Place, positionality, and priorities: Experts’ views on women’s health at the Mexico–US border

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A B S T R A C T

Improving health care in the Mexican–US transborder region presents challenges not only of harmonization of systems but differences in values and expectations for policies. We explore the contrasting and overlapping views of health experts in both countries regarding the ways in which geographic location, scale, and professional roles shape their notions of the region, priorities for women’s health, and interpretations of the socio-cultural concept of gender in relation to health. The study is based on interviews with legislators, health administrators, health advocates, and researchers on each side of the border. We suggest ways in which more nuanced perspectives might be brought to bear in the policy discourses on the region.

How the transboundary spaces of health care might be (re)produced in a way that minimizes the contradictions between international boundary politics and the production of local, transboundary geographies of shared culture, values, and knowledge is pivotal. (Morehouse and Salido, 2004, p. 279).

When one reads the border literature, one sometimes feels that Chicanos are the only people capable of taking full advantage of the border and its opportunities, leaving out not only Anglos, blacks, American Indians, and Asians, who also experience the border, but also Mexicans who are not Chicanos and therefore cannot be fully understood as ‘border crossers’ or ‘hybrids’. (Vila, 2003, p. 327).

The geographic boundary of Mexico and the United State is a contentious and complex space in material and symbolic ways. It is a focal point for political and economic debates related to migration, commercial transactions (both legal and illegal), and economic development that come together in concerns about national and human security. It is a border that is at once highly fluid, yet tightly bounded, where policies and public opinion grapple with restricting some movements while facilitating others and reveal numerous inconsistencies. Its population is diverse, in terms of class, ethnicity, immigration history, legal status, generation, and gender. Some live in large cities, others in small towns or sparsely populated rural regions. The region symbolizes the encounter of asymmetrical but interrelated worlds and presents the challenges of addressing multifaceted inequalities and inequities (Bustamante, 1989; Bronfman Pertzovsky et al., 1998; Staudt and Coronado, 2002). In this context, meeting health care needs is a long-standing and complex concern for health politics, provision, and practice.

This article explores the priorities for women’s health care identified by health “experts” who are engaged with health care concerns on both Mexican and US sides of the border, and in particular to consider perspectives that exist or might be developed across professional and place boundaries. We are interested in the views of health professionals, legislators, and community activists—professionals who are invested in formulating health policies and engaged with their implementation. We pay attention to the ways in which they incorporate socio-cultural perspectives into their discourse as they define the border as a region, identify priorities for women’s health, and draw on the concept of gender as it intersects with policies and priorities relating to women’s health. Though gender is not always acknowledged as a central issue in political and popular discourse about the region, as feminist scholars have revealed, it is a critical
consideration in understanding health. Additionally, we are especially interested in perspectives on gender because they differ markedly in the policy approaches of two key organizations whose missions involve improving health in the region, the United States–Mexico Border Health Commission (USMBHC) and the Pan American Health Organization (PAHO). Whereas gender perspectives are largely invisible in key documents of the former, the latter has specifically advocated “gender mainstreaming” (PAHO, 2003). By analyzing the perspectives of health experts, we hope to gain insights into ways in which the gaps in these visions might be bridged.

We come to this task via our collaboration in the Transborder Consortium for Research and Action on Gender and Health at the Mexico–US Border, a group established in the mid-1990s to bring together researchers and non-governmental personnel. Through the Consortium we have supported ethnographic research and activities with community agencies, conducted staff development programs, and reflected on processes of cross-border and cross-disciplinary collaboration (Denman et al., 2004a, b; Monk et al., 2002; Manning et al., 2006). We begin with background on the region and a synopsis of the approaches of USMBHC and PAHO and then review our approach to the research. We next take up three themes: border, women’s health, and gender. Given our interest in action as well as research, our concluding section addresses both the scholarly and applied implications of our findings. Since we are especially interested in issues of place and the positionalities of health experts, we first identify our own places and positionality. We have lived and worked for over 20 years in the region, two of us in Arizona, two in Sonora, (though also with other experiences). We are a, respectively a feminist geographer, educator, and administrator; a medical anthropologist who has researched issues related to primary health care, promotoras\(^1\)-based health education, working women, and a facilitator of cross-border health research; a political scientist with long-term commitments as a human rights and social justice activist; and a feminist activist-researcher who engages with grassroots health advocacy and promotion organizations and researches bi-national health policy-making.

