program presentation varies as each Witness Project role model contributes a different set of experiences, resulting in a quilt of stories of survival by African American women. Given that there are now hundreds of Witness Project role models, this provides a diverse and rich foundation of knowledge and experience.

3. The first phase of intervention research in The Witness Project in Arkansas (1992–1995) used a quasi-experimental, pre- and post-test observational design to measure project effectiveness in increasing breast self-examination (BSE) and mammography rates among 206 rural African American women in two rural Arkansas study counties, compared with 204 women in control counties. Women who participated in The Witness Project program significantly increased mammography screening behavior ($p < .005$) and BSE ($p < .0001$) compared with women in the control counties, who did not attend these programs (Erwin et al. 1999). The Witness Project was shown to be especially effective in reaching lower-income, lower-education-level, and aged minority women (Erwin et al. 1996). Another study, which took place from 1998 through 2001 and was funded by the Centers for Disease Control and Prevention, demonstrated that The Witness Project model could be successfully replicated and sustained in more than twenty sites over four years with comparable screening outcomes (Erwin et al. 2003). A review in 2005 showed that thirty sites in twenty-one states continued to sustain The Witness Project in their communities. Over a twelve-month period, these states reported conducting 595 educational programs on breast and cervical cancer screening for more than 25,000 African American women. Perhaps more striking than the screening evidence, a standard requirement for "evidence-based" effectiveness within biomedical sciences, are the continued acceptance and support of the intervention method by communities of African Americans across the United States, as evidenced by grassroots sustainability more than six years post research funding. This sustainability of community outreach may be rooted in the cultural "competence" (Hedrick 1999) of the spiritual, narrative, and metaphorical components of the program beyond the measurement of scientific and theoretical outcomes.

8

Wasting Away in Neoliberal-ville

Mexican Immigrant Women's Views of Cervical Cancer, Social Inequality, and Gender Relations

Leo R. Chavez

We've got an interesting debate in health care in America. And I guess if I had to summarize how I view it, I would say there's a choice between having the government make decisions or consumers make decisions. I stand on the side of encouraging consumers. I think the most important relationship in health care is between the patient and their provider, the patient and the doc....And health care policy ought to be aimed at bolstering the consumer, empowering individuals to be responsible for health care decisions.

—President George W. Bush

I will put up with the pain because they charge one hundred dollars each time I go to the doctor, and if I have something bad, they will send me somewhere else, and I will have to pay more. If they have to operate, that will be very expensive. The truth is, we are not in the position to pay.

—Lupe, thirty-three-year-old undocumented Mexican immigrant, explaining why she would not seek medical care as indicated by a Pap exam

Since the 1970s, the neoliberal doctrine of free markets and minimal government intervention, especially through social support programs, has become pervasive in the world, owing much to policies of the United States (Reaganism) and England (Thatcherism) (Dumenil and Levy 2004; Harvey 2005). According to this doctrine, governments should work toward liberating the individual to pursue entrepreneurial interests while guaranteeing property rights, free trade, and the integrity of money (Harvey 2005). Although economic inequalities have increased with neoliberal reforms, the

so-called welfare state has taken on a negative connotation (Goode and Maskovsky 2001). As a result, "deregulation, privatization, and withdrawal of the state from many areas of social provision have been all too common" (Harvey 2005). How low-income and poor people have managed under neoliberal policies has been a recent concern of anthropologists (Goode and Maskovsky 2001; Lyon-Callo 2004)—a concern that also motivates this chapter.

In this chapter, I examine two key aspects of neoliberalism in relation to the health of Mexican immigrant women in the United States (see Harvey 2005). First, it lays out the neoliberal context of these women's lives in the United States. As Vincent Lyon-Callo observed, "Neoliberalism is more than just a set of practices and policies. Rather, it is a set of ideas and ways of imagining the world" (Lyon-Callo 2004:11). A crucial aspect of this imagined world is the assumption that personal responsibility is the key to individual freedom and economic competitiveness. Under US neoliberalism, immigrants are "free" to participate in the labor market. Even undocumented immigrants find only token, or symbolic, resistance to their employment (Calavita 1982, 1996). However, governmental policies have reduced immigrants' access to social and medical services. Immigrants' lives are subject to what Michel Foucault has called "biopolitics" and "governmentality," the control of the conduct of populations, a process in which the media plays a central role in communicating values, shaping information, and producing neoliberal subjectivities (Briggs and Hallin 2007; Foucault 1991, 1997; Rabinow and Rose 2006). As this chapter will argue, neoliberal assertions of personal responsibility are contradicted by Mexican immigrant women's views of their unequal position in society and the labor market, despite their individual efforts.

