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## ONE Taming Men's Natural Desires in Oaxaca

At the bedrock of our [Western] culture's thinking about sexuality is the assumption that a given pattern of sexuality is native to the human constitution.

R. W. Connell and G. W. Dowsett (1992:50)

"Well, you know, they did it to *me* a few years ago. . . ." That is how I began my interviews with men who wanted vasectomies in Oaxaca, conducted during their operations. It seemed to break the ice and get the men talking. They told me why they decided to get sterilized, about discussions they had had with their wives before the procedure, and, invariably, about anxieties as to what would happen with their postoperative sexual desire and performance. Sometimes a man would get jumpy and I would excuse myself. The last thing the poor guy needed was to be interviewed, I assumed. But the doctors and the men themselves would insist, "No, stick around!" I became the anthropologist-as-emotional-anesthesiologist.

Vasectomies were not common in the mountainous provincial capital of Oaxaca, in southern Mexico. But I was not looking for common men—

whatever that term might mean. I wanted to know why men who got sterilized decided to do so. The answer turned out to be deceptively straightforward. For many, if not all, of the men I spoke with in Oaxaca, the most common explanation for getting vasectomies was that their wives had already suffered enough—taking birth control for years, getting pregnant, giving birth—and now it was their turn. When I asked these same men why they had long relied on their wives to use contraceptives in the past, and why they had not used a male form of birth control, the men responded with a simple incredulous question: “Like what? The condom?” In Oaxaca, as elsewhere in the world, most artificial, modern forms of contraception—and all the most reliable ones—are for women. The men asked me if I thought they had much of a choice about what form of birth control to use. I responded honestly that the choices available to the men of Oaxaca were part of a larger picture that involved, among others, the international pharmaceutical industry that develops and manufactures birth control devices and medications. Unless a modern contraceptive is made and marketed by these companies, it will not be available in Oaxaca or anywhere else in the contemporary world.

International pharmaceuticals were also involved in the lives of other men I spent time with in Oaxaca, those who traveled to the United States as migrant workers, became infected with HIV while living there in new labyrinths of solitude, and returned home, whereupon they infected wives and girlfriends. When I lived in Oaxaca on and off in the period 2001–05, fewer than two hundred men and women received the life-saving antiretrovirals manufactured by the multinational drug companies and sold to the state-run clinic in Oaxaca. Unlike some countries in the world, in Mexico the government health sector paid the pharmaceutical companies top prices for AIDS medications. As a result, thousands of men and women in Oaxaca who were HIV+ or had AIDS were inevitably going to face premature deaths, many without ever knowing what disease was killing them. I spent time with these dying patients, and I attended the Wednesday-morning meetings with the medical personnel where decisions were made about exactly which men and women would be given the drugs and who was doomed to an early demise.

In Oaxaca, doctors said the migrant men had become infected with

HIV after having sex with other men in the United States. When I asked one doctor how he knew this and why he was so sure, he told me, "That's what Mexican men do: they have sex with other men." When I asked him if he had sex with men, he looked startled. When I asked if his father or brother or son or uncle or neighbor had sex with other men, he began to get annoyed. It turned out that a lot of what passed for knowledge in this realm was based on common sense and cultural folk wisdom. The notion of "men's natural sexual desires" was blamed for a host of health problems like AIDS in Oaxaca. And if these generalizations were not necessarily accurate for all men—"That's just the way men are!"—then at least they were true for men who grew up in Mexico. Mexican culture and Mexican male culture were considered the culprits in many a Mexican medical schema.

Surprisingly to me, the medical people who seemed least taken with dichotomous views of men's sexuality and women's sexuality as entirely and naturally distinct were the men and women who called themselves traditional indigenous midwives and healers. From these *médicos tradicionales* I also heard of techniques that women can employ to keep their men from straying, and I learned why men go on sexual diets after their wives give birth. In distant rural communities along the coast and in the mountains of the state I often discovered a far more expansive and self-conscious understanding of what culture means for the diagnosis and healing of illness than I heard in the various biomedical clinics in Oaxaca City where I spent time.

My arrival in Oaxaca coincided with efforts launched from Mexico City—and the implementation of an earlier 1993 report by the World Bank—ordering that health care throughout the country be further privatized and decentralized. These stringent measures further exacerbated an already inadequate situation in providing care to those most in need, which in Oaxaca nearly always means the nearly two million indigenous people, most of whom live in poverty and some in extreme poverty. The conditions of poverty and miserable health care are the same as those that propel so many people to try their luck as migrant workers in the United States. Seen in this context of scarcity and suffering, issues of impotence, infertility, and infidelity among men might seem inconsequential. I can

only affirm that none of the men and women with whom I spent time in Oaxaca from 2001 to 2005 belittled my questions about sex, birth control, and AIDS.

#### MEN AND WOMEN TAKING POLITICS PERSONALLY

Many studies on reproduction to date have focused on women. This book provides the stories of certain "missing" players in most accounts of the reproductive process. Nonetheless, rather than compound the error of viewing the essential (though certainly not universal) human activity of procreation as a matter of *either* women *or* men, this study examines negotiations between women and men with respect to men's reproductive health and sexuality, as part of a larger effort to address questions of gender differences and inequalities in line with expanding notions of gender and sexuality.

Important steps have been made since the early 1970s in understanding women and gender inequality in a diverse range of cultural situations. There are still few parallel studies of men. For example, we do not yet have a clear understanding of how men in different cultural contexts utilize formal and informal health services, including with respect to contraception, AIDS care, and other matters of reproductive health. My purpose here is not to replace studies of women with those of men or even to suggest that studies of men should be seen principally as a complement to studies of women. Instead, in *Fixing Men*, I argue that studies of men's reproductive health and sexuality must be developed as central to understanding gender relations overall. This is because men, too, are engendered and engendering beings.