**Approaches to women’s bodies and health**

Border residents manage their health care in multifaceted ways. Among common strategies are those of Mexicans crossing to the US to obtain services not readily available (or possibly legal) at home, and US residents going to Mexico to purchase medications unavailable or more expensive north of the border and/or for more affordable or culturally more desirable care than they can obtain in the US (Hansen, 2006; Morehouse and Salido, 2004; Ojeda de la Peña, 2006). Such activities present complex barriers to harmonization of policies and services, including differing histories in relation to public and private systems of care, lack of portability of health care plans or records, and differing policies and capacities in relation to the provision of emergency care (Morehouse and Salido, 2004). In both countries, individuals contend with the pervasive effects of neoliberal approaches to the provision of health services. In the Mexican case, key changes are associated with increasing emphasis on privatization and decentralization in the provision of services (Nigenda et al., 2003; Merino, 2003) and in the US with substantial gaps in insurance coverage or prohibitive costs of care (Warner, 1999).

1 The word promotora is used on both sides of the US–Mexico border to refer to community health workers or community health promoters. Although men are not excluded, promotoras on both sides of the border have traditionally been women.

Feminist scholars, focusing not entirely, but significantly, on women, have identified ways in which the construction of femininity has been integral to developments at the Mexico–US border that have implications for women’s health and their roles as caregivers. These include the practices of foreign-owned export-processing industries on the Mexican side, with ideologies and practices that have focused on sexualization of the labor force (e.g., Salzinger, 2000, 2003; Wright, 2006) by, for example, intrusive pregnancy testing of women workers, the linking of access to health services to places of employment, and changes in domestic relations that relate to care giving (e.g., Cravey, 1998; Denman, 2006; Denman et al., 2003). Most recently, attention has turned to women’s security and the unsolved murders of hundreds of young women in the Mexican border city of Ciudad Juárez (Wright 2001, 2005, 2006, 2007; Staudt and Vera, 2006) and the traumas and deaths of women attempting to enter the United States by extended hikes through isolated desert regions (Sundberg, 2006). Our perspectives parallel those of Bianet Castellanos and Boehm (2008) whose work on Mexican migration argues for “looking at the interaction between gender and political economy, including class formation, settlement patterns, state formation, sexuality and race” (p. 5) and notes that institutions, including state policies, are shaped by gender ideologies. While there has been much valuable and recent research on gender issues at the border, much of it, however, has been situated in the large metropolitan region of Ciudad Juárez–El Paso, often focusing on young women, especially those working in the maquilas and the femicide in Ciudad Juárez (e.g., Garwood, 2002; Salzinger, 2000, 2003; Staudt and Coronado, 2002; Staudt and Vera, 2006; Vila, 2003; Wright, 2001, 2005, 2006, 2007). In comparison, we have been attuned to diversity within border contexts, of women and men, and in relation to socio-cultural notions of gender, and to various constituencies involved with women’s health. We have sponsored and engaged in ethnographic research projects on such topics as the health concepts and concerns of older women in Hermosillo and Tucson, of older rural men in Sonora, of indigenous women migrants in from southern Mexico in Baja California, of discourse around breast cancer among Latinas of diverse origins in Texas, and of gender relations in relation to constructions of the body among Mexican migrant agricultural workers in California (Denman et al., 2004a, b). We have organized workshops bringing together promotoras from both sides of the border, offered cross-disciplinary and cross-border academic seminars, and given testimony before the US–Mexico Border Health Commission. We have frequently participated in the annual conference, “Border Health: Information for Action” for researchers and health workers from Arizona and Sonora. In reflecting on the border context, we are aware of the geographic and contextual limitations in research. The border is, after all, an east–west dividing line of over 3100 km in length, including six Mexican and four US states that recorded over 13 million in population at the national censuses of 2000 (Denman et al., 2004a, b). Economically and demographically complex, the region includes major metropolitan areas, towns of diverse size, some quite isolated, rural, mining, and military economies, and vast areas of desert.