The second objective of this chapter is to redirect the focus from government policies to lived experiences. Neoliberalism's emphasis on personal responsibility pervades the epidemiology of cervical cancer. As such, it builds on what Deborah R. Gordon calls the "tenacious assumptions" in Western medicine concerning individualism, "a complex of values and assumptions asserting the primacy of the individual and of individual freedom" (1988b:21). Risk, in medical discourse, becomes a way of constructing subjects with identifiers that define them in contrast to the "normal" and as needing medical interventions and control (Foucault 1977a, 1980; Santiago-Irizarry 2001). However, medical anthropologist Emily Martin (1987) showed how women's perceptions of their bodies served as points of resistance to biomedical constructions. Rayna Rapp (1988) found similar resistance to the language of risk among genetic counseling recipients.

To what extent do Mexican immigrant women come to embody risk (Robertson 2000) as viewed within the current neoliberal context? That is, does their understanding of cervical cancer posit the individual as responsible for her own health problems?

Mexican immigrant women complicate the risk factors for cervical cancer in two ways. First, they are aware of the political and economic constraints that relegate them to the fringes of medical care in America. Being poor, powerless, and defined as illegitimate members of society constitutes, for them, risk factors for diseases such as cervical cancer (see McMullin, chaptr 4, this volume). Second, they do not fully buy into the concept that the individual is the cause of all her own medical problems. Mexican immigrant women emphasize their husband's or partner's role as a risk factor for cervical cancer, rather than assume all the risk as their own personal responsibility. That is, Mexican immigrant women view their health in relation to their social relationships, particularly gender relations, which also increase the chances of acquiring cervical cancer (Hirsch et al. 2002). Such understandings of their vulnerable status in society and gender relations offer both a critique of and an alternative to neoliberal constructions of medicine. This suggests the importance of what Ann Robertson calls the phenomenological level, one in which particular forms of subjectivity emerge—that is, "a particular way of thinking about, relating to and situating the self in terms of the broader social and political context within which the self is embedded/located" (2000:230).

The data examined here come primarily from in-depth, qualitative interviews with thirty-nine Mexican immigrant women for a study of cancer and Latinas in Orange County, California (Chavez et al. 1995). (Interviews were also conducted with twenty-seven Anglo women and thirty physicians; however, these data will not be examined in depth here.) In addition to these qualitative interviews, the final example presented here utilizes data on the use of Pap exams collected through a random-sample telephone survey that was also part of the cancer and Latinas study (Chavez et al. 1997).

NEOLIBERAL POLICIES, PERSONAL RESPONSIBILITY, AND ACCESS TO MEDICAL SERVICES

Mexican immigrant women living and working in the United States are at the apex of neoliberalism's "culture of indifference" (Nguyen and Peschard 2003). They are stigmatized as "foreign" labor and relegated to low-paying jobs, often without medical insurance. They are the targets of nativistic wrath, government surveillance, and often violent crime, all factors that are detrimental to their health (Chavez 1997, 2003; Inda 2006;

Zavella 1997). They are also unwilling pawns in the politics of immigration, in which the demand for immigrant labor is greater than the "acceptable" number of immigrants allowed to enter the country legally. Thus, the Mexican women who come to the United States to meet our labor demand without authorization are called "unwanted," "unauthorized," "undocumented," and "illegal," terms that underscore their position of social inequality. As if this is not bad enough, Mexican immigrant women are also caught in the crosshairs of a war on terrorism and a war on the poor (Farmer 2003). Their migrations for family reunification are everyday made more difficult and dangerous by increased border surveillance and fences, and medical care for themselves and their newborn children is increasingly being restricted (Gaouette 2006; Pear 2006). As a result of neoliberalism's hallmark practices of benign neglect and personal responsibility, Mexican immigrant women must often choose between personal health and economic survival in US society. The objective evidence on morbidity and mortality rates for cervical cancer is testimony to Mexican immigrant women's embodiment of their low status in the nation's social hierarchy (Nguyen and Peschard 2003; see also McMullin, chapter 4, this volume).

Mexican immigrant women's lives are subject to increasingly draconian policies restricting their access to medical and other social services (see Heurtin-Roberts, chapter 10, this volume). On August 22, 1996, President Bill Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, ending the federal government's sixty-one-year commitment to providing assistance to every eligible poor family with children (Shogren 1996). This welfare reform law was expected to save the government $54 billion over the ensuing six years, with about half of those savings, or $24 billion, to come from restricting legal immigrants' use of food stamps; Supplemental Security Income; and aid for low-income elderly, the blind, and the disabled. Legal immigrants were barred from using Medicaid for five years after their entry (US Congress 1996). Undocumented immigrants, already denied virtually all federal aid, continued to be barred from assistance except for short-term disaster relief and emergency medical care. Benefits, however, were soon restored to some at-risk populations, especially the elderly (McDonnell 1998).

