices in this context is absurd (Nazar et al., 2003; Overmyer-Velázquez, 2003).

Coercive policies such as the ones I have described restrict people's reproductive freedom and rights. Modified versions of *Oportunidades* have been developed across the globe, some of which are specifically targeting reproductive health and, as such, are deeply problematic. Some of these conditional programs have focused on increasing the rate of contraception in places where fertility is high, discouraging teen pregnancies (especially among

poor or disadvantaged girls), or encouraging participants to have negative STI and HIV rates (if they acquire an STI/HIV they are removed from the program) (Medlin & de Walque, 2008). Such projects take the *Oportunidades* conditionality argument to a highly coercive point and border on targeted reproductive control and eugenics. Here the state has created a repressive means to maintain the body politic in place (Green, 1989; see also Ginsburg & Rapp, 1995). People in these contexts have lost all semblance of reproductive rights. The dangers of this sort of control are frightening.

Studies on the doctor–patient relationship have usually focused on physicians and not on support staff. But it is the latter staff that has significant effect on patient's lives and decisions (Preloran, Browner, & Lieber, 2005; Sargent & Larchanche-Kim, 2005). When the women of this region go to the clinic or hospital they interact most frequently with the nurse. The nurse is the first person they talk to, who gives them their check-up, and manages their file; she also makes suggestions about lifestyle changes, additional treatments, and follow-ups since she is also the last person whom they talk to before they leave. The nurse's most important role is regarding *Oportunidades*, since she is also the person who marks their attendance on the program's roster, making her role pivotal in women's compliance. Though doctors are considered to be the ones who are in charge and who make the important decisions, nurses significantly influence the women's lives because they interact with them to a much greater extent than the doctors do. It is through their position of authority as medical practitioners and gatekeepers for *Oportunidades* that nurses are central to the process by which the women become informed about their reproductive bodies and the eventual decisions they take regarding them.

The women's interaction with the doctors also shapes their reproduction. The women's humorous response to their treatment at the clinic glosses over their humiliation and lack of power and also removes any outrage that they feel. The humor diffuses their possible political engagement and resistance to their treatment at the medical settings. Humor calms any anger and turns the women into docile patients.

In these clinical encounters there is an existing structure based on gender (mostly male doctors and female patients), class/ethnicity (middle class/*mestizo* and poor/indigenous), and educational level (educated and uneducated). This trifecta makes it difficult for the women to have much say in their reproductive health and—by coupling medicine with *Oportunidades*—practically impossible. Thus the women's agency is frequently overruled by the structure; the benefits of one institution (i.e., economic development and cash transfer programs) are co-opted by the individuals in another (i.e., medical staff and family planning) to push their own agendas. Unintended authority emerges from this situation, and it is this authority to which the women are responding. This nexus creates the circumstances and processes that indicate a forcible undercurrent in these women's experiences within the medical setting.

Because the women cannot risk an important part of their income, they comply with the attendance as well as many of the procedures offered at these centers. The women view the connection between *Oportunidades* and the clinics as so strong that they would be unable to differentiate between the elements of *Oportunidades* that they must follow and those that simply emerge from the synergy with the clinic. The outcome of this situation is that powerful people control women's financial lives and consequently also control their reproductive lives. As Browner (2000: 784) argues, economic factors are invariably important in women's reproductive activities; these economic impediments often work in concert with cultural norms to legitimatize female subordination.

I want to clarify that my intention in this article is not to demonize the medical staff, but rather to indicate the friction and complexities intrinsic in their interactions with the women, especially in light of the entangled nature of the clinical setting and *Oportunidades*. I particularly show that the primary nature of the clinics/hospitals is to promote reproductive health through the state's population policies; yet it is their secondary function—as monitors of women's compliance—that is a stronger determinant of women's reproductive health. It is for this reason that I refer to the consequences of this synergy as being unintended rather than purposeful or eugenic (as opposed to the more overtly controlling programs I described above).

The Mexican government's commitment to neo-Malthusian ideas of population growth and modernity (Braff, 2008), and the ensuing fear of overpopulation has created a situation where the populations perceived to be the problem are poor, rural, and/or indigenous. Strong evidence suggests that in the first two years of enrollment in *Oportunidades* there is a definite increase (by 5–10%) in knowledge and usage of family planning methods, particularly among those who have the lowest income (Lamadrid-Figueroa et al., 2008).

Though I have spoken of the unintended consequences of government programs, there are some—such as population policies—that are very intentional. An example is the Post-Obstetric Event Contraceptive Program (Castro, 2004) that promotes permanent (or at the very least semi-permanent) contraception to low-income women as soon as they have given birth. The intent of such policies is to prevent certain segments of the population from over-reproducing. It is the combination of these intentional policies with development programs—such as *Oportunidades*—that creates the unintentional effect of reproductive constraints and disempowerment evident in these women's lives.

