Women's Work and Women's Health in Mexico: Understanding the links

Jane R. Rubin-Kurtzman
Catalina A. Denman

CCPR-067-07

December 2007

California Center for Population Research
On-Line Working Paper Series

Women's Work and Women's Health in Mexico: Understanding the links

Jane R. Rubin-Kurtzman
California Center for Population Research, UCLA
Programa de Salud y Sociedad, El Colegio de Sonora
jrubink@ucla.edu

Catalina A. Denman
Programa de Salud y Sociedad,
El Colegio de Sonora
cdenman@colson.edu.mx

Paper submitted for presentation at the
Journées Internationales de la Sociologie du Travail, JIST2007
London, June 20-22nd, 2007

This paper presents a conceptual framework and methodology to study women's work and health among migrant women in Hermosillo, Mexico and Los Angeles, California. The framework incorporates multiple dimensions of women's work; the process of health, illness and care; socioeconomic and demographic transformations; and *ways of life.*

Key words: Hermosillo, Mexico; Los Angeles; women, work and health; migration, comparison

Introduction

In Mexico the characteristics of women's work changed significantly in the last decades of the twentieth century, both in the way work was understood and in terms of female activity in the labor market. A gender perspective refined and broadened understanding of women's work by incorporating dimensions not previously considered. Recurring economic crises and socio-demographic transformations also contributed to increased participation of women in the labor market.

Most studies of women's work have focused on the adverse effects of changes in the world of work, emphasizing low wages, flexibility and precariousness. The relationship between work and health has been studied far less, and if at all, usually in terms of specific health issues such as reproductive health risks associated with paid labor; occupational health and security; and the health of workers in export-oriented industries.[1]

The breadth of changes in Mexican society and their implications for the daily life of women and families points to the relation between women's work and women's health as an important, yet surprisingly neglected, research focus. This paper has two objectives: first, to present a framework that articulates the complex and multi-tiered factors that affect the relationship; and second, to demonstrate how this framework can be applied to an analysis of work and health among migrant women in two very different locations where female migrant labor is a shared characteristic of the urban labor market: Hermosillo, Sonora and Los Angeles, California.

Background

In Mexico major economic, social and demographic transformations in recent decades have profoundly affected the daily life of women and families. On the economic front, the adoption of a neo-liberal model of economic development created employment opportunities for women in the tertiary sector, in export-oriented industry and in commercial agriculture. Concurrently, the expansion of an underground economy, growing dependence on sub-contracting chains tied to advanced industrial enterprises, and the increased precariousness of working conditions and contractual arrangements affected women in particular.[2] Deteriorating economic conditions and population changes also altered the demographic profile of women in the labor force so that increasingly, married women with young children entered local labor markets or migrated to work in elsewhere.[3] Cutbacks in the state-supported social safety net and structural adjustment programs aimed at reducing public expenditures disproportionately affected women through cuts in the health sector, education, and social services. Finally, these transformations necessitated a redefinition of the way households organized time and labor, distributed limited resources, and responded to basic needs, including health.[4]

Historically, Mexican women always have been the gatekeepers of family health, in part due to socially-defined notions of women as nurturers and care-givers, and in part because women were less likely to work outside the home and thus more available to respond to household needs. Women combined the services of traditional and Western medical practitioners with unpaid home care they provided themselves.[5] Today, increased work responsibilities challenge the established ways that women care for health and new time demands compete with traditional practices and expectations.

Why has the relationship between women's work and health not been addressed adequately in the past? One reason is because past research has been fragmented, with a piecemeal vision that prevented comprehensive understanding of the larger issue. Another reason has been the lack of a multifaceted conceptual approach. Our innovative framework attempts to fill this void by incorporating the macro- and micro-level factors that affect women's work and health within the context of everyday life.

The Conceptual Framework

The conceptual framework presented in Figure 1 identifies four elements necessary to understand the relationship between women's work and women's health.

FIGURE 1 HERE

Element 1: A culturally-sensitive and nuanced characterization of the multiple dimensions of women's work

By the end of the twentieth century, feminist scholarship had rejected the idea that women's work is limited to market labor, arguing instead that all activities which produce goods and services essential for human reproduction should be considered as work. Studies of gender inequality focused on the gendered division of labor which awards primary responsibility for market work to men and responsibility for children and the household to women. Based on the premise that work related to the daily reproduction of the household is as important as market labor, scholars advanced the concept of social reproduction.[6] Yet, despite considerable effort to increase the visibility of women's work and legitimize the integration of women's market labor and unpaid domestic labor, a segmented vision of women's work in Mexico still prevails.