In addition to welfare reform, the US Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (Bunis and Garcia 1997). Among the changes to the nation's immigration laws included in this act was the provision making an immigrant's sponsor financially responsible for public benefits used. This provision, according to Mohanty and colleagues, "created confusion about eligibility and

appeared to lead even eligible immigrants to believe that they should avoid public programs" (Mohanty et al. 2005:1436).

On December 16, 2005, the House of Representatives passed HR 4437, the Border Protection, Antiterrorism, and Illegal Immigration Control Act (US Congress 2005). The bill represents a "get tough" attitude toward undocumented immigration. Its many provisions include more border fences and surveillance technology, increased detention, employer verification of employees' work eligibility, and increases in the penalties for knowingly hiring undocumented immigrants. Moreover, the act makes living in this country as an undocumented immigrant a felony, thus removing any hope of becoming a legal immigrant. The bill also broadens the nation's immigrant smuggling law so that people who assist or shield illegal immigrants living in the United States would be subject to prosecution. Offenders—who might include priests, nurses, social workers, or doctors—could face up to five years in prison, and authorities would be allowed to seize some of their assets. These measures may or not be part of a final immigration reform law, but the willingness of the House of Representatives to pass these measures sends a clear message to undocumented immigrants about their stigmatized status in the United States.

The nation's welfare and immigration laws reflect the government's deinvestment in social and medical services, especially for immigrants. Such neoliberal policies have had significant implications regarding immigrants' use of medical services. For example, a recent study in the United States (Mohanty et al. 2005), based on the 1998 Medical Expenditure Panel Survey and the 1996–1997 National Health Interview Survey, found that health care expenditures are substantially lower for immigrants than for US-born persons. This was especially the case for Hispanics. Mohanty and her colleagues found that the adjusted per capita health-care expenditures among immigrant Hispanics was $962—significantly less than the $3,117 and $1,747 spent on US-born non-Hispanic Whites and non-Hispanic White immigrants, respectively; a little more than half the $1,870 spent on US-born Hispanics; and less than that spent on both US-born and immigrant African Americans and Asian Americans. As the authors conclude, "Our study refutes the assumption that immigrants represent a disproportionate financial burden on the US health care system" (Mohanty et al. 2005).

The problem is that Mexican immigrants may not be getting the medical care they need, especially nonemergency medical care. Access to the US health care system is primarily determined by third-party payment guarantees—that is, government or private medical insurance. If a patient does

TABLE 8.1
Cancer and Latinas Project (Early 1990s)

		Private or Government Insurance	
	N	Insured	Uninsured
Mexican immigrant women	39	13 (33%)	26 (67%)
Anglo women	27	24 (89%)	3 (11%)

not have such payment guarantees, the door to medical care is pretty much closed (Carrasquillo and Pati 2004; Rodríguez, Ward, and Pérez-Stable 2005). The Mexican women interviewees in question were definitely at a disadvantage with regard to medical insurance, compared with their Anglo counterparts (table 8.1). Twenty-two of the women (56 percent) were undocumented immigrants and were much less likely to have any form of medical insurance than were their legal counterparts (77 percent versus 53 percent). These qualitative interviews are comparable to the random sample of 803 Latinas and 422 Anglo women that we collected the following year (Chavez et al. 2001) in Orange County. Thirty-seven percent of the undocumented Mexican women in the survey (N = 140) had government or private medical insurance, compared with sixty-five percent of legal Mexican immigrants (N = 269).These surveys were conducted in the early 1990s, but a survey I conducted in 2006 found similar results. Fifty-percent of the undocumented Mexican immigrant women in Orange County in that survey (N = 128) had no medical insurance of any type, compared with 61 percent of their legal resident counterparts (N = 148).[1] Mexican immigrant women today face obstacles to medical care similar to those described by the women we interviewed in the early 1990s.

The Mexican immigrant women we interviewed were well aware of the problems they experienced accessing medical care. Their comments stand as stark testimonials to their position in the neoliberal health care system of the United States.

Laura (all names are pseudonyms), a thirty-seven-year-old, married, undocumented immigrant woman from Michoacán, Mexico, had been in the United States for about a year and three months when we interviewed her. She explained why she did not seek cancer screening tests: "These have got to be expensive, and often one does not have enough for food for the children. There are people who can afford to get such care. But poor people like me—I have been poor all the time—I don't have the wherewithal to get checkups."