The range of gender issues revealed in the literature and our work, has, however, low visibility in the key document outlining border health goals. The stated agenda of Healthy Border 2010: An Agenda for Improving Health on the United States–Mexico Border (USMBHC, 2003) it to increase and improve the quality and years of healthy life to eliminate health disparities among the region’s populations. While the report indicates that attention should be paid to differences by, for example, race, ethnicity, and gender, its goals are circumscribed by those health issues on available statistical indicators on the “general population.” Of 20 objectives
identified, two relate specifically to women’s health, the first to childbearing (increasing the number of women receiving prenatal care and reducing adolescent pregnancy rates) and the second to cancer (reducing breast and cervical cancer through improved screening). Goals relating specifically to men’s health are not articulated, though some may have particular salience for men such as reducing alcohol and substance abuse and the rates of motor vehicle crashes and their consequences.

In contrast to the USMBHC goals, since the 1990s PAHO has advocated “gender mainstreaming” in the development of health policies. PAHO conceptualizes gender from socio-cultural perspectives. Its documents refer to equity and recognize differences among women (for example, by life stage), the gamut of women’s roles, their risks and responsibilities as caregivers, both within health systems and as providers of primary care within homes and communities. They acknowledge the importance of including women’s voices and perspectives in policy and program development (Gómez-Gómez, 1993; PAHO/WHO, 1999). In some settings, for example, in Chile during health sector reforms, PAHO has promoted integration of gender perspectives into policy formulation, though this has been a difficult process (Gideon, 2006, 2007). Other scholars concerned with gender in relation to the development of health policies and initiatives have offered guidelines for mainstreaming gender (Gender and Health Group Liverpool School of Tropical Medicine, 1999; Standing, 1997; Theobald et al., 2005). These documents identify differences in women’s and men’s roles and responsibilities and their unequal access to resources, information, and power. They address differences in vulnerability to illness, health status, access to preventative and curative measures, burdens of ill-health, and quality of care.

Perspectives vary on what is implied by such concepts as equality, equity, and mainstreaming, especially in relation to policy development. Doyal (2000) for example, outlines three alternative interpretations: “traditionalist,” a view that emphasizes male/female “natural” differences while arguing for equity; “feminist radical” which is skeptical of mainstreaming and focuses on the rights of women; and “gender radical” that seeks equity within a social justice framework that addresses gender relations between men and women. Other scholars have examined ways in which mainstreaming presents tensions in theory and practice (e.g., Walby, 2005) and in which the contingencies of local cultures and politics come into play in implementation (e.g., George, 2007). As Standing (2002) has argued, “much of the debate is conducted at too high a level of abstraction...debate...have to...examine which women, in which contexts suffer disadvantage, and what desired policy outcomes should follow” (p. 364).

The frame of reference in our research is multifaceted. We draw on literature on health and place that has addressed women’s lived experiences, perspectives, and caregiving concerns and that aims to go beyond frameworks that tend to focus on individual behavioral change (e.g., Dyck et al., 2001; Panelli and Gallagher, 2003; Parr, 2003). We are sensitive to poststructural perspectives on difference (e.g., Gesler and Kearns, 2002; Kearns, 1995), and the ways in which knowledges are situated, framed in relation to place, positionality, and power (Davies et al., 2004) whether in professional communities or different geographic locations. We note studies of local differences in discourses on policy implementation (Atkinson, 2002, 2006), of bringing lay and professional perspectives together (Dyer, 2004; Davies and Burgess, 2004), and of competing discourses of social scientists and biomedical professionals in public health education (Williamson, 2004). We are especially interested in studies of people who bring differing perspectives to making, influencing, and implementing policies. Lewis (2006), for example, addresses the networks of influence among the players in making state health policies in Australia; Gauld et al. (2006) document different weightings given to health concerns by policy makers and advisors in a range of government departments in New Zealand; and Gideon examines the tensions and challenges of bringing multiple groups together in integrating gender interests into health policy in Chile (2006). Beyond the health field, we note the work of Mountz (2003) on the roles of identity and language of governmental bureaucrats and non-governmental personnel involved with immigration issues in Canada. Highlighting the significance of their identities and geographies she writes, “the state does not exist outside of the people who comprise it, their everyday work, and their social embeddedness in everyday relationships (p. 640).” She reminds us the importance of individual decision-makers within the operations of the state.