Our approach attempts to counteract this vision and advance understanding of the nature of women's work. While the dichotomy between market and domestic labor once was at the vanguard of feminist thinking, a more refined analysis of the interrelations among the various dimensions of women's work is essential to capture the ways in which the daily life of women influence their health. Inspired by Hilfinger, *et al.* (1997), we define ten,

interrelated dimensions of women's work specific to the socio-cultural context and economic conditions prevailing in Mexico: paid labor; unpaid labor, including work that facilitates the market activities of others; domestic housework; biological reproduction; the manufacture or cultivation of goods for home consumption; childrearing and socialization; safeguarding the family health; the work of being a wife or partner; the work of extended family membership and *compadrazgo;* and voluntary community work.

Element 2: Women's health as part of the process of health, illness, care and attention.

The process of health, illness, care and attention is embedded in other socio-demographic, health, and economic processes that govern the reproduction of the population. This process, which emphasizes socio-cultural constructions of health, illness, care and attention related the human body, encompasses not only specific diseases and health services, but also gendered perceptions of the body, health and illness, cultural practices, and self-care. Research based on this approach investigates the ways in which knowledge and beliefs related to the body, health, illness and care are culturally determined, negotiated and renegotiated in a dynamic process that varies over time and place.[7] Methodologically, the task is to describe cultural perceptions and narratives constructed around the body which clarify the ways in which the body is expressed socially, politically and by individuals.

A gender focus enriches analysis of the process of health, illness, care and attention. Gender relations profoundly affect women's health, not only in terms of gendered patterns of morbidity and mortality, but also in terms of access to and the availability of health services. Women's health is strongly influenced by social group, age, labor market activity, working conditions, place of origin and current residence, position within the household, domestic labor, number and ages of children, ethnicity, and migration status.[8] Gender is a fundamental and historically-specific determinant of differences between women in men in terms of identity, body image, sexual and reproductive behaviors, how health and illness are experienced, how personal health and the health of others are cared for, and how sickness is expressed.[9]

Element 3: Local, national and global transformations affecting Mexican society.

Global, national, regional and local transformations affecting Mexico provide the lens through which to analyze the relationship between women's work and health. These include the reorganization of labor markets; processes of labor flexibility and precariousness at the levels of production and the labor force; the fragmentation and relocation of productive processes on a global scale, sectoral reforms and structural adjustment policies implemented to counteract economic crises; the mobility of labor, capital, technology and

information; the growth of underground economies; privatization of state enterprises; regionalization, and decentralization.

We synthesize these transformations into three categories:

- Changes in the world of work that affect the characteristics of work and of workers.
- Changes in relations between the State, civil society and the individual.
- Social, economic, and demographic changes within households, especially regarding gender.

Transformations in one category are related to changes in the others and cannot be fully understood independently. In the following pages, we assess the impact of these transformations on women's work and women's health.

Changes in the world of work and **women's health**

Structural changes resulting from the economic crises arising from the stagnation of the import-substitution model of economic development and increased competition associated with processes of globalization greatly altered the world of work for women and men in the last several decades. Mexico adopted a neo-liberal economic model oriented toward external markets, private enterprise, and the reduced role of the state. Male employment declined, female labor force participation increased, unemployment and underemployment expanded, low-paying jobs proliferated, real wages declined, income distribution became more skewed, levels of absolute poverty rose and public sector employment dropped. While these trends abated somewhat in recent years, the precariousness of work remains an ongoing process.[10]

Despite their increased labor market activity, women remained concentrated in traditionally female occupations in the service sector, especially health, education and domestic service; in trade; agriculture; and in traditional industries such as food and clothing manufacture. While occupational segregation was nothing new, women's employment in export-oriented industries and commercial agriculture expanded in this period. [11]

Women's participation in the labor market also became increasingly precarious. Women were concentrated in an underground economy characterized by poorly- or unpaid jobs requiring little or no skill, flexible contractual arrangements including part–time work, variable work schedules, long hours with no overtime, payment by the piece or by quota, unregulated subcontracting chains ranging from small, home-based workshops to individual sub-contractors reduced job security, disregard for occupational safety, and stressful psychosocial working conditions.[12] While the link between increased female labor market activity and the growth of the underground economy is subject to debate, evidence shows that the majority of workers, and especially home-based workers, are women.[13]