Marcela was fifty-three years old, married, and a legal resident who had been in the United States for about seventeen years. Even though she had a major medical problem, she had difficulties getting medical care: "I had a mammogram months ago, and they told me that I had to get a biopsy, but I have yet to do it. I don't have the resources because my spouse has been out of work for six months, and we don't have insurance to cover it."

Ester was thirty years old and a legal resident who had been in the United States for about thirteen years. Although she had medical insurance at the time of the interview, for many years she did not. She explained what it was like trying to get medical care without insurance:

> It is very difficult to get service if you do not have money in your hand. For example, at the hospitals, if you do not have money in your hand, although you look like you are ready to pass out, if you are dying, they will not give you service. You have to have a deposit of one hundred to thirteen hundred dollars. So that was the problem, if you did not have money, and no insurance.

Luzmilla was twenty-seven years old and single, had been in the United States for about seven years, and was not a legal permanent resident at the time of the interview. She admitted,

> I don't have insurance. Not to have insurance is something awful, right? Because here in the United States, medical care is very expensive. And you know that, for many people, what we earn is barely enough to eat and live. So when we have these types of illnesses, we don't go to the doctor because of a lack of money. Insurance would help a great deal because then they would attend to you and you would not have to pay.

Lola was twenty-seven and married, had been in the United States for about ten years, and was a legal permanent resident at the time of the interview. Without insurance, she often had to decide between health care for herself and health care for her children: "Sometimes people don't have money for exams. Because these exams are expensive, right? Sometimes they have many children, and their money is not enough for everyone to have medical care."

As these women's observations suggest, medical care is an endangered commodity in today's neoliberal climate of reduced government responsibility, especially for noncitizens. Policies that emphasize the individual's personal responsibility for health care resonate with the epidemiology of

cervical cancer risk factors and also place an inordinate responsibility on the individual woman for her health problems.

CERVICAL CANCER RISK FACTORS AND PERSONAL RESPONSIBILITY

The following are commonly cited epidemiological risk factors for cervical cancer:[2]

- Infection with human papillomavirus (HPV)
- Early age at first sexual intercourse
- Multiple sexual partners
- Smoking
- Chlamydia infections
- Use of oral contraceptives
- Multiple pregnancies
- Low socioeconomic status

All of these risk factors except low socioeconomic status target the individual and her behavior as the underlying explanation for her illness. She is personally responsible for avoiding these factors; in so doing, she will lower her risk for cervical cancer. Inda (2006), building on Crawford (1980), refers to the ideology of health and well-being attained primarily through modification of personal lifestyles and behavior as "healthism," which he views as a central component of the government's policies promoting marketplace-based medical care in lieu of government-financed medical programs. The inclusion of low socioeconomic status on the list is a nod to a lack of resources, money, and medical insurance, all of which may reduce a woman's access to medical care and cancer screening exams. It is important to note that none of these risk factors, despite the explicit link to sexual encounters, locates a woman in relation to her spouse or partner.

Physicians I interviewed as part of a study on cancer and Latinas (Chavez et al. 1995) followed this list of risk factors very closely. Thirty physician interviewees volunteered the following list of cervical cancer risk factors (percentages indicate the portion mentioning the risk factor):

- Multiple sexual partners (93 percent)
- Exposure to sexually transmitted diseases (90 percent)
- First sex at a young age (63 percent)
- Smoking (30 percent)

- Family history (20 percent)
- Poverty (13 percent)
- Use of birth control pills (10 percent)

The importance of a woman's sex-related behavior was so evident to the physicians that few even bothered to list other accepted risk factors. As one physician put it, "Human papillomavirus is the big thing now. Multiple sexual partners...that's a kind of generic coverall that just increases the risk by increasing your exposure to sexually transmitted disease." In other areas of the interview, three (10 percent) of the thirty physicians raised the issue of a spouse's or partner's behavior but still did not list this as a risk factor. The lack of epidemiological attention paid to women's spouses or partners is interesting because it occurs despite the observation many years ago that "a number of recent studies highlight the need for considering not only female influences on risk of cervical cancer, but also male factors, since the sexual behavior of the male consort appears to play an important role" (Brinton 1992:3).[3]

The importance of a woman's spouse or partner is particularly apt for Latinas, especially immigrants. The Mexican immigrant women in our study on cancer and Latinas placed the men in their lives at the center of their risk for cervical cancer. Eighteen of thirty-nine (46 percent) Mexican immigrant women explicitly called attention to men's behaviors creating a risk for them. This view contrasted not only with the physicians' but also with that of the twenty-seven Anglo women interviewed as part of the study. None of the Anglo women raised the issue of their spouse's or partner's behavior as a risk factor. Mexican immigrant women clearly saw risk as a social, not an individual, responsibility.