When I use the term *gender*, I refer not just to women but also to men, and to the ways in which differences and similarities related to all human physical sexuality are understood, contested, organized, and practiced by societies. With Susan Bordo, in studying men as engendered and engendering, I am especially interested in "the 'direct grip' (as opposed to representational influence) that culture has on our bodies, through the practices and bodily habits of everyday life" (1993:16), including here in

relation to birth control and sexually transmitted infections (STIs). How is culture inscribed on male bodies through beliefs and practices associated with their sexuality? And more pointedly for the present study, how do women as themselves gendered and engendered beings affect men's sexualities?<sup>1</sup>

Unless we understand the subtle cajoling, the vehement rage, and the abject frustrations of daily interactions—to say nothing of love—between women and men in households throughout history and in different cultural milieus today, we will continue to analyze intimate gender relations simplistically. Until we view such everyday interactions as productive and not simply reductive sources of culture change, we will persist in underestimating intersubjectivity as a basis of socially significant collision and collusion. The shifting moods and sentiments of men and women are indicators and also, potentially, critical catalysts imparting novel ways of understanding gender identities and relations, and, sometimes, new manners of living together as women and men in households and society.

*Fixing Men* develops these arguments through ethnographic portraits of three topics related to men's reproductive health and sexuality in Oaxaca—AIDS, vasectomy, and traditional medicine for men. In chapters on these subjects, and others that focus on the theoretical issues of men's sexuality and the history of family planning in Mexico and Oaxaca, my aim is to address five interrelated issues.

Although women have been conceptually “denaturalized” and biology and destiny disengaged in feminist and other writings in the last several decades, attributing ubiquitous and uniform qualities to men's sexualities is still curiously in fashion. In this book I ask why such commonplace notions of male sexuality persist, in Oaxaca and elsewhere, and examine why men's sexual desires and activities are treated as if these were “natural” and uniform among all men in the state, despite the fact that even many medical practitioners seem to accept same-sex desire among men as sufficient proof that men's biologies do not dictate their sexual destinies.

A second area of attention relates to the negotiations between men and women as couples, especially with respect to birth control and safe sex practices to protect each other from HIV. In academic gender studies, women's participation in the construction of masculinities and practices

associated with these identities has been extensively discussed in the literature of mother-son bonding, Oedipal conflict, and mother-son estrangement.<sup>2</sup> Yet I think we need to challenge the tacit assumption in the social sciences that women have a negligible influence on males beyond infancy and childhood, and that male identities and practices are necessarily and uniformly grounded in homosociality alone, that is, in the identities and relations of men among themselves. On the intimate level of families and households, for example, we know too little about how women and men discuss, debate, and decide on sexual behavior and make reproductive decisions. And in general scholars still lack detailed information on how changing affective relations between men and women in turn alter cultural values concerning reproductive health and sexuality.

The research for the present book evolves from previous studies of mine focused on changing masculine identities and cultures in Mexico City and extends an earlier examination of the ways that couples cope practically with sexuality, childbearing, and child rearing.<sup>3</sup> In Oaxaca, one of my aims was to learn about women's relationship to men's reproductive and sexual lives and decision making around contraception, and in this way gain new insights into the ways through which men and women enact and transform gender relations rooted in power disparities.

Because I wanted to carry out most of the research in clinics, where different people come and go every day, there were certain inherent limitations in my ability to develop long-term relationships with patients, though of course I spent much time with the same doctors, nurses, social workers, psychologists, and other medical personnel. Thus, when I wanted to document and chart negotiations in couples about birth control and sexuality, I was obliged to rely more than I wanted on what people remembered and were willing to share with me about their histories of using contraception, deciding when to get pregnant, and associated events. And, truth be told, I started my research with the somewhat unrealistic expectation that I could "isolate" the process of decision making in couples by learning of the specific events and discussions and personal histories in their lives. Nonetheless, decisions about what forms of birth control to use, how many children to have, the spacing of children, and

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A variety of contraceptive methods promoted on wall in San Agustín  
Tlacotepec in rural Oaxaca, 2002.

where to give birth cannot be understood as decisions made in isolation from the larger issues of political economy, cultural prejudice, and social networks. I knew this in a general sense, of course, but I had to bang my head against a few walls in Oaxaca for the implications of the broader political and economic influences and constraints to become more clear for me. In this book I trace how I came to understand these decision-making processes that appear so personal and yet clearly are so intimately linked to broader social pressures and restrictions.

The third theme I address in this book concerns a process known as medicalization, and here I am especially interested in the medicalization of men's sexuality. Among health care specialists and the population at large several beliefs concerning male sexual practices and urges that have little basis in biologically established fact nevertheless become enshrined as scientific truth. In this process of medicalization, men's sexualities are pathologized; it is taken for granted by many medical practitioners that men's sexualities are more or less similar, that men are in some sense "controlled" by their sexualities, and that their sexualities are

innately problematic. Further, in considering health problems associated with male sexualities, like impotence and infertility, a medicalized model considers as secondary broader social and political relationships—for example, between women and men and between men themselves—and instead accentuates what are considered individual bodily malfunctions and abnormalities, for example, a lack of sexual desire on the part of men. This study considers the ways such ethnomedical beliefs among biomedical personnel about male sexualities are grounded in folk wisdom yet presented as innocent scientific truth, and the relationship of medicalized thinking about male sexualities to broader questions of sexual reproduction and women's sexuality.