Four, interrelated dimensions of the changing world of work are especially pertinent to women's health: increased participation in the labor

market; persistent occupational segregation and gender-based discrimination; the process of labor precariousness, and female labor migration.

a. Women's Market Labor and Women's Health

In earlier work we described the risks and rewards associated with women's labor market activity in Mexico.[14] On the positive side, women's health has been enhanced by increased income, greater autonomy, higher levels of self-esteem, and the opportunity to interact and share experiences with co-workers. Conversely, studies of occupational health, particularly among *maquiladora* workers, have documented an array of health problems including muscular-skeletal disorders, eye strain, hearing loss, emotional stress, sexual harassment, reproductive problems, and exposure to environmental hazards.[15] Once conceptualized as the double burden of household and market labor, we now suggest that women in the labor market bear the weight of multiple, interacting responsibilities which contribute to fatigue, stress, and exposure to a variety of health hazards.

b. Occupational segregation* and *gender-based discrimination

Occupational segregation creates separate work environments for women and men that carry differential health risks, work demands, and stress factors. Evidence from a number of countries indicates that men suffer more from more accidents and injuries, while women are exposed to greater psycho-social risks, including sexual harassment and the fear of job loss for non-compliance.[16] Gender-based obstacles to advancement, training and performance can affect women's health through lower salaries, greater pressures, frustration, and a diminished sense of self-esteem. Discrimination in terms of training, employment, occupation, work arrangements, and working conditions also tends to push women into precarious jobs that may determine gender-specific patterns of risk, morbidity and mortality, self-perceived health status, and mental health.[17]

c. Women's health* and *labor precariousness

There is little theoretical or empirical research on the relationship between precarious labor and women's health in Mexico or elsewhere. Studies describing the conditions of women in the labor market do not always distinguish between effects attributable to gender discrimination and those associated with flexible work arrangements and/or hazardous conditions. Similarly, flexibility and precariousness are concepts that tend to be used interchangeably. This distinction is nevertheless important because, when voluntarily chosen, some flexible forms of labor may be beneficial to health insofar as they enable women to fulfill multiple roles. When imposed by

employers, part-time work, long hours, and night shifts can intensify the workload and contribute to stress, physical and emotional exhaustion.[18]

Health risks associated with precarious labor can be divided into those related to low wages and those associated with poor working conditions and non-standard contractual arrangements. Low and unstable wages provide few resources for health care and food and contribute to economic insecurity and stress at work and at home. Low wages also make it difficult for women to make regular contributions to health insurance plans.

Poor working conditions and non-standard contractual arrangements can affect health in several ways. Obviously, a lack of health insurance poses a direct threat to health. Long working hours can have negative impacts on sleeping and eating habits, reducing resistance to disease and contributing to mental exhaustion. Low-paid sub-contracting increases health hazards through reliance on ill-equipped and poorly maintained equipment and erratic revenues. Inadequate working conditions (equipment, ventilation, light, ergonomics) are associated with a wide range of physical and emotional health problems.[19]

d. Labor migration

Migration flows have changed considerably as a result of globalization and the emergence of job opportunities in new locations. Whereas historically female migration was characterized by the movement of young, single women from rural areas to Mexico City, today, married women with children also migrate to the northern border in search of work in the *maquiladora* industries; to rural areas where commercial agriculture has expanded; to fast-growing medium-sized cities, and to the United States.

While the obvious rationale for labor migration is the expectation of better job opportunities and higher wages, migration also incurs social costs, especially for those least qualified and only able to find low-paying jobs with poor working conditions. Migration as a response to gender-specific labor demand contributes to distortions in the sex ratio and household composition and increased female household headship in areas of origin and destination. These distortions tend to modify the amount and intensity of domestic and extra-domestic work done by women. Labor migration also interrupts social networks which furnish support systems, information and help.