Those whom we have identified as health “experts” are individuals whose work relates to health care for women in the Mexico–US border region. We include potential policy advocates and/or those with responsibilities for policy implementation in each country. We see our research as exploratory, given that previous studies have in the region have not focused on such actors and that we hope to gain insights that could point the way to more sustained research and actions for improving women’s health. In this we share the views of Staudt and Coronado (2002), who sought to identify ways of enhancing collaboration across common spaces and interests at the border which they see as “beset with obstacles” (p. 17) but where change is reliant on “numbers of generally strategically placed people” (p. 23).

We conducted qualitative, semi-structured interviews with 28 people, 14 on each side of the border, focusing our research in Arizona and Sonora though including some respondents working beyond those locations in federal-level agencies in both countries. The interviewees were selected for their professional roles; they included federal government administrators engaged with women’s health, state legislators from Arizona and Sonora who are interested in health, statewide public health advocates, women who take leadership at the community level as health advocates, and researchers who study border health. In Mexico we interviewed 11 women and three men, in the US two men and 12 women. With the exception of the federal employees they were geographically situated in locations ranging from the state capitals to the towns and rural communities served by health administrators and activists. Ethnically, six of the 14 on the US side would be considered as of Mexican–American origin. Interviews were conducted by women researchers, in English in the US and Spanish in Mexico. Questions focused on conceptions of the border as a place, identification of priorities for women’s health care, and interpretations of gender as a salient concept in relation to health care. Interviews varied in length from approximately 30 min to 1 h, partly dependent of the availability of the participants. Most were conducted in person, though those with federal officials working outside the region were completed by phone. All were transcribed then coded manually by at least two members of the research team. In examining the interviews we focused on the ways in which their discourses are situated in place and reflect the positionality of the interviewee within the health establishment.

We recognize that such persons are only part of a dynamic context in which policy-making and implementation occur. Health policies and services in both the US and Mexico are enmeshed in the larger national and international political discourses, especially those of neoliberalism that pushes health care provision and access into the private sector (Bambra et al., 2004).

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2 Spanish responses have been translated into English for this paper.
Defining the border

Theoretical and empirical research on borders, a traditional concern of Anglophone political geography, points to the ways in which borders are both fixed and fluid spaces where contradictions and tensions of differences are evident and unconscious assumptions challenged. Sometimes borderlands may constitute “liminal spaces of becoming, spaces for redefining ‘what is’ and ‘what might be’” (Morehouse, 2004, p. 30). They serve to restrict and to protect, to define and differentiate, to provoke resistance to and foster compliance with policies and practices. In a somewhat different vein, much of the Mexican scholarly work on borders examines the effect that modernist discourse (with its emphasis on economic modernization) has had on theoretically constructing borders as transcendent spaces (Kramsch, 2002; García-Cancilini, 1990; Garduño, 2003), arguing that they are not peripheral spaces where national interests are relaxed and cultural identity blurred but rather, spaces where nationalism is reinforced and even negotiated.

We have identified commonalities yet also differences in how our respondents define and interpret the border. Most striking were the ways in which professional identifications and lived experience were important in distinguishing responses within the national groups. Federal governmental administrators or those holding elected state-level public offices but living away from the border tended to speak in terms of bounded political and jurisdictional spaces, though these varied widely in spatial extent from right at the line to 4100 km or to entire states. On either side, the terms of reference reflected the speaker’s own national space. Some whose responsibilities extended beyond the state level saw the border extending east–west not simply as a north–south line but also as having a fluid dimension. By contrast, those with lived experience in border communities were more likely to see it as a fluid space or a “joint community” (Mexican local health administrator) and to incorporate both sides, though their frame of reference could be confined to local spaces: “I’m working from Nogales/Nogales to Douglas/Agua Prieta (twin border towns). So that’s what I would define as the border region—what I work with” (US local government health administrator). A US health care provider said “I’m Mexican, you know, and it’s like I don’t see much difference.” We can also see instances of different scales being linked, as in the comments of a Mexican federal administrator who identified herself as having grown up in the border region. She recognized larger international concerns, referring to it as characterized geopolitically by rising trafficking of drugs and human beings, but also characterized a local border culture, a place rooted in a “peculiar kind of machismo and gender violence.”