MEXICAN WOMEN AND THE MEN IN THEIR LIVES

Gender relations are the "background assumptions" that must be considered in relation to cervical cancer risk factors (Gordon 1988b). As the Mexican women's comments underscore, the assumptions about and taken-for-granted understandings of their gender relations inform their practices toward cervical cancer. By including their spouses or partners in their discussion of cervical cancer, the women complicate the risk factors. By this I mean that the Mexican women we interviewed saw both women's and men's behavior as having health consequences. They believed that women have to take responsibility for their lives by making the right decisions in relation to their bodies. The cervix, as part of the area related to sexual relations, is embedded in their understanding of morality and

normative behavior. In this sense, Mexican women believed that they must also take responsibility for their actions by not transgressing social norms or morality. However, the behavior of spouses or partners is often more difficult to control and thus decenters the women's notions of individual responsibility. Their chances of acquiring a disease like cervical cancer are also influenced by the actions of the men in their lives.

Let us first examine the circumstances under which Mexican women do consider individual responsibility as important for reducing the chances of getting cervical cancer. There are two areas of behavior over which a woman has some control. The first is how she "takes care of herself." For example, according to one interviewee, a woman must wait forty days after giving birth before exerting herself physically, and this includes avoiding sexual relations. She must also tend to matters of hygiene, mainly using douches as a way of keeping the vaginal area clean and healthy and free of infections.

According to Ester, "Developing cervical cancer can be from bad hygiene. By bad hygiene I mean that women don't take care of themselves. For example, they have a baby and immediately begin sexual relations."

Teresa, a sixty-seven-year-old widow and legal permanent resident who had been in the United States for about forty-one years, focused on cleanliness as a way to avoid health problems. Referring to douches, she said, "One needs to clean herself often to avoid contracting a disease."

Patricia—fifty years old at the time of the interview, divorced, and in the United States for three years as an undocumented immigrant—elaborated on the need for personal hygiene. As she said, "One must take care of oneself, clean oneself inside.... A married woman should keep herself clean, with these things they sell, right, the things they sell to clean you vaginally. I say that if one does this, then you'll get none of these things [diseases] that result from a lack of attention to cleanliness."

The second area of personal responsibility has to do with respecting normative behavior. Women who flout normative behavior may increase their risk of diseases such as cervical cancer, the "price" for such transgressions. This is, it must be emphasized, not fatalistic in the sense that it is God's will or God's punishment. Abortions, for example, may increase a woman's chances of getting cervical cancer, as Dolores, a fifty-nine-year-old Mexican immigrant, explained: "I think that there are illnesses that one looks for. For example, there are women who search out clinics to abort children. They are more likely to get this [cervical cancer]." When asked whether she thought God gave these women cancer, she responded, "No. They look for it." Having sexual relations outside marriage also transgresses normative behavior. As Dolores said, "Having sexual relations with people you don't know I believe is a cause [of cervical cancer]."

According to Lupe, women who engage in nonnormative sexual relations increase their chances of getting cervical cancer. As she explained, "There are women who do it for nothing more than to pay the rent—that's all. But now, even when the man does not fool around, now also the woman goes out with men other than her husband, and they get infected, and then they have children." By marking this behavior as a risk factor, Lupe emphasized the consequences of the personal decisions women make.

Teresa also pointed to nonnormative behavior. She said, "Another thing [that increases a woman's chances of getting cervical cancer] that I see here in the United States is that it is very natural for a woman to go out and be with a man, even though she is married, and later go out with another and another. For me, I do not believe that this is right, to have so much contact with men."

Interfering with the normal progress of a pregnancy can also create the possibility for health problems. Graciela, a fifty-two-year-old woman who had been in the United States for about six years as an undocumented immigrant, said,

> Maybe it [cervical cancer] is because they stop the baby from coming and they yank it out using herbs, like women who do it with teas, and there remains like a sore or wound. Just think about how a germ can get in there. Because sometimes it's one's own fault to be practically rotting because of a stupidity like that. It's preferable to have a baby and not yank it out, because a sore remains there. Afterwards, if she makes love too soon and her partner is not clean in that area, a bunch of dirty junk is going into her wound.

Nonnormative behavior and hygiene are combined in this narrative, and the emphasis is placed on the individual ("one's own fault") for these actions and outcomes.

The next area of possible concern for Mexican women is the inherent susceptibility of the vaginal area to physical stress and trauma. It is here that we begin to see the logic of these women's views, how men's actions can increase the risk of getting cervical cancer. Women spoke of the vaginal area, which includes the cervix, as having a "delicate" and "weak" nature. Women need to be careful not to "overtax" the area in order to avoid physical damage. This is an important part of the reason that starting sexual relations at a very young age is considered a problem, as Leticia, a

thirty-two-year-old married woman who had been a legal permanent resident of the United States for three years, explained: "Women who begin to have intimate relations when very young, they are more likely to get cancer here [the cervix]. Wouldn't that be from so much use? [*laughs*] That's why I tell my husband, 'Honey, stop!'"