Research on the relationship between adult migration and health emphasizes the lack of access to care, migrant self-selectivity in terms of education and health status, specific health risks associated with the nature of migrant labor, housing conditions, and the importance of social networks. Few studies incorporate gender relations into the host of economic, social, political and cultural determinants of health and illness.[20]

The impact of labor migration on women's health can be mixed. On the positive side, migration may encourage new health care strategies through information, contacts and educational programs at work and in the community. Some industries such as the *maquiladora* industries along the border are

required to offer workers health insurance. This is in sharp contrast to the situation in Los Angeles, where many migrants, especially if undocumented, have no insurance. More negatively, migration creates stress and strains mental health through separation, uncertainty, a sense of loss, loneliness and anxiety about family members left behind. This is particularly true when migrants are undocumented and unable to come and go freely. A study of male and female migrants to Los Angeles found that loneliness led men and women to adopt previously unknown or unacceptable high-risk sexual behaviors which increased the risk of HIV/AIDS infection. [21]

The effects on health of other aspects of the migration process are more ambiguous. Migration may disrupt access to and the utilization of local health services, thereby creating health risks which a lack of knowledge or access to resources in areas of destination may accentuate. Migration may affect sources of information about health and health-related issues such as fertility control formerly available through the local media or social networks. Nutritional changes may affect the nutritional status of women and families. Better nutritional information in areas of destination may be counterbalanced by economic constraints which prevent women from buying nutritious foods. The conflict between customs and cultural images in areas of origin and destination can be stressful and challenge local, national, ethnic and gender identities. Finally, migration can influence reproductive decisions in several ways. Some *maquiladora* industries refuse to employ pregnant women and subject female employees to periodic pregnancy tests. Female-headed households created in response to female or male migration typically have less flexibility in terms of work at the same time they may have greater economic need. Female household heads thus may be more likely to resort to resort to illegal abortions if confronted with an unexpected pregnancy.

Effects of Changing Relations between the State, Civil Society and Individuals

Profound changes in relations between the State, civil society and the individual stemming from the economic crises and subsequent restructuring of the economy have had important, yet often unperceived implications for the relationship between women's work and health. State support for programs aimed at channeling income and welfare toward the poor was reduced, thus diminishing the historic role of the Mexican state as defender of progressive social policy. Monetarist economic policies designed to adjust fiscal structures and curb inflation contributed to growing socioeconomic inequality and a regressive income distribution that concentrated wealth at the top while adding to ranks of those living in poverty.[22] Many state enterprises were privatized and public sector employment was cut back, particularly in the social sectors of health, education and welfare. Food and agricultural subsidies were reduced or eliminated. The decentralized management of programs and services placed an

untenable burden on inadequately financed and trained provincial governments and local agencies.[23]

Reform of the social security system was aimed at reducing state responsibility for health care costs. Social programs offered by the social security system received lower priority and the number of beneficiaries was reduced. An individualized approach introduced mandatory private individual capitalization accounts and created a system based on occupational structure and the capacity of individual workers to finance their own benefits, health and retirement plans.

We suggest a number of hypotheses to describe the potential impacts on women's health of the declining social welfare role of the State. The elimination or reduction of food subsidies can reduce living standards and nutrition. Privatization and the decentralization of family planning services can increase unwanted births and illegal abortion, with associated impacts on women's health and autonomy. Budget cuts in education can adversely affect women's' ability to obtain better jobs, access information about health, and utilize the information available effectively.

Health sector reforms also can affect women in several ways. The most obvious is through declining employment in the health sector where women have been disproportionately represented. Health sector reforms also can contribute to increased domestic responsibilities. Cuts in health programs, hospital services and the number of persons entitled to receive benefits can transfer the burden of care for the sick and elderly from paid professionals to unpaid family members, thereby increasing the workload, fatigue, stress and risk exposure of many women already overloaded with responsibility.[24]

The reform of the social security system can place women at a disadvantage. The calculation of benefits based on individual contributions and risk levels fails to consider a number of factors that negatively affect the capacity of women, and especially poor women, to make regular contributions to this type of health plan. First, women get sick more than men at the same time their life expectancy is longer, thus exposing them to greater risk of non-fatal disorders and higher average of years of illness or disability, including the degenerative diseases of old age.[25] Second, the current system does not contemplate the fact that women participate less in the labor market, their work is more intermittent and part-time, their salaries are lower, and they retire at younger ages than men.[26] The nature of women's labor market activity means there are relatively long periods when women do not make contributions to their health and retirement plans, their capacity for accumulation is less, and they are forced to confront situations more difficult than those of men in relation to their health, welfare and retirement benefits. These factors are especially hard on widows, the elderly and female household heads.