Quite widely shared was the recognition of the border as a marginal and/or contentious space, also usually expressed in national terms. US respondents spoke of problems of poverty, drug trafficking, isolation, rurality and the politics of contemporary Mexican immigration to the US. In contrast, Mexicans spoke of being marginal in relation to national priorities for resources, or of the stresses that internal migration to the northern border region places on local services. Finally, we note some invisible spaces and people. Few interviewees on either side mentioned the indigenous populations whose territories straddle the border or indigenous migrants within Mexico. Other ethnic and racial diversity was also overlooked, including long-standing African American communities and recently arrived African refugees on the US side, as were diverse and substantial communities such as (Anglo) retirees, military personnel and expanding numbers of law enforcement agents and their families. Indeed, our interviewees, regardless of their origins, predominantly constructed the border as a Hispanic space. We are reminded of the similar limitations of widely recognized Anglophone scholarly literature which Loustaunau and Bane (1999) have critiqued for its neglect of complexities, and Vila (2003) for its privileging the trope of Hispanic hybridity.

Identifying priorities in women’s health

We now turn to what these health experts identify as key concerns for women’s health and how they think about those in relation to biomedical and socio-cultural constructions. Distinctions are marked between the two countries. US respondents overwhelmingly identified health priorities in sex-based biomedical terms, often rather traditional. Mexican respondents, in contrast, while also identifying some priorities in biomedical terms, included more attention to aspects of health that involved social and cultural relations. Common to both groups was a focus on reproductive health, especially among US personnel who often prioritized pregnancy and childbearing as key issues for women’s health. Additionally, they placed some emphasis on chronic health issues, especially diabetes.3 While Mexican respondents also discussed reproductive and sexual health, it was in wider terms; they included cervical-uterine and breast cancers, sexually-transmitted infections and HIV/AIDS. Socio-political perspectives related to health varied more markedly across the border. Access to health care is a constant element of health discourse in the US, especially because of rising costs of insurance and limited public services. US respondents thus emphasized access in terms of affordability, geographic location (rurality); women’s educational status, and spoke of the need for more preventive care. Interestingly, issues of violence did not surface, though we note that addressing violence against women is a key public policy priority of the Arizona Governor’s Office for Children, Youth and Families, Division for Women (AGOCYF). Mexicans paid considerable attention to domestic and family violence, half of them mentioning it as one of their key concerns. Their perspectives are likely

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3 Diabetes is the focus of considerable research attention and funding (especially for prevention education) in the US.
influenced by recent media and activist attention to gender violence, spurred both by national and international attention to the situation in Ciudad Juárez (Staudt and Coronado, 2002; Wright, 2007), the publication of a national study reporting a high incidence of domestic violence (including physical, verbal, psychological, and economic abuse) (INEGI and Instituto Nacional de las Mujeres, 2004), and recent federal and state legislation which addresses violence against women and girls (Medellín, 2007; Expide, 2008).

Some important exceptions emerged within national identifications of priorities related to women's health. US federal women's health administrators rejected the pervasive identification of women's health with maternal and child health and/or what they called “bikini medicine”—a focus on breast cancer and reproduction. They insisted on recognizing differences among women over the life span. This is consistent with the views being advanced by leaders in the women's health establishment in the US and Canada who also include the impacts of “racism, classism, ageism, and sexism, at the societal, institutional, and individual level (sic) as contributors to health inequities” (Bierman, 2003). It was also federal agency personnel among the US respondents who raised concerns about mental health and violence. A US Border Health Commissioner, for example, lamented that “women are not wanting to take a very active role in defending [their] rights” seeing this as part of their cultural heritage. But in Mexico, attention to violence crossed positional lines (federal administrators, local health providers, local health advocates, and researchers). They mentioned not only the current femicides in Ciudad Juárez but persistent cultural values and power structures within and outside the family. Their responses are elaborated and related to border culture and current crises such as drug trafficking.

Violence does not let you advance, grow, empower yourself, take on leadership; it limits you or can make you sick…. It can affect STDs, violence within sexuality itself, decision-making and caring for one's body…. They are all very much interrelated. Changes begin the moment a woman is employed, in being able to leave the violence behind and begin caring for her body. (Mexican local health advocate).