Another quote ties together the delicate nature of the vaginal area and men's behavior in a way that undercuts the notion that women alone have responsibility for their health problems. Rather, Mexican women often view gender relations as central to raising the risk of conditions such as cervical cancer. In particular, men who treat women roughly during sexual relations can create health problems that lead to cervical cancer. Aurora, a fifty-five-year-old married woman, in the United States for thirteen years and a legal permanent resident at the time of the interview, said, "It is possible that there is a propensity for cancer [in the cervical area]. That is one's weakest part, that has the least defenses, and so in the woman, it is the part most affected and it is there that cancer strikes. Also, the manner in which one makes love, very savagely or very brusque, all of this I imagine has something to do with it. These are delicate parts."

Lupe concurred. When considering the factors that might increase a woman's chances of getting cervical cancer, she said,

> Well, I imagine that sometimes when the man and woman have sexual relations that are very exaggerated....There are some men who are very rude or brutes, you could say. They grab the woman as if she was an object. They don't know how to treat a woman delicately. That's not good. Sometimes these [physical] pressures, from seizing the woman badly, also cause these illnesses.

Luzmilla, when discussing the factors that might increase a woman's chances of getting cervical cancer, also focused on men's overly physical treatment of women. She said, "It could be because Mexican men aren't careful. They think of themselves as very macho, no? So they aren't careful with their own woman, even if they are married and he loves her a lot. Sometimes they are very rough. At the moment of having sexual relations, he can hurt her without realizing it."

Other Mexican women added to this theme. Socorro—thirty-nine years old, married, in the United States for eighteen years, and a legal permanent resident—described men as sometimes being rude or drunk, "grabbing the woman without being careful." Maria—fifty-six years old, a widow, seventeen years in the United States, and a legal permanent resident—added that the cause of cervical cancer might be that a man hurts a

woman during sex, because sometimes men are not careful. "You know how they satisfy themselves and you are not important."

Mexican women interviewees often drew a connection between sex during menstruation and cervical cancer, perhaps because the idea transgressed their sense of normative behavior. Here, too, they emphasized that men were the problem. As Luzmilla said, "Many men are very demanding. They demand that the woman has relations when her period is not yet over. I think that this is one of the causes [of cervical cancer]." Leticia agreed: "Men are very demanding....They demand a lot from the woman. Perhaps this is a cause of this illness, because he demands that the woman has relations when her period is not over. This is a cause, I believe."

Mexican women also blamed men for pressuring women for sex too soon after they have given birth, before the traditional forty days of rest have ended. According to Leticia, "There are women who do not get the forty days. They barely have three weeks, and they are having relations. The man insists on having relations, and what is her womb like? Sensitive; it is very delicate. This is partly a cause of cancer, I imagine."

According to the Mexican immigrant women interviewees, men also pose a risk for women because of their sexual activities away from home. As Lola said, "Cancer of the cervix—there are men who sometimes have sex with others and then infect their wives."

Carolina, twenty-three years old and married, had been in the United States for only about five months as an undocumented immigrant when she was interviewed. She agreed that men's behavior could create a risk for women. "If a man does it with a woman of the street, who are very dirty and are with many men...later, very often...you can get infected from your own husband. You don't know if he has had contact with another person or not. And it doesn't necessarily have to be with a woman of the street."

Soledad—twenty-eight, married, in the United States for about twelve years, and also undocumented—noted that women are vulnerable to their men's behavior. "For example, if a man goes and does it with other women that are infected and then comes and is with you, I imagine that you get everything that other woman has."

Monica noted that even a woman who does not have sexual relations outside marriage is not safe. She was thirty-six years old and married, had been in the United States for about nine years, and was also undocumented. "One can try and keep clean, but that will not protect you if your man gets an infection. Because one does not know where a man goes. Even if a woman is decent, if her husband has another woman, a lover, or goes where there are such things, and one doesn't know, you cannot protect yourself."

Finally, some of the interviewees noted that women may be ashamed or afraid to tell their husbands that they have a disease like cervical cancer. Teresa noted, "Some women are ashamed and very restrained. They don't know how to talk about such things because they are embarrassed. This includes many women who are ill but are ashamed and don't want to tell their husbands. Because their husband is going to think they were with another man; that is where she got that disease."