Yet as injurious as medicalization models of diagnosis and treatment may be, an even more pervasive and pernicious problem for the world's health is, as Lock points out, globalization, characterized in part by a process in which "people everywhere adopt the concept of risk and become familiar with the disease nosologies [the classification of ill persons into groups] of biomedicine" (2001:483). As we will see in the chapters to follow, it is impossible to understand AIDS in Oaxaca without a broader, global analysis of international migration, multinational pharmaceutical companies, multinational religious institutions, and foreign health agencies. It makes equally little sense to talk of birth control in Oaxaca absent broader discussion of many of the same global institutions and agencies.<sup>4</sup> Globalization is therefore the fourth topical thread in this study. Studying reproductive health politics (around contraception, AIDS, and other issues) requires an appreciation of the international interests and involvement of governments and private organizations in the cultural construction of sexual realities and meanings. The fact that between 1920 and 1950 numerous medical doctors and anthropologists became involved in the international eugenics movement—in the process finding "Mexico's various poor populations (from rural Indians to urban workers) as comparatively deficient" (Lomnitz 2001:139)—is but one historical illustration of how global trends and pressures have influenced reproductive health in Mexico.

## MEXICAN MALE CULTURE

The fifth and final theme that spirals through this book is how culture is used to explain, blame, maintain, and extend banalities about men's reproductive health and sexuality in Oaxaca. Comparisons with earlier platitudes about how women in such a Catholic country would never adopt contraceptives in large numbers are irresistible. Several decades ago, before family planning programs were launched in Mexico, "culture" was similarly invoked as an insurmountable obstacle to family planning, both because the purportedly dominant cultural ethos of machismo prescribed that couples had to go forth and multiply and because of Catholic doctrine that disallowed artificial forms of contraception that could limit the future progeny of the church.

As we will see in chapter 5, however, the actual historical role of the Catholic church, and the actions of tens of millions of Catholic lay women with regard to artificial birth control, present us with a far more complex picture. Total fertility rates plummeted in Mexico from around seven births per woman in 1955 to women having between two and three children, on average, forty years later. This rapid decline in the birth rate commenced in the 1970s, when the Mexican government abruptly shifted from a pronatal ideological stance to active family planning policies and rhetoric. When given the opportunity, people in Mexico have availed themselves of contraceptives, and birth rates have tumbled as a result, despite the fact that life expectancy rose from fifty years in 1955 to almost seventy-five years in 2005. Somehow, "Mexican culture" survived the mass expansion of modern forms of birth control.

In part, "Mexican culture" survived because it never existed in the first place. What I mean is that there has never been a single, homogenous Mexican culture. Nor is it helpful to talk of a uniform Mexican female culture or a typical Mexican male culture. Yet culture is often blamed for a variety of sins, as when *la influencia cultural* is blamed for the fact that few men in Mexico get vasectomies or when it is claimed that many if not most men in Mexico have sex with other men at some time in their lives. Lest this seem far-fetched, an e-mail message I received from an official of the U.S. National Science Foundation in 2003 invoked precisely such

sweeping (and inaccurate) cultural characterizations about Mexican men, and is worth sharing here. In response to a query of mine asking about possible funding for a project comparing differential vasectomy rates in various parts of the world—why they are substantially higher in China and the United States than in Mexico, for example—the official seemed to have already cracked the mystery: “There should be some interesting cross-cultural differences, for example between machismo and non-machismo cultures (Brazil, Mexico, Spain vs. China & US?).” It would seem that in the opinion of this official, whether men in different countries get sterilized can be explained by reference to national cultural traits, as in, Brazilian-Mexican-Spanish “machismo cultures.” Such a notion of national cultural traits is obsolete and this argument diminishes obvious and widely known factors of government involvement (or lack thereof) in family planning campaigns, for example, the one-child policy in China.

In a sense, notions of macho/non-macho, active/passive, traditional/modern gender dichotomies in Latin America are nothing new (see Gutmann 2003a). Confusion about macho and non-macho cultures is really just an illustration of a larger misunderstanding that says “traditional” men approach reproduction and sexuality differently than “modern” men. The polarity traditional/modern makes as much sense with respect to men as a group as does active/passive with regard to sexual behavior—that is, not very much at all. There is no such thing as a traditional man and there never has been, despite the fact that the term “traditional man” is frequently used as a shorthand to describe what are presumably a consistent set of attitudes and practices associated by the labeler as premodern—for example, if men want many children or if men do not utilize some form of modern, artificial birth control. Among the many problems with this formulation is the fact that it is rooted in stereotypes of imagined social relations and ideologies from the past, far more than it is grounded in actual knowledge of these phenomena. To speak of traditional men implies that they are people who come from a changeless and uniform cultural milieu, in comparison to those men involved in the rapidly transforming “modern world.”

This traditional/modern man dichotomization is particularly harmful for the analysis of men, sexuality, and reproduction because it can easily

lead to false assumptions about men's sexual relations with women (some might describe a man as sexually traditional if he shows little concern for women's sexual pleasure) or about why men may not practice birth control (it might be held that traditional men are less willing to use certain forms of contraception). Such a conceptual framework fails to incorporate diversity, change, and contestation among the very populations we late-modernists too haphazardly brand as traditional, even as we make unwarranted assumptions regarding the sexual proclivities and practices of our own families and friends. We await a well-grounded study of the modern sex habits of members of university communities.

In this book I examine these and other fallacies relating to supposed Mexican male cultural traits.

#### MEN AS THE MISSING (F)ACTORS IN REPRODUCTIVE HEALTH

Prior to the advent of the birth control pill that came into widespread use internationally in the 1960s, and in Mexico a decade later, two things were different for many men in Mexico. One, as with women, heterosexual sexual relations usually carried a far higher risk of pregnancy and therefore sex itself was more directly associated with anxieties and/or expectations linking the act to procreation. Two, more men were more often more responsible for contributing to preventing pregnancies, whether through slipping on a condom prior to sexual intercourse or, more often, withdrawing from the woman prior to ejaculating: *coitus interruptus*.