National differences occur in discussions of women's use of preventive health care, especially in relation to cancer. Among Mexicans, the discourse related less to cost than it did among US respondents, acknowledging the Mexican government's public health services; Mexicans referred to time constraints, poor-quality services, lack of education, and women's prioritization of family care over self-care. Similar to the life span perspectives expressed by US federal officials, the principal differences recognized among Mexican women related to their age (e.g., menopause, or youth and STDs).

As with the discussion of what constitutes the border region, again we noted silences. The absence of discussion of reproductive/abortion rights was striking, particularly in the US where this has long been politically controversial. Only one (federal, Mexican) health official mentioned abortion within the context of a wider discussion of reproductive health, perhaps acknowledging recent activism around legislation passed in the Distrito Federal allowing first-trimester abortions. There was also little discussion among US respondents, except by federal-level administrators, of chronic health issues such as cardiovascular health, obesity and diet, topics that are in the forefront of US health discourses. Nor were environmental health hazards discussed, though by contrast they have been highlighted as urgent border issues by political scientists (Udall Center for Studies in Public Policy, 1993), and linked to poverty, undocumented migration, and to occupational hazards of migrant agricultural workers. Political scientist Bromley (2002), who interviewed community women in Nogales AZ/Nogales Sonora, also focused on the structural and environmental problems that impinge on women's health: poverty, housing, water and air quality, and waste disposal. We suggest that disciplinary positionalities are influencing interpretations. The biomedical training and milieux of our respondents might reflect their orientations to individual and behavioral perspectives, compared with the structural issues that we identified in the political science research. Health policy analysts point to important antecedent influences on the training of health researchers and care providers, identifying the homogenized and conservatizing influences of the government and private funding agencies that underwrite health research (Muntaner and Navarro, 2004), an over-reliance upon the forms of scientific knowledge that lead to an individual behaviorist approach to health promotion, the omission of a critical examination of the politics of knowledge production (Bryant, 2002), and the focus of the international agreements on economic themes rather than more inclusively on issues of social well-being (Navarro and Muntaner, 2004; Staudt and Vera, 2006).

The boundaries of “gender”

Our final theme relates to the ways in which our respondents conceptualized gender. Feminist scholars in the social sciences and humanities have devoted considerable attention to cultural constructions of the body and intersections of sexualities and gender, as have feminist health researchers. But what about professionals engaged with policy and practice related to women's bodies? How do they express their interpretations, especially as these might reflect positionalities and situated knowledges? In this arena, we saw relatively few differences among our respondents by position or across borders. “Gender” tended to be equated with “women” (or “men”) and was likely to be discussed in terms of biological sex.

Gender equity and equality perspectives were not clearly distinguished. “I think when you are discussing, or when you are making policy for health issues, it should be equal. There shouldn't be more or less available to men or women...” (US local health administrator). Mexican respondents frequently used the term “gender” but that seemed to reflect more its usage in official trainings, instructions, and publications, or was conflated with women's reproductive health concerns or sex-based medicine, as in the US. As a Mexican researcher noted: “It is difficult because the providers aren't just people following professional norms; they bring to it their personal history, their cultural background…. So they assume a paternalistic stance and do it without any bad intention to be sexist; it's their medical culture…. So all this about gender perspective is something that is widely talked about but little understood or applied.” Gender mainstreaming was also mentioned by Mexican federal health officials as well as local community advocates. They agreed that although it has become state policy, implementation greatly depends on the sensitivity and training of local administrators: “I think that's the big problem with [gender mainstreaming] right now. It's decreed, and if you check the official program documents

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4 The Ley General de Acceso a las Mujeres a una Vida Libre de Violencia (General Law for Women's Access to a Violence-Free Life) has been ratified at the Mexican federal level as well as by the Mexican Distrito Federal (Federal District). Though the Arizona state government's Division for Women in the Office for Children, Youth and Families reports high rates of violence against women as a key concern (see http://goacyf.az.gov/Women/), this priority has been in place for some years and did not emerge in the interviews with informants in the state.
gender is everywhere, but if you look a little closer at how they're implemented, there's absolutely nothing” (Mexican health researcher).