The government fears are manifested in policies that demonstrate the deepest notions of power, where the most marginalized become the target of these population policies. Their noncompliance is quickly ascribed to culturalist explanations of the ignorance and obstinacy of the indigenous poor. For this reason, the state (and its many arms) perceives itself as the only entity that can control these women's obstinate reproduction. The belief holds that if these women are far too ignorant to know what is best for them, then the state needs to do it for them (Farmer, 2006; Maternowska, 2006).

The state's perceptions of the ignorance of rural indigenous women are compounded by the opinion of their excessive fertility, as one of the doctors I spoke with said, "It's just that the woman of the countryside is very fertile; she has many children. If you take away these women's contraceptives, by the next month they are pregnant. Not in the city, there the women even take six months for their body to get rid of the toxins, but here they become pregnant immediately." This comment is similar to one made by one of the nurses, who said, "Because a short while after [giving birth] they are pregnant once again. They say they don't menstruate for months but they don't realize and they are already three months pregnant" (see also Braff, 2008). These perceptions shape the interaction between the doctors, the nurses, and the women who come to the clinics and hospitals. The medical opinion is that in order to protect the women from their high fertility (and to protect the country from the mouths of the poor), they have to be encouraged to use contraception (and especially to be sterilized) so that they can lead richer and more fulfilling lives, by enjoying their newfound sexuality without the consequence of children. They can become modern (see also Greenhalgh, 2003; Laveaga, 2007).

These policies show the concern that the Mexican government holds regarding population growth. Even though the population growth over the next 50 years is projected to gradually taper off with the country reaching a negative population growth, the government continues to be fearful of high population (CONAPO,

2004), so much so that it has effectively introduced a new form of birth control veiled as a social good. These fears are not aimed at the population in general but rather at those that are more economically vulnerable, i.e., the poor, the rural, and the indigenous.

Conclusions

Drawing on ethnographic data I have sought to develop a grounded understanding of the unforeseen complexities emergent in the interaction between *Oportunidades*, medicine, and indigenous women's decisions about reproduction. The multi-scaling present in these interactions shapes the women's reproductive lives and decisions. All these scales—domestic, local, and national—work synergistically to form a system that the women have to negotiate in their reproductive lives. None of these factors exist independently of each other, particularly because of the women's enrollment in *Oportunidades*, which requires their involvement in larger processes (medical and educational) outside of their community.

Unintended consequences emerge when *Oportunidades* is implemented by the linked groups—the clinics and hospitals. Because these linked groups are also acting under the rubric of national population policies, both of these programs become coalesced in the clinics/hospitals and directed at the target population of indigenous, rural women. This process furthers the authority of medical practitioners by making them the monitors of the women's compliance with the *Oportunidades* conditions. The staff controls women's access to *Oportunidades* as well as to medical techniques, which makes them doubly powerful in this context. As Browner (2000: 782) informs us, "Larger contexts that are both structural and social, and within which cultural values offer resources and opportunities as well as constraints and limitations, shape women's reproductive activities."

This evidence shows how the control over women's reproduction is contested by all parties involved. The women's bodies are a contested state that they have to negotiate every time they go to the clinic. The well meaning but patronizing attitude of the medical staff, backed by the perceived or real threat of the loss of their *Oportunidades* money, erodes the women's control over and ownership of their body. Were it not for the cash transfer in *Oportunidades,* the medical practitioners would not have as much power. Instead the women would have more agency; now they have no choice but to go to the clinics and bear the consequences. The choice is to be a "good" mother or a "bad" one. The loss of the *Oportunidades* money is neither an idle fear nor an imagined threat for the women.

Though part of the population discourse revolves around the increase in women's well-being (Molyneux, 2006; Skoufias, 2005), there is evidence that there is no strong positive relationship between their well-being and the adoption of family planning programs (Nazar et al., 2003). Instead, the sometimes coercive population policies undermine women's autonomy and lead to their disempowerment.

A deep revision to these population and development policies must take place in order to return agentive control and dignity to the indigenous women. As Brett (2006) states, this revision needs to shift from an evaluation at the macro/institutional level to one at the micro/household level to identify the forces and factors that condition women's success within development programs. This revision is particularly important considering how successful such programs are regarded in development circles and how likely it is that *Oportunidades* undermines various arenas of the women's lives beyond health. Without such revisions the future consequences of these programs could be incalculable. Thus we need more studies that explore the unintended impacts of conditional cash transfers on health and beyond in order to reveal the nuances—economic, political, social, or moral—that shape people's lives. Such evidence needs to be included in future social reform and policy-making in Mexico and elsewhere.

By applying this research to practice, as researchers we can align ourselves "as advocates of the people [we] are studying while effectively engaging [them] as able agents of change" (Maternowska, 2006: 161). Thus the understanding of the women's choices regarding their health has to take place within this dynamic layering of domestic, local, national (and even global) scales. These competing and complementary realities of the local through the global can highlight the ways that health and development policies can be introduced and developed for the greater benefit of local, indigenous populations, while simultaneously addressing reproductive rights as part of the larger struggle for human rights.

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