The pill and other forms of artificial contraception that tens of millions of women adopted in Mexico beginning in the 1970s transformed these two aspects of men's relationship to reproduction and sexuality. Like women, men were now enjoying sex at a time when "sexuality could become separated from a chronic round of pregnancy and childbirth" (Giddens 1992:26). Unlike women, men also now began to have less and less direct involvement in the most reliable forms of available birth control.

To take but one example, in international health and development agencies men have historically been of secondary concern in matters of reproductive health, presumably because women, not men, get pregnant—

[To view this image, refer to  
the print version of this title.]

“Family planning is a question of love.” Painted wall in rural Oaxaca,  
2002.

that is, for straightforward biological reasons. In recent decades, men have been absent from efforts around reproductive health for social and political reasons as well. This is because, one, improving the health of women in general, including with respect to reproductive matters, was identified as an urgent need and there was no parallel or complementary demand for improvements in men's health, and, two, in these agencies, as in government and nongovernmental institutions, men were in effect excluded from participation in many health and development programs.

As Sylvia Chant and I describe elsewhere (see Chant and Gutmann 2000), in development work historically, “male blindness” was in part a practical application of the policies that grew out of the United Nations Decade for Women (1975–85), when the Women in Development movement emerged as a first step in the struggle against seemingly universal male bias in development programs. Yet the tactic of focusing exclusively on women failed to shake the patriarchal foundations of mainstream development thought and practice and it became increasingly evident that women-only approaches to reproductive health, domestic violence, edu-

cation, and a host of other social problems were insufficient to resolve gender imbalances at the grass roots in any fundamental way.

In an analogous manner, anthropological studies of reproductive health have generally concentrated on women. Perhaps this has been true, Ginsburg and Rapp speculate, "because in our own social categories we disassociate men from domestic domains" (1995:4). Van Balen and Inhorn, in their volume on infertility, in the same way "acknowledge with dismay the relative lack of male 'voices,'" and in fact argue that "male infertility per se, as well as male experiences of partners' infertility, represents the great uncharted territory in the social science of infertility" (2002:19).<sup>5</sup> In addition to inserting men as the missing players in the field of reproductive health and sexuality, this book seeks to contribute to another area of study that is woefully underexamined in anthropology: contraception. Despite the fact that hundreds of millions of women and men use birth control worldwide, and despite the considerable attention paid within anthropology to new reproductive technologies, as Russell and Thompson (2000:3) point out, interest in contraception has been scant.<sup>6</sup>

Perhaps, in part, men have been missing from studies of reproductive health both because it was women researchers who were taking the first steps to address the problems facing women and because few men researchers were interested in exploring issues of gender and sexuality with respect to reproduction. I do not wish to imply any rigid principle dictating that women scholars will study women and men will study men. But political choices as to whether, when, and how to address problems of gendered social inequalities have undoubtedly been factors in the history of the study of reproductive health and sexuality. For all these reasons, and also in light of anthropological attempts to challenge "the mainstream demographic view of fertility as a one-time biological event (childbirth)" and to rethink reproduction as "an ongoing social and political construction" (Greenhalgh 1994:5), it should be apparent why there is a need to involve men in studies of the full range of reproductive practices in which men are so unambiguously implicated.

As I mentioned above, one intellectual puzzle I was seeking to resolve with this study revolved around decision making in couples about birth

control, how many children to have and when, and issues related to reproductive and sexual health, like impotence and infidelity. To the extent that I began my research thinking I might discover the source of decisions about contraception and the like among heterosexual couples in Oaxaca, I was invariably disappointed. It was just too obvious that much of the decision making—about what birth control methods, and about what antiretroviral treatments for people with HIV and AIDS, are available—takes place in the boardrooms of pharmaceutical companies located in Basel, Switzerland, and New Jersey. It is there that men, for the most part, develop and market contraceptive products and antiretrovirals—or not. Nevertheless, I was still able to learn a great deal about the decision making in couples that takes place in Oaxaca, albeit within a limited set of alternatives, established elsewhere, with regard to several aspects of men's reproductive health and sexuality.

Of course, there is a broader question as to how accurately we can study sexual practices in general. Without doubt, the principal complicating factor in any research on sexuality is the uncomplicated fact that people may not wish to tell the truth, they do not remember the truth, they misremember, and they lie, and that it is often impossible to tell if and when one of these conditions pertains. The central conceptual conundrum of research on sexuality is therefore the extent to which these kinds of problems severely and irremediably limit what can ever be known in this realm. As frustrating as it may be to admit that certain parts of human existence in some profound way might be unknowable, no amount of wishing it were not so, and no amount of variables run through multiple regression analyses, will make it otherwise. Because we cannot jump into bed with people, would not want to in most cases, and if we did we would hopelessly skew subsequent events, we must seek indirect ways to study who does what to whom, how, and when. And we must rely to a great extent on self-reporting. Undoubtedly, there are ways to compare quantitative survey research, with oral histories, for instance, in order to gain a better idea about sexuality and reproduction. But there are limits to our ability to chart this terrain.

We can also invent ways to get a rough fix on how often people are probably doing a range of things to each other. If we extrapolate from

condom sales, for example, we might assume we can then get an approximate count of how often men engage in ejaculatory forms of sex. Yet what can condom sales actually tell us? For example, what can we learn about men, masculinities, sexualities, and reproduction from the fact that sales are higher in Tokyo and Buenos Aires than they are in Topeka and Budapest? Without a local cultural perspective on the meanings of condom use in particular locales, and without understanding global pharmaceutical marketing practices and their local impact, such comparisons must be relegated to the realm of speculation far more than many researchers are comfortable admitting.