Some respondents identified gender issues as power issues, specifically in terms of how medicine has been androcentric—e.g., “not too long ago, maybe twenty years ago, everything in medicine was based on the average man” (US regional government health administrator). A Mexican state government health administrator reflected: “breast cancer is not something that's been a problem for only the past four or five years, if we look at the statistics, it's been a problem for 10 or 15 years, but we began to [consider it a priority] only recently, and that's due to the inclusion of gender [considerations] in our programs.” But although gender discrimination is acknowledged, there is little sense of how gender-sensitive policies can help eliminate disparities: “I don't think you could develop good policy, ignore, and pretend that we are just sort of sexless. You can't develop policy that says we are not going to address sexual differences in men or sexual differences in women. So, I think gender has to play a role. Now, I don't know how, you know, but I think it has to be addressed” (US regional government health administrator). Furthermore, many interviewees identified statistics and indicators as the foundation for health policy-making, but did not discuss how these statistics and indicators can be gender-biased or gender-blind.

All but five of our interviewees were women. Two of the (US) men quickly moved away from discussions of women's health to men's disadvantages, while a third man acknowledged that women faced inequalities but remarked in relation to gender and health policies “It's not an issue I've thought much about, beyond having programs that are tailored specifically towards women's needs” (US health researcher). Among Mexican male respondents only one, a state-level NGO activist, demonstrated a socio-cultural understanding of gender, while the other two (a state public health official and a national official) often used language reflecting sex-based medical-professional training focused on morbidity and mortality measures. Though not the case among Mexican male or female advocates, a woman state-level health advocate in the US was relatively unfocused on women/gender throughout her interview, at times moving to children's health as though it was interchangeable with women's health. Her positionality could well reflect her professional responsibilities as a health advocate at a time when children's health was on Arizona's legislative agenda.

More cultural constructions emerged in discussions of women's socialization and their roles in the family and community, tied generally to normative views of Hispanic culture according to which women were perceived to be passive and submissive to men, yet held responsible “for our surroundings, our children, our husbands, politics, schools, and whatever else” (Mexican local health advocate). At the same time that women were constructed as “victims,” or accepting of “traditional” cultural roles, they were involved in community advocacy roles, especially as health promoters going into communities as health educators and resource liaisons.

Yet this advocacy may be presented in individual terms, not linked to significant structural changes. As one Mexican federal official replied: “Generally speaking, among activists, their priority is the health problem that has changed their lives, and they lobby around their personal needs,” though she continued that there are those in civic organizations, women's movements, and academia who conceptualize issues from more theoretical and abstract perspectives. Ironically, while the contributions of promoters continued to be acknowledged, there were also sharp criticisms of their increasing marginalization by the health system: “The promotora movement of the 1980s, which was revolutionary in all senses, has been absorbed by the medical bureaucracy as the lowest rung. Promotoras are below the custodial/cleaning staff, and are of course five rungs below the secretaries. Wherever you go today in the [Mexican] Republic a shop clerk still earns more than a promotora” (Mexican state-level NGO activist). Thus while motivations may be seen in individualist terms, structural obstacles to their work were recognized.

Looking back, looking forward

In linking interpretations of positionalities and places in relation to thinking about priorities for women's health care, we have emphasized geographic location and professional positions. We find that the geographic scale of responsibilities and frames of reference are connected, as are location in Mexico and the US, respectively. Further, professional background and responsibilities are evident in the views presented. These distinctions are notable in identifications of what constitutes the “border” as a field for action and in identification of priorities to address health care for women. Among almost all interviewees there were lacunae in the discourse, especially with respect to life stage and ethnic differences, and in relation to environmental health. The Mexican and US differences in relation to identifying violence within the family are marked, while the silences around reproductive rights occur on both sides of the border. Given the limited understandings expressed about ways in which gender is implicated in health it would appear that there is a need for greater and more effective incorporation of this theme into health education at regional and local levels in particular and in efforts by PAHO if it aims to promote gender mainstreaming.

Our findings support the perspectives of research noted in other contexts by Atkinson (2002, 2006) and Williamson (2004). Nevertheless, we also want to make clear that we are not being deterministic, and that we recognize nuanced constructions. Like Mountz, we see the importance of individual biographies (life experiences) as they intersect with situations and positionality. These are exemplified by the views we reported of the Mexican federal administrator who spoke of growing up in the border region and of the US federal administrator who likened women's health issues in the border region to those with which she was familiar among low income and immigrant groups elsewhere in the US.