This final aspect of gender relations, fear of relating information about an illness to a husband or partner, can create a problem for a woman in two ways. First, such an attitude may be an obstacle to her seeking a Pap exam. Second, women who find that they do have a problem via a Pap exam may not return for follow-up care. Either way, the fear of telling a spouse about medical problems of this type—related to sexual organs—could significantly increase a woman's chances of getting cervical cancer or dying early because of delayed care.

How widespread was this fear among Mexican immigrant women? As part of the cancer and Latinas project, we followed the ethnographic interviews with a random telephone survey of Latinas (N = 803) and Anglo women (N = 422) in Orange County, California (Chavez et al. 2001). One of the questions we asked was whether interviewees agreed with this statement: "I would be afraid to tell my husband or partner that I have cervical cancer because it would affect our relationship." Responses to that question suggest that this belief is an important one among Mexican immigrant women. Of Mexican immigrant women surveyed (N = 371), 19 percent agreed with this statement, compared with only 2 percent of Anglo women —a significant difference.[4]

How important is this fear in relation to the use of Pap exams? The effect can be examined through logistic regression analysis using the same survey data. Never having had a Pap exam or having had a Pap exam more than two years before the interview is defined as low compliance, the dependent variable in the analysis. Mexican immigrant women were the subjects of the logistic regression. Seven independent variables were entered in the analysis: medical insurance, a language/acculturation index score (based on four questions concerning use of Spanish and English), years in the United States (below or above the median ten years), annual family income (below or above the median $15,000), years of schooling (less than twelve years and twelve years or more), marital status, and fear of telling a husband or partner about cervical cancer.

The results of the logistic regression (table 8.2) indicate that all the variables except years in the United States and income are significant predictors of the Mexican immigrant women's use of Pap exams. As the odds ratio (Exp[B]) indicates (table 8.3), women with medical insurance were 89 percent more likely than those without insurance to have had a Pap exam recently, holding all other variables constant. Women who were above the mean on the language/acculturation index were more than two and a half times more likely to have had a Pap exam recently than those who used English less in their daily lives. Women with twelve years or more of education were also more likely to have had Pap exams than those with fewer years of schooling. Married women were almost three times more

TABLE 8.2
Frequencies of Variables in the Logistic Regression

Pap Exam	
Never, or more than 2 years before interview	40.6%
Within 2 years before interview	59.4%
Language/Acculturation Index (5-Point Scale)	
Median = 1	50.7%
Above median = 1.2–5	49.3%
Medical Insurance	
No private or government insurance	44.9%
Yes, private or government insurance	55.1%
Years of Schooling	
Under 12 years	76.4%
12 years or more	23.6%
Years in the US	
10 years or less (median)	50.2%
11 years or more	49.8%
Income	
$15,000 or less (median)	56.0%
More than $15,000	44.0%
Marital Status	
Not married	23.4%
Married/living together	76.6%
Belief about Cervical Cancer	
Afraid to tell spouse	19.4%
Not afraid to tell spouse	80.6%

TABLE 8.3

Logistic Regression: Use of Pap Exams by Mexican Immigrant Women

Variable	*Beta*	*S.E.*	*Sig.*	*Exp(B)*
Insurance	.639	.305	.036	1.89
Language/acculturation	.986	.321	.002	2.68
School 12+ years	.842	.403	.036	2.32
Income	.300	.334	.369	1.35
11+ years in US	.201	.335	.549	1.22
Married	1.074	.351	.002	2.93
Not afraid to tell Spouse	1.110	.346	.001	3.04
Constant	-6.248	1.136	.000	.002

Model coefficients: X2 = 57.757, df = 7, Sig. = .000. (N = 271)
Source: Latinas and Cancer Study, University of California, Irvine

likely than unmarried women to have had Pap exams recently. Mexican immigrant women who said they were not afraid to tell their husbands or partners that they had cervical cancer were three times as likely to have had a Pap exam recently as the women who feared that such disclosure would change their relationship. Important for the argument here, the two variables pertaining specifically to women's relationships with men—being married and the fear of telling their spouses or partners that they had cervical cancer—had the highest odds ratios among the variables in the analysis.

MEXICAN WOMEN'S VIEWS RECONSIDERED

Paul Farmer observed that "the 'neoliberal era'—if that is the term we want—has been a time of looking away, a time of averting our gaze from the causes and effects of structural violence" (Farmer 2003:16). This chapter has attempted to refocus our gaze on the lives of Mexican immigrant women who worry about medical care for themselves and their families while at the same time struggling to make a living in a society in which they are often considered "matter out of place," as Mary Douglas ([1966]2002) might have put it. As such, society views them not only as expendable but also with a certain stigma, especially because of their use of social services, including medical care. Working in predominantly low-wage jobs without such benefits as medical insurance and finding government insurance increasingly difficult to obtain, Mexican immigrant women see medical care as but one of the many demanding concerns of their lives. Paulo

Freire (1970) made a similar observation many years ago concerning the low priority personal health can take among the poor, whose more immediate concerns have to do with daily survival.