### THREE CLINICS AND A GARDEN

This study was conducted in Oaxaca de Juárez, a metropolitan area of around 500,000 people located in a mountain region 300 miles south of the Mexican capital. Approximately half the population of the state, totaling over 3.7 million people, self-identifies as belonging to one or another indigenous group (the largest being Zapotec and Mixtec). According to nearly all indices, living standards in the state of Oaxaca are among the lowest in Mexico, especially in the countryside. In 2000, the average years of schooling in Oaxaca were 6.0 for males and 5.2 for females. The national averages that year were 7.6 and 7.1, respectively; only the state of Chiapas had lower figures.<sup>7</sup> Life expectancy in 2001 was 72.9 years in Oaxaca; again, only Chiapas had a lower figure, and not by much (72.8). The national figure was 75.7 years.<sup>8</sup> In 2001, the average hourly income in Oaxaca was 9.8 pesos, the lowest figure for any state in the country. By way of contrast, the state with the highest average hourly wage was Baja California, with 31 pesos; the national average was 19.4 pesos.<sup>9</sup> And, again, living standards were qualitatively more tenuous in rural areas of the state, compared to urban areas.

Oaxaca is a major tourist destination in Mexico for North Americans and Europeans, who arrive seeking a charming locale of "indigenous traditions," a place that visitors like to imagine has just emerged from an ancient, remote, and changeless purity. The cultural traditions of Oaxaca are

indeed as rich as any on earth, but they are far more diverse and contentious than many tourists realize in their brief stays.

In 2006, Oaxaca the tourist mecca was severely disrupted by pitched battles in the streets, pitting a variety of civic organizations against the state government of Ulises Ruiz. It all began in May, when, as they do each year, school teachers raised demands for higher salaries. Unlike in previous years, however, the notoriously inept and reputedly corrupt governor Ruiz refused to even meet with the teachers who were occupying the downtown *zócalo*, or central square. On 14 June, police attacked the teachers' encampment, though the protestors returned and put up new barricades within hours. In response to the police violence, the Popular Assembly of the Peoples of Oaxaca (APPO) was formed, made up of teachers, clergy, and an assortment of community activists and organizers from throughout the state. Leaders of the teachers' union and APPO now demanded the resignation of the governor. On 28 October, police and local paramilitaries attacked the protestors, leaving six people dead, including a U.S. journalist.

The next day, the federal government sent troops to Oaxaca to forcibly remove APPO from the *zócalo* and a local university campus. Several more protestors were killed and more than a hundred people were arrested. In an interview conducted in late 2006, Mexican cultural critic Carlos Monsiváis offered this assessment of the events to that point in Oaxaca:

What we see on the ground is an unarmed and bold popular insurgency that is expressing its generalized rejection of the current situation and of the neoliberal policies that have brought it to a head. In Oaxaca, neoliberalism is anything but an abstraction. It is the economic system that forces massive migration to the United States, that provokes massive dropout rates at the primary school level, and that has led to a decline in life expectancy. Savage capitalism and neoliberalism have forced far too many to live in ignorance and under conditions unfit for human beings, but-tressing the abuses and crimes of machismo along the way. The poverty of Oaxaca is a terminal situation. (Monsiváis 2007:7)

Nor are the political and social struggles of contemporary Oaxaca some kind of historical fluke. Despite the absence of such history from the

tourist brochures, even the street names give a taste of the cultural politics in Oaxaca City, and reflect a history that has been anything but tranquil and placid. There is one street called *Mártires de Chicago* (Martyrs of Chicago), in reference to the anarchists killed in the Haymarket Massacre in Chicago on 4 May 1886. *México 68 Street* makes reference to another politically inspired massacre, this time in Mexico City in 1968. Another street is named simply *Obreros y Campesinos* (Workers and Peasants). Then there are streets named after the heroes of the Mexican Revolution that began in 1910, Francisco Villa and Emiliano Zapata, in addition to *Democracia*, *Independencia*, *Libertad*, *Joon Lokke* (John Locke), and *1° de Mayo* (May First) streets. All in all, the names of the streets in Oaxaca City reflect a tumultuous history that is rather at odds with the quaint, sleepy Indian villages of the tourist posters, and the political conflict and turmoil that are illustrated in the discussions of men's reproductive health and sexuality in Oaxaca that follow are thus of a piece with the overall turbulent social, economic, and political climate of contemporary life in this area of the world (see Anaya Muñoz 2004).

My ethnographic fieldwork in Oaxaca City in 2001–05 was carried out in two vasectomy clinics, in the state-run AIDS clinic, and in the Ethnobotanical Garden of Oaxaca, where I worked as a laborer clipping cactus and digging ditches for planting and irrigation.<sup>10</sup> To learn about AIDS in Oaxaca, I spent one or two days a week at the state-run AIDS clinic, meeting and talking with men and women who came there seeking medical services. Often these patients would have monthly appointments, and I would try to coordinate my schedule so as to coincide with their visits in order to develop an ongoing relationship with them, though in most cases our relationship remained a fairly formal one of conversations about health between patients who were HIV+ and the gringo medical anthropologist.

To learn about male sterilization, I interviewed men at the *Centro de Salud Urbano #1*, operated by the Ministry of Health, which is supposed to provide health care services for the rural and urban poor in the Oaxaca City metropolitan area. And I met men at another clinic, the *Unidad Médica Familiar #38*, that is part of the Mexican Institute for Social Security, which officially serves workers in the formal private sector of the

economy. The two doctors who performed vasectomies in Centro #1 were both originally from Oaxaca and had received their medical training, including in this procedure, there. One of the doctors at the Unidad #38 was from Mexico City (where he went to medical school), and the other was from Oaxaca and was finishing her residency there. In Centro #1, one of the doctors was a man and the other a woman, and there was a female nurse generally present throughout a procedure. In Unidad #38, one of the doctors was a man, the other a woman, and nurses were rarely present.