We see our research as significant for opening up the multifaceted and sometimes competing discourses that bear on conceptualizations of what matters for women's health at the border and for fostering advocacy of more effective, inclusive, gender-aware policies and services that recognize the conditions and dilemmas of the border region. In this we identify with the arguments of Gideon (2006), Gould et al. (2006), and Lewis (2006) about the importance of crossing levels. We do, however, recognize that when one moves into a setting where local, regional, national, bi-national, and transnational scales come into play with multiple discourses, both organizationally and in terms of health care practices and understandings, the challenges are complex and important, as suggested by Curtis (2008) in addressing issues of place and region in relation to health policies in Europe and by Paasi (2004) in his review of the complexities of the concepts of place, region, and scale.

Since our interests are in action as well as in research, we conclude with some preliminary thoughts about strategies for fostering changes, which, as Morehouse and Salido (2004) argued, are “pivotal” for this (and potentially other) border contexts. We suggest several actions. First, our findings indicate that in this setting, more attention needs to be paid by health experts to
issues of violence against women on both sides of the border and as they (attempt to) cross the border. Such actions could include curriculum development seminars, gender-sensitive training for health workers and advocates, workshops at conferences that bring together practitioners and researchers from both sides, and the development of web-based materials. Efforts should address not only individual, behavioral approaches or be expressed in relation to stereotyped or “traditional” notions of Hispanic/Mexican culture, but also be cognizant of larger systemic issues, of diversity within the population, and addressed to building capacity for thinking about responsible citizenship and institutional agendas. Second, more spaces are needed for dialogue among officials within both countries and between them. Some of the urgent policy changes require federal implementation within each country, yet state, regional, and local perspectives need to be simultaneously brought to bear. We see the necessity of attending to the situated and contextual differences in roles, frames of reference, and identities of players (George, 2007; Standing, 2002). We are aware that changing the discourse is not an easy task. Our research makes clear that the voices and perspectives are partial (in both senses of the word), disparate, and situated. Our experience of trying to promote gender considerations as invited presenters at a hearing of the US–Mexico Border Health Commission offers one example of the difficulties. During our oral testimony the English–Spanish translator persisted in translating “gender” as “general” although we passed a note to the effect that we were speaking of “género,” not “general.”

Tellingly, as we noted at the beginning of this paper, the summary document, Border Health 2010, does not discuss how gender impacts the health of men and women, and thus includes no strategies to address gender-specific issues. Furthermore, the document is offered as a “bilateral agenda” with a “bi-national program” but its priorities and objectives are based on those established by respective national-level officials with different indicators and goals for each side. This leads us to wonder how much flexibility there is for including priorities and interventions relevant to transborder practices. Others have recognized (Bruhn and Brandon, 1997) the difficulty of attaining consistent transborder cooperation on health when governments design and implement national-level policies and attempt to induce change by mandate without empowering local communities to adapt those for implementation given their context and capacity. They suggest that cooperation can be successfully achieved in small-scale, local projects, something that the Consortium has endeavored to do in its research and action programs. Recommendations by Gideon (2006, 2007) in the Chilean context, by Standing (1997), Theobald et al. (2005), Health Canada Women’s Health Bureau (2003), and by the Liverpool School of Tropical Medicine (in relation to their work in several African countries,) as well as in PAHO’s Plan of Action on Gender and Equality, all argue for forming strategic alliances across jurisdictional boundaries in order to ensure effective integration of gender perspectives into health policies and services. Based on the Consortium’s experience, we would affirm those conclusions as applicable not only across organizational or sub-national divisions but across international boundaries as well. We share the view that “[ultimately health is political because power is exercised over it as part of a wider economic, social and political system” (Bambra et al., 2005, p. 187), and thus acknowledge the logical and strategic rationales of forming alliances across all jurisdictional boundaries that impinge on health policy and shape the range of possible outcomes for women’s health status.

Borderlands such as those we inhabit are important sites and laboratories for approaches that go beyond sectoral analyses that reveal health disparities. Borderlands are important for unmasking ideological claims by revealing connections between political values, assumptions, and models of decision-making that reflect gendered outcomes in individual, group, and population health. In order to promote policies that would acknowledge women as fully valued and diverse persons and health as a human right instead of a variably rationed commodity, we need to find ways to foster cooperation and responsibilities that transcend multiple borders of place and positionalities and to elucidate the intersections of “sex” and “gender.”

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References