Mexican women in the United States confront policies that make acquiring medical care difficult. Policy makers use the women's noncitizen status as a way of rationalizing neoliberal policies that reduce the government's support of social and medical programs. Immigrants are increasingly "on their own" when it comes to illness and disease. Citizens support such policies becaues these appear to reinforce the privileges of citizenship. As the Mexican immigrant women's observations indicated, they are fully aware of the barriers they must negotiate and the priorities they must set in their struggle to survive in the United States. Personal medical care, in such a draconian calculus, does not always rise to the top of the list of priorities. In this sense, Mexican immigrant women do embody their social and political circumstances; their bodies are often neglected in terms of medical care.

In respect to cervical cancer, there is a tension between individual bodies and social bodies. Mexican immigrant women place gender relations at the center of their understanding of the factors that might increase their chances of getting cervical cancer. Men create risks for women in many ways. Women characterize their own behavior as something for which they should take responsibility, but they express less agency in their gender relations. Men seem to make demands, exert pressures, and have expectations that the women must negotiate. The men in their lives may also bring home problems (infections, disease) unexpectedly, undermining women's own attempts at prevention (keeping within the bounds of normative behavior, practicing good hygiene, and taking care of themselves). The decision to seek Pap exams is influenced by Mexican immigrant women's understandings of gender relations.

These women are, on the issue of cervical cancer, ahead of medical interventions for the disease, which typically do not focus on men. For example, vaccinations for HPV are currently targeted only at women, despite the fact that men also carry the virus. As the testimonies of these women suggest, men should be included in any discussions and interventions focused on cervical cancer risk factors.

The women examined here do not reproduce the tenacious assumption about the individual as the focus of biomedical risk factors. Their lives are more complex, situated within the messy world of immigration politics, a neoliberal labor market and medical care system, and gender relations. An understanding of such facts would be beneficial when developing interventions for explaining cervical cancer risk factors, which tend to focus

on women and their behaviors. If the findings here can serve as a guide, interventions need to focus more on the social world of Mexican immigrant women. Their gender relationships are meaningful in, and clearly a part of, their decision making regarding medical care. To ignore this fact—or to be blinded by the assumptions about individual responsibility so inherent in neoliberal doctrine and epidemiological research on risk factors for cervical cancer—limits the efficacy and relevance of medical interventions.

Notes

The first epigraph in this chapter is from "Health Transparency in Minnesota," a speech delivered in Minneapolis, Minnesota, August 22, 2006. See http://www.whitehouse.gov/news/releases/2006/08/ 20060822-4.html, accessed December 19, 2008.

1. The Orange County Survey was conducted in 2006 under the auspices of the Center for Research on Latinos in a Global Society, University of California, Irvine. Interviewing Service of America conducted the telephone survey January 4–31, 2006. For more on this survey, see Chavez 2008b.

2. For example, see http://www.cancer.org/docroot/CRI/content/CRI_2_4_2X_What_are_the_risk_factors_for_cervical_cancer_8.asp on the American Cancer Society Web site, acccessed December 19, 2008.

3. For more on Latina sexuality, see Martinez, Chavez, and Hubbell 1997 and Zavella 2003.

4. Chi-square test, p = <.0001.

9

Notes from White Flint

Identity, Ambiguity, and Disparities in Cancer

Simon J. Craddock Lee

Along a busy commuter thoroughfare in the suburban neighborhood of White Flint—sometimes Bethesda North, but more truly Lower Rockville—set back in a soulless office park in a suite of offices like any other is a group of people that is not like any other. Each day, a cadre of scientists and other specialists—a community, in practice—is at work and routinely devote its energies to the idea of cancer control and prevention as a social problem posed in terms of human groups and populations.

Established in 1997, the Division of Cancer Control and Population Sciences (DCCPS) of the National Cancer Institute (NCI) supports research in epidemiology, social-behavioral sciences, health services, surveillance, and cancer survivorship. DCCPS promotes research across the cancer continuum, in both fundamental and intervention sciences. It also sponsors statistical data-collection efforts such as the Health Information National Trends Survey (HINTS), which tracks how Americans find and use information about cancer, and the Surveillance Epidemiology and End Results (SEER) program, which, in conjunction with cancer registries across the country, monitors rates of cancer over time. In the sea of biomedical bench science that is the National Institutes of Health (NIH), this NCI division is one of the most well-established resources for population science and, within that domain, for social and behavioral sciences in