As I describe in some detail in chapter 6, my role in these vasectomy clinics developed beyond that of passive observer and interviewer, and my tasks came to include what I call "emotional anesthesiology." Nonetheless, as in the AIDS clinic, my ongoing relationships with people were sporadic and somewhat restricted to issues of sex, birth control, and AIDS. Pleased to be learning about these issues, but frustrated by the limitations of my interactions with patients, after a few months of fieldwork in 2001, I happened to have lunch with a friend, Alejandro de Ávila, then director of the Jardín Etnobotánico de Oaxaca, the Ethnobotanical Garden of Oaxaca. When Alex asked how my work was going, I mentioned my ambivalence arising from not having more systematic and informal contact with a specific group of people and spending most of my time in the socially grim hospital clinics.<sup>11</sup> He then asked me, "Why not come work at the garden?" He meant I should work there as an unskilled laborer. I think I replied something to the effect of "Why? It's a magnificent garden, but what could that have to do with my study of birth control and AIDS in Oaxaca?" The garden contains hundreds of species of plants from all over the state, one of the most biodiverse spots on the earth, but what did this have to do with vasectomies and AIDS? Alex then explained his offer: "You are studying men. There are twenty to thirty men who work at the garden. Come, work alongside them, get to know them in a less barren setting than a clinic." It was the best advice I got that year.

Discussing what form of contraception a couple uses is not a topic that casually arises in my everyday conversations with other Brown University faculty and staff, or with the parents of friends of my children, or with my neighbors, or with members of my gym. But after working alongside them for months in the Ethnobotanical Garden of Oaxaca, many of my fel-

low laborers had a general sense of my research on sex, birth control, and AIDS, and to my surprise and delight, they were the ones who initiated our conversations about contraception and sexuality. Daniel's wife had had a tubal ligation. Before this she had used "métodos naturales."

"Like what?" I asked. "Herbs?"

"No, you know, there are days when she's most fertile."

"Oh, *ritmo* [rhythm]," I replied.

"What did you call it?" Daniel asked. "Rhythm? Oh, right."

Then there was Roberto, who told me one morning, as we were digging ditches for the irrigation system, that he had used condoms, but his wife never used anything. Roberto's father's first wife was a midwife, and she knew about herbs for not having babies. I told Roberto that I would have enjoyed talking to her. "No," he responded, "she wouldn't have talked to you. Only to women."

Another day, while we took a lunch break, Eladio mentioned "prostitutes." He probably noticed my ears prick up because he went on to mention something about a young man he knew who had visited one recently. I nonchalantly asked him to elaborate. Most young men go to prostitutes, he reported. He had, and his friends had too. In all my years living and doing research among men in Mexico City, few of my male friends confessed that they had been to a prostitute. In Oaxaca, many seemed more than willing to narrate their experiences with prostitutes.<sup>12</sup> Whereas men in Mexico City seemed insulted by the allegation that they ever had to pay for sex (see Gutmann 2006:133), in Oaxaca men merrily told me where they went to hire a prostitute, where they had sex with her, how much they paid, how many times they returned, and how long their sexual activity lasted. They paid the equivalent of \$8 to \$10 U.S. for street hookers, \$20 for the ones who worked the cantinas. And after you are married, why pay? When you are still single, according to Eladio, it is sometimes difficult for a young man to find a young woman he can have sex with. Although I could have learned about such practices through a random survey of anonymous men, the nuances of the men's desires and frustrations and curiosity came into sharper relief if I simply waited for these topics to emerge in the course of the daily banter on the job at the Ethnobotanical Garden of Oaxaca.

[To view this image, refer to  
the print version of this title.]

Workers at the Ethnobotanical Garden of Oaxaca, 2003.

More than anywhere else in Oaxaca, in the Ethnobotanical Garden I could contextualize what I learned through my interviews in the vasectomy and AIDS clinics. The men from the garden who accepted the challenge of trying to teach me how to care for their plants became my mentors and friends, with whom over the years I have been able to share ideas, experiences, worries, and dreams about far more than just plants, or even sex, birth control, and AIDS. The stories of their lives and families are among the most insightful, humorous, and poignant that I offer in the pages of this book. As everyone at the garden had a nickname—at least everyone who did the shoveling, pruning, transplanting, and maintenance—before long I was given the nickname Zorra (Fox) because, I was told, foxes show up to scrounge around and then they disappear for a while to parts unknown.<sup>13</sup> My pattern was show up to work in the hot sun for a day, then disappear for several more.

My research on men's reproductive health and sexuality in Oaxaca was motivated not by the magnitude of the numbers—vasectomies were fairly unusual in Oaxaca, and AIDS was a growing problem there, yet by no means epidemic—but instead was sparked by a set of straightforward

questions about a very human activity: sex. How did men and women in Oaxaca avoid making babies? How did they avoid sexual disease? What were their reproductive health options, and how did they make decisions about them? Over the course of several years, there was not a man at the garden who did not have something to say about these issues. And most of the men had different things to say at different times. When I heard the men contradict themselves, express ambivalent and inconsistent opinions, and challenge one another about religion, government, and family views regarding sexuality, I finally began to trust what I was learning. Instead of relying largely on what people in the clinics reported on some particular occasion after having been prompted by me as the interviewer, in the garden I was able to wait for topics to arise through casual conversation.