Changing household relations, women's work and health

The changing work panorama and relations between the state, civil society and individuals have contributed to adjustments in household relations and economic behaviors as well as a growing diversity of household types and family arrangements, including duo-local households, increased female household headship and single person households. Gender and family relations and expectations regarding roles formerly prescribed by age, gender and position in the household also evolved. The sum of these transformations has been to modify the way individual household members and households assigned values, established priorities and related to each other. Scholars have called attention to the asymmetry and "unequal burden" of intra-household relations, noting that needs associated with social reproduction, income generation, and the administration of household labor vary by gender, age, social group, household type, and the socio-demographic and health characteristics of household members over course of the life cycle. This combination of factors has meant that the burden of work is greater for women than for men.[27]

Research on household vulnerability in relation to economic adversity, poverty, social exclusion and precarious labor emerged as a result of the economic crises and restructuring of the 1980s. One dimension of this research was to highlight women's work in the labor market, labor migration, and the contribution of domestic labor to household production and reproduction as central strategies adopted to stave off the erosion of scant resources.[28] Another dimension called attention to the dual role of households as places of residence and exchange shared by families and/or non-related individuals and as places of social reproduction where prevailing economic conditions and the need to protect available resources converted them into units of production and social agency.[29] In the first instance, households embodied the demographic, economic and socio-cultural attributes of its members. In the second, they were the locus of activities directed toward the market and carried out by some, but not necessarily all household members.

The transformations described have generated new household vulnerabilities that can particularly affect the physical and mental health of women. Female-headed households with few economic contributors may be especially susceptible and may confront health risks associated with poverty, poor nutrition, inadequate housing and the ability to obtain health care.[30] The coexistence in one physical location of living and market production areas can result in a mix of gender-differentiated health risks which, although difficult to disentangle, are derived from different sources. For example, households as units of production may contain environmental and physical hazards not usually found in places of residence. The mix is further complicated in duo-local households when not all members permanently reside in the same location, such as, for example, migrant worker households where the circular migration of individual family members can also entail circular health risks.[31]

Household income instability can contribute to nutritional risk and morbidity. Although dietary changes tend to affect all household members, evidence from other parts of the world suggests that when resources for food are scarce, adult women are likely to sacrifice their own nutritional needs for the sake of their children.[32] Household strategies aimed at cutting expenditures can intensify the amount of time and effort women devote to the production of goods and services for home consumption, lengthen work days, and contribute to greater fatigue, physical effort, stress and exposure to environmental contaminants. Faced with cuts in social programs, women assume greater responsibility for the health and well-being of other household members. These responsibilities also may entail gendered decisions to seek medical attention. Economic uncertainly may affect women's decisions regarding market labor, family, and maternity. A reevaluation of future expectations has implications for women's health and reproductive behavior, including decisions regarding the number and timing of births; total number of children wanted, child spacing and abortion. Last, but certainly not least, male unemployment and the erosion of work can lead men to doubt their traditional role as breadwinner. This questioning can contribute to male feelings of inadequacy, failure and frustration which may be expressed through acts of physical, psychological, emotional, economic or sexual domestic violence.[33]

Element 4: The concept of *Ways of life*

In our framework the concept of *ways of life* provides the bridge between women's work, women's health and the structural changes in Mexican society just described. *Ways of life* pertinent to this relationship are outlined in Figure 1. They are the mechanisms through which changes in the world of work; in relations between the state, civil society and the individual; and in household relations affect women's work and women's health.

According to D. Bertaux, a pioneer of this concept, *ways of life* combine material conditions, social relations, and the meanings and values attributed to different aspects of human existence. The relative importance of specific *ways of life* varies over time and place, as well as by gender, household type, life cycle stage, and social group. Two key elements in the concept are first, that, consciously or unconsciously, households mobilize to resolve their material and symbolic needs, and second, that decisions emanating from this mobilization are not necessarily the result of a deliberate or collective household strategy.[34] Thus, issues related to women's work and health can only be understood within this larger household context.