Oaxaca was a bit exotic for me at first. I had visited many times before 2001, when I arrived there with my family, but it was different in many ways than any place I had lived in the United States or Mexico. Although I was born and raised in the United States, I had lived for several years in Mexico City and written about changing gender relations and popular politics in a squatter settlement there (Gutmann 2002, 2006). In the Mexico City neighborhood of Santo Domingo, where I lived and worked on and off in the 1990s, most of my friends and neighbors had been born and raised in the capital, if not necessarily in that *barrio*. In Oaxaca, I was constantly in contact with people who had been born and raised in small villages in the countryside. In Mexico City, although a few of my friends spoke one or another indigenous language, like Yucatec Maya or Nahuatl as spoken in the state of Puebla, the overwhelming majority of my acquaintances considered themselves *mestizos*, "mixed-race" Mexicans, and did not self-identify as Indians of any kind. In Oaxaca, even my lightest-skinned friend boasted of his Zapotec grandmother's special recipe using *mole* sauce and grasshoppers.

Which is not to say that discrimination and racism are in any way absent from Oaxaca; the epithet *yope* (similar in ring to *nigger*) is spray-painted on city walls and signs. At the Ethnobotanical Garden, I quickly learned that asking someone if they are "indigenous" is akin to calling them a *yope*. *Indigenous* is a term dear to anthropologists and activists, but

for most people in Oaxaca it sounds too much like *indio* (Indian), the slur used by the Spanish conquistadors. Instead, the men at the garden were delighted to inform me that they were Zapoteco or Mixe or Mixteco, and more than once I heard the older men urge the younger ones not to lose their ability to speak other languages or, as they called them, "dialectos."<sup>14</sup>

Following on earlier work by anthropologists in Oaxaca City, I also wanted to know what difference ethnicity made in people's health and treatment for illness.<sup>15</sup> Was the clear and present significance of indigenous ethnic groups and racism in rural areas of the state overpowered by issues of class and class subordination after these people arrived in the city? Doctors complained regularly to me about their stints in the countryside, which in Oaxaca is overwhelmingly populated by indigenous peoples. "Despite the best of intentions when I went out there to do my service," one callous physician snarled to me, "they pull guns on you out there. So there's no point in going to some of those areas." Nor is this a matter of a few racist public servants. In a section called "ethnographic perspective" of the official training manual for medical personnel working in reproductive health in the state of Oaxaca, practitioners are advised to discuss among themselves "who among you would like to share any experience related to popular beliefs, values, or customs that has interfered with a technical-medical indicator or intervention?" (Proyecto IMSS-PRIME 2001: sección I, p. 5). God forbid in the state of Oaxaca that indigenous beliefs, values, and customs should be found valuable. In this way, medical professionals are trained to especially denigrate the indigenous peoples they are charged to heal.

In the course of my fieldwork I came to share the view that although ethnically grounded bigotry and discrimination are clear and evident in large and small ways in Oaxaca City, in urban areas, more often than not, class trumps ethnicity as an explanation for relations of power and inequality. Ethnic identities and racism pervade urban Oaxaca, too, but I found few patterns, in terms of disease or curing, in the city that I could associate unmistakably with one or another indigenous group. Instead, I came to see class and gender as the most salient factors to explain the state of people's reproductive health and sexuality. Despite the fact that virtu-

ally every tourist to Oaxaca visits the archaeological site of Monte Albán, many of Oaxaca City's poor have never been there. Nor have they attended the Guelaguetza festival in July—the tickets are simply too expensive for most people, so they watch on television. “That neighborhood is so poor,” goes the saying, “parents wait six months before they buy clothes for their babies.” It is true that even in the wealthiest neighborhoods, like San Felipe, the braying of burros and the necessity of side-stepping a full team of yoked-up oxen are common occurrences, displaying a mingling of classes that is less common than in other parts of Mexico. Yet in Oaxaca, when the wealthy get very sick, although they may live alongside goat paths, they do not hesitate before booking a flight to the medical centers in Houston.

Class and ethnic divisions are rampant and blatant in Oaxaca, and I was very concerned that social stratification would impede my ability to gain the trust and friendship of people who I perceived to be from very different cultural and economic backgrounds than my own. Yet when I raised this with anthropologist friends early in my fieldwork, I was surprised that no one shared my anxieties. Yes, I was distinct from most people in Oaxaca by virtue of class, education, ethnicity, national origin, and many other visual and implicit characteristics. And, as has been true so often with research worries spawned by erroneous preconceptions, I soon learned that as much as tourists to Oaxaca find themselves fascinated by difference, so too there is never a shortage of Oaxaqueños eager to learn about the lives and cultures and experiences of long-term and short-term visitors, anthropological and other.

This situation of mutual curiosity pertains for many reasons, including the very practical one that many thousands of men and women each year journey from Oaxaca to the United States, where at a minimum another 100,000 Oaxacans live, work, marry, and die. In 2005, I carried out a little experiment: in both Oaxaca and Mexico City I asked friends the going rate for a *coyote*, a person who guides Mexicans across the Mexico–U.S. border. Despite being several hundred miles farther away from that border, many more people in Oaxaca than Mexico City could answer (\$2,000 to \$3,000 U.S.). Then, too, many more friends and acquaintances in Oaxaca depend on remittances from the United States than is the case for my friends and

neighbors in Mexico City.<sup>16</sup> Men from Oaxaca go north seeking work to earn money to send back to Oaxaca. Growing numbers of these men get infected with HIV and then return to Oaxaca and infect their wives and girlfriends. The shape of AIDS in Oaxaca is therefore different than in some other cities in Mexico, where self-identified *homosexuales* continue to be the main group of people with HIV. In Oaxaca in 2005 the largest group of people with AIDS was poor Indian men who had migrated to the United States. The second largest group was poor Indian women.

#### HOW TO EXPAND AND ABANDON PUBLIC HEALTH

From the 1970s into the 1980s, health care coverage in Mexico increased by as much as 10 percent annually, and during this period the federal government launched initiatives, such as IMSS-Solidaridad, to incorporate unprotected groups into the health care network.<sup>17</sup> From 1991 to 1995, physical infrastructure was strengthened in poor rural areas; in Oaxaca, for example, hundreds of new clinics were built, including some in remote regions of the state, although, to be sure, many of these facilities were not well staffed. Thus, despite the persistence of tremendously uneven coverage and inadequate treatment and prevention programs in the 1970s and 1980s, there were discernable improvements in health care coverage—as measured by the numbers of hospital beds, the ratio of doctors and nurses to the population, per capita spending on the uninsured—and citizens had a sense that government attention to health was headed in the direction of more and better care for the poor in Oaxaca. Then, in the 1990s, the government began to dismantle the infrastructure of social security services in Mexico.

In 1996, with the Program of Health Sector Reform, many earlier efforts to expand health care were downgraded as a priority; the reform was aimed at moving to replace the previous social security strategy with a dual policy of market commodities and poor relief (see Laurell 2001). The private sector was promoted more than ever before as a key agent in health care, including for the poor, despite their lack of economic resources with which to pay for private services. Not coincidentally, the

structural changes contained in the program shared much in common with the policies explored and promoted in the World Bank study *Investing in Health*, which was published in 1993. Following the announcement of the Program of Health Sector Reform and the publication of *Investing in Health*, the federal government launched the so-called Program for Extension of Coverage, to be implemented over the period from 1996 to 2000. Although the stated purpose was to offer basic health services to 10 million additional Mexicans, in practice this program was guided by the Mexican government dictum of "equal pay for equal services." This privatized approach to health care delivery stood in direct contrast to the earlier government guideline of "Pay according to income and receive according to need."

In practical terms, the withdrawal of the state from *public* health has meant that as public services became privatized, health care became increasingly decentralized. This change became marked in urban areas, as health care was shifted from public to private institutions, including from public clinic to private home. What is more, as clinic and hospital care were transferred to home care, health care practitioners necessarily shifted from medical personnel to the mothers, sisters, and wives resident in these households. As a result of neoliberal economic reforms, health care spaces, like clinics and hospitals, that had been touted as public became increasingly inaccessible to those without the personal funds to pay for health services. Although Oaxaca was not one of the fourteen Mexican states incorporated into the first phase of decentralization (1983–88), it was especially impacted in the second decentralization phase (1995–2000), as inequalities in the services provided grew and the quality of the services offered suffered. One example from the late 1990s is the decline in primary services available in the rural areas of Oaxaca, as states were expected to take over hospitals previously run by the federal government, although insufficient funds were provided to the states to accomplish these tasks.<sup>18</sup> Such social exclusion, prompted by structural readjustment policies, represented a reduction of citizens' rights, as the mere existence of new clinics, for example, was supposedly sufficient evidence of expanding coverage. Never mind that the actual services provided were less available to those without money to pay.

Such is the content of democracy and the democratization of health care in Mexico, all in all a fitting illustration of the roles offered to contemporary citizens to participate in Mexican society and a good illustration of the benefits they can expect based on their personal (private) ability to pay for such cultural membership. As an anthropologist from the United States, I was often asked by patients, doctors, friends, and neighbors about health care availability and services there. I found it especially difficult to explain why so many citizens of the United States consider their country as the paragon of democracy when so many of its residents have so little access to decent health care. My first research year in Oaxaca, from August 2001 to August 2002, was also a hell of a year to spend outside the United States, a unique time when people repeatedly sought explanations for the actions of the U.S. government and military following the September 11 attacks. Although everyone I and my family came into contact with following the events of 9/11 was sympathetic—"Did you have family in New York? Are they OK?"—most Oaxacans I spoke with were aghast at the war on terror launched by the Bush administration that followed. Paragon of democracy indeed.

#### THE LIMITS OF ETHNOGRAPHY AND FIXING MEN

The Irish poet W. B. Yeats is said to have suffered from a condition about which he once complained, "It was terrible. Like putting an oyster into a slot machine."<sup>19</sup> To cure his presumed impotence, Yeats sought out a treatment prescribed by some doctors in the 1930s to restore men to their "natural" state: vasectomy. The procedure was "intended to increase and contain the production of male hormone, thus arresting the ageing process and restoring sexual vitality" (Foster 2003:496).

The study of sexuality and decision making about sexual relations is inherently delicate and difficult. Men who cannot get erections are considered by many to be less manly. Men who are manly get erections easily and, I was informed on more than one occasion in Oaxaca, are *irrefrenable* (unstoppable). The subject lends itself to wonderful stories and jokes, but suffers from an intrinsic problem: people who study sexuality

are always dependent on what people tell us about their sex lives. Philippe Bourgois (2002), in particular, has discussed the problem of self-reporting in public health studies, in his case with respect to drug addiction and needle use. The fact is, there are practical limits to studying sexuality and sexual relations, a point to which I return in the final chapter.<sup>20</sup>

But within those limits there is much that can and needs to be said. The anthropological study of human sexuality has ancient roots. But studies of sexuality and reproductive health have been propelled and guided, in recent years especially, by two new and powerful political movements within the academy, namely feminism and the struggle against AIDS. The significance of men's reproductive health and sexuality is enormous, though except for work on AIDS largely uncharted. Scholarship on these matters is scarce, and the present study aims to contribute to a broader discussion of reproductive health by focusing attention on several crucial aspects of men's reproductive health, sexuality, and sexual relations in Oaxaca in the early years of the twenty-first century, which in turn is part of the larger process of exploring those whom Rayna Rapp has called "the exotic male sex" (2000:6).