Ways *of life* are constructed from the interaction and interdependence of institutions and individuals as social actors. Recurring practices taking place in five domains of everyday life - work, family, health, education, and community - reflect structural constraints that determine the nature of this interaction and interdependence. These practices are ordered by interrelated cycles of varying duration. Short cycles occur with predictable temporal regularity, such as daily,

weekly or seasonally. Longer cycles such as health/illness or employment/unemployment are more unpredictable.[35] The connection between cycles is evident in the relationship between women's market labor and health. While health is a pre-condition for meeting the daily requirements of a job, many types of work pose a threat to health. Similarly, paid work is a prerequisite for consumption while consumption fuels employment.[36]

The Application of the Framework to the Empirical Study of Social Groups and Contexts

In this section we illustrate the way in which our framework can be applied to the empirical study of specific social groups and contexts by focusing on work and health among migrant women in two very different cities where female migrant labor is a shared characteristic of the labor market: Hermosillo, Sonora and Los Angeles, California. We focus on these cities because they represent long-standing migrant destinations and because obvious differences in the structural conditions migrants confront underscore the importance of examining the local, national and international contexts that govern women's work and women's health. While most studies take local context for granted, our comparative approach makes clear the importance of local factors such as public policies and labor market conditions when analyzing women's work and women's health. This approach is equally valid for cross-national comparisons and comparisons of one population group across regions.

How does the daily life of Mexican migrant women influence the nature of their work and the ways they care for their health and that of their families as they cope with the positive and negative aspects of work in new surroundings? Under what conditions is the health of working women improved or jeopardized in their new circumstances? More specifically, how do the multiple dimensions of women's work, limited access to health services and other social benefits, the growing precariousness of paid labor, and strains within the household compromise the health of migrant women in different migration destinations?

The methodology we propose is adapted from BETWIXT, a comparative study of poor neighborhoods in seven European cities. BETWIXT examined processes through which households in precarious, yet still viable, economic circumstances struggled to avoid falling into social exclusion.[37] The study emphasized efforts to resist household destabilization, and the various resources, which, when available, made those efforts successful. We seek to identify health-threatening situations and the strategies women implement to counteract them and we focus on neighborhoods as a locus of health care, information, services and source of support.

Social and health scientists suggest that, especially in poor neighborhoods, neighborhood environment furnishes an important context for shaping health outcomes and directing interventions.[38] The importance of

colonias in Mexican urban residential patterns indicates that this is particularly valid in Mexican neighborhoods within Mexico and in the U.S. The point of departure for the research is the identification of one neighborhood in each city with a preponderance of migrant households.

The methodology combines quantitative and qualitative data to create a chain of information going between the county or *municipio* level and the individual.[39] Stage 1 focuses on the community setting. In this stage, census and existing survey data should be used to quantify the demographic, social and economic characteristics of the county and neighborhood. Additionally, ethnographic fieldwork should include interviews with key informants who have specialized knowledge of the community.

Stages 2 and 3 involve case studies of migrant women and their households. In light of the changing demographic profile of women in the labor market, the criteria for selection are as follows: (1) women with or without a resident partner who (2) live with their own primary school-age children, (3) receive monetary remuneration for work, and (4) are differentiated by type of household and length of time since migration.

The *ways of life* presented in Figure 1 furnish the empirical bridge between women's work, women's health and the three arenas of social transformation specified. As such, *ways of life provide* the basis for the interview guides to be developed for case studies of migrant women and their households. Interviews should explore they ways in which the multiple dimensions of women's work affect their health and contribute to shifts in health care strategies for themselves and their families. The aim of the interviews is for migrant women to describe in their own words the actions and strategies they adopt to protect their health as they attempt to balance limited resources (i.e., money, time, personal energies and emotional stability), given the constraints stemming from their *ways of life*.

Interviews should collect basic information about the health, economic, social, and demographic characteristics of the household and detailed information on the work, health and reproduction, migration, and marital history of the women interviewed. The nature of qualitative research implies an interactive and iterative relationship between questions and answers. Thus, our understanding of migrant women's *ways of life* will be informed and modified by the narrative provided by the women themselves. Analysis of the data obtained in Stage 2 should help to refine the interview guide used in Stage 3.

Conclusion

Our goals in this paper were to elaborate a conceptual approach to examine the relationship between women's work and women's health in Mexico and to illustrate how this framework can be applied to specific population groups and contexts. The framework incorporates multiple dimensions of women's work; the process of health, illness, care and attention; economic, social, demographic and cultural transformations taking place in the

world of work; relations between the state, civil society and the individual; and relations within the household. *Ways of life* furnish the theoretical and methodological bridge connecting all the elements. In order to emphasize the importance of local context, the methodology focuses on the relationship between work and health among migrant women living in Hermosillo and Los Angeles.

The social and economic transformations occurring in Mexico are not unique. On the contrary, the framework and methodology presented here are relevant to situations in many rich and poor countries. Indeed, our comparative approach emphasizes the global, national, and regional factors that influence local situations. We invite researchers in other parts of the world to find common ground with our approach and engage in comparative research that illuminates the processes that endanger or enhance women's work and women's health. We also hope this approach provides policy makers with a more comprehensive understanding of the factors affecting women's work and health in order to design more effective policies and allocate more resources to address this important, yet often overlooked issue.

Notes

[1] Balcázar *et al.* 1995; Cedillo *et al.*, 1997; Denman, 2001. Denman, *et al.*, 2003.
[2] Ariza and Oliveira, 2002; Benería, 2001; Díaz and Medel, 2002; García and Oliveira, 1992.
[3] García, 2003; García and Oliveira, 1992.
[4]Ariza and Oliveira, 2002; Donato and Kanaiaupuni, 2000; Garcia and Oliveira, 1994; González de la Rocha, 1991; 1994; 2006.
[5] Denman, 2001; Haro, 2001.
[6] Benería, 1979; Meillassoux, 1981; Oliveira and Ariza, 2000.
[7] Lock and Scheper-Hughes, 1996; Menéndez, E., 2003.
[8] Chant, 2003.
[9] Ravelo, 1995.
[10] Beneria, 2001; Chant, 2003; Charmes, 2000; García, 2003; García and Oliveira, 1992; González Marín, 1998; Oliveira, 1989.
[11] Cruz, *et al., 2003;* Lara, 1998; Oliveira and Ariza, 2000; Ravelo, 1995.
[12] Benería, 2001; Charmes, 2000.
[13] Benach and Muntaner, 2007; Beneria, 2001; Chant, 2003; Chen, *et al.* 1999; Gideon, 2007; UNIFEM, 2005.
[14] Rubin-Kurtzman, *et al,* 2006.
[15] Balcazar, *et al.*, 1995; Cedillo, *et al, 1997;* Denman, *et al*, 2003; González Block, 2001; Lara, 1998; Harlow et al. 2004; Meservy, e*t al.*, 1997; Rubin-Kurtzman *et al*, 2006; Rubin-Kurtzman and Denman, forthcoming.
[16] Díaz nd Medel, 2002; Lara, 1998.
[17] Menéndez, *et al,* 2007
[18] Gideon, 2007.
[19] Rubin-Kurtzman, *et al, 2006.*
[20] Boyd and Grieco, 2003; Bronfman and Rubin-Kurtzman, 1999; Feliciano, 2005; Kanaiaupuni, 2000; Palloni and Arias, 2004; Wallace, *et al.*,2003; Wyn and Ojeda, 2003.
[21] Bronfman and Rubin-Kurtzman,1999.
[22] Szasz and Lerner, 2002.
[23] Langer, 2003.
[24] Robles, 2003.
[25]Szasz, 1999; Chant, 2003; Gómez, 1993.
[26] Cerutti, 2000; Parker and Gómez, 1999
[27] Ariza and Oliveira, 2002; Benería and Feldman, 1992; Benería and Roldán, 1987; García, 2003; González de la Rocha, 1991; 1994; 2000; 2006; Oliveira and Ariza, 2000.
[28] García and Oliveira, 1994; González de la Rocha, 2000.
[29] Ariza and Oliveira, 2003.
[30] Although the issue of whether female-headed households are poorer than households headed by men remains unresolved in the literature, Smyke (1993) notes that poverty carries greater risks for the health of women than for men.
[31] Bronfman and Rubin-Kurtzman, 1999.
[32] Leslie, *et al*, 1988
[33] Chant, 2003.
[34] Bertaux, 1983.
[35] Bertaux, 1983.
[36] Bertaux, 2006. Personal communication.
[37] BETWIXT ("Between Integration and Social Exclusion") examined these processes in London, Dublin, Lisbon, Turin, Helsinki, Toulouse, and Umeå. See.Bertaux, *et al*, 2002.
[38] Andersen, 2002; Shin, *et al*, 2006
[39] Mexican *estados* are composed of *municipios*, within which there are cities, towns and villages of varying sizes. The *municipio of* Hermosillo is located in the northern border state of Sonora. Located in the *municipio* of Hermosillo, the largest city and capital of the state

(population 545,928 at the time of the 2000 census), is also named Hermosillo. Hermosillo city has a large migrant population concentrated in the northern *colonias.* Counties in the United States are the approximate equivalent of *municipios* in Mexico. Mexican migrant communities are scattered throughout the county, particularly in the east and southwest.