

Health Sector's Views Toward Bolivian Women in Argentina: An Approach from the Intersectionality

Miradas sanitarias en torno a las mujeres bolivianas en Argentina: un aporte desde la interseccionalidad

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ABSTRACT

This article analyzes the perceptions of health teams concerning Bolivian migrant women in the provinces of Córdoba and Mendoza, Argentina. The research consisted on a qualitative, exploratory-descriptive study based on semi-structured interviews. From the intersectionality theory it analyzes how health professionals construct the culture of the other in relation to Bolivian migrant women's health and the way in which the later influences health care. It shows the "cultural reductionism" that characterizes the perceptions of health teams as well as the different forms of social domination behind the reproduction of sanitary inequalities.

Keywords: 1. Bolivian immigration, 2. health teams, 3. gender, 4. culture, 5. intersectionality.

RESUMEN

Se analizan las percepciones de los equipos de salud en torno a las mujeres migrantes de origen boliviano en las provincias de Córdoba y Mendoza, Argentina, mediante un estudio cualitativo y exploratorio-descriptivo basado en entrevistas semiestructuradas. Desde la teoría de la interseccionalidad se analiza cómo los profesionales de la salud construyen la cultura del otro/a en relación a las prácticas de salud de las mujeres migrantes bolivianas y cómo dicha construcción influye en la atención sanitaria. Se evidencia el "reduccionismo cultural" que caracteriza las percepciones de los equipos así como distintas formas de dominación social que influyen en la reproducción de desigualdades sanitarias.

Palabras clave: 1. migración boliviana, 2. equipos sanitarios, 3. género, 4. cultura, 5. interseccionalidad.

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INTRODUCTION

As a field of study, migrant health is still under construction, particularly in Latin America. However, one aspect that has featured heavily in explanations on migrants' health is the notion of culture (Viruell-Fuentes, Miranda, & Abdulrahim, 2012). Although the health system has faced the *problem of culture* for centuries, the presence of the migrant population in health services has led to growing concern over the *Other* and the problems that come with the sociocultural distances between patients and health providers (Caramés, 2004). In the social sciences, culture has been identified as one of the main causes of low health status among migrant populations, distrust between professionals and users, migrants' lack of access to modern health systems, poor performance in women's health care, and difficulty exercising rights to health care (Cerrutti, 2011; Jelin, Grimson, & Zamberlin, 2009; Baeza, 2014; Aizenberg, Rodríguez, & Carbonetti, 2015; Goldberg, 2014, among others).

The problem of migrant health takes on particular relevance in modern-day Argentina. Since the end of the last decade, migrants' health struggles have been reshaped by the approval and implementation of the new Migration Law (Law 25.871). This law marked a new paradigm in protecting migrants' broader human rights and, in particular, health, by stipulating that "under no circumstances shall any foreign national who so requires be denied or restricted access to the right to health, social welfare or medical care, regardless of migratory status" (Article 6). Not only does Law 25.871 represent a turning point in considering migrants from a rights-based perspective, it also falls within a new paradigm of *regional integration* through a state discourse on cultural differences based on an underlying model of a "multicultural, inclusive society integrated into the region, which respects the rights of foreign nationals and values their cultural and social contribution" (Novick, 2004, p. 84). Despite this law, studies have shown that South American migrants living in the country are exposed to high levels of vulnerability, poor living conditions, and limited access to health services (Pantelides & Moreno, 2009).

The international literature on migrant health has found that culture has a significant impact on individuals' health status (Lara, Gamboa, Karhamanian, Morales, & Hayes Bautista, 2005; Alegria et al., 2004). The underlying idea is that migrants share a common culture based on their country of origin, which leads them to develop particular health behaviors (Lara et al., 2005). Various studies have shown that migrants' behaviors, which are the result of the culture they are immersed in, hamper communication with health providers, the development of preventive behaviors, and the quality of care offered (Cerrutti, 2011; Aizenberg, Rodríguez, & Carbonetti, 2015; Aizenberg & Maure, 2017).

On this basis, a substantial number of academic papers, programs, and policies have pointed to the *intercultural perspective*² as a key tool to create bridges for horizontal dialogue, reduce cultural barriers between service providers and migrant populations, and improve migrants' access to health services (Albó, 2004). While some studies have shown that so-called *assimilation* or *integration*³ into the health model desired by receiving countries worsens health outcomes (Escarce, Morales, & Rumbaut, 2006; Salant & Lauderdale, 2003), others have noted that the culture of the country of origin helps migrants to take care of their health and can even lead to better health indicators than some native populations (Waldstein, 2008; Waldstein, 2006; Molina, 1994, Aizenberg & Baeza, 2017).

This view of migrants, I argue, has been based on an interpretation of culture as a set of individual attitudes, values, and behaviors (Parsons, 1951). The idea of culture as a homogeneous and static feature of populations can be likened to cultural interpretations of poverty associated with *blaming victims* for their own fate, in which the Parsonsian vision has wrongly distorted the connection between poverty and culture, transforming social notions into psychological and individual reasons while also implying that people can break out of poverty *if they change culture* (Viruel-Fuentes, 2007). This view of culture understood as a homogeneous and static repertoire that collectively defines people's identity and behaviors has permeated the perceptions of health providers.

Nonetheless, cultural studies have shown that culture is not necessarily determined by social structure or by the individual socioeconomic conditions that dictate certain behaviors, but it can be molded differently in accordance with the way people respond to a context based on the set of tools and repertoires they use to organize their practices (Swidler, 1986). In the health field, for instance, this approach has been widely incorporated into the primary care paradigm, among other health care models based on a perception of the user of health services as an active subject in promoting and preventing health-disease-care processes (PAHO/WHO, 2003). Various studies have presented a critical review of cultural explanations of health outcomes in migrant populations. These reviews have revolved around stressing the importance of raising awareness of the sociohistorical context from which migrants carry over the health-disease-care process to the receiving countries, noting that focusing on interpersonal relationships or

²The intercultural perspective, as applied to the health field, has been defined as an approach that seeks to reduce the gaps between the "Western" and "traditional" health systems on the basis of mutual respect and an equal recognition of knowledge systems (Torri, 2012, p. 31).

³Here I am referring to migrant adaptation processes in the receiving society, which seek and presuppose the homogenization of the receiving society, requiring the migrant group to adopt the customs and lifestyles of the host community and forgo their own, thus no longer being an outsider or different (Malgesini & Giménez, 2000).

communication problems between providers and users distort explanations of the social, political or economic causes behind these processes (Menéndez, 2006).

On this basis, various authors have made advances in approaches that have stressed, in addition to the many cultural processes associated with health care practices and communication with medical staff (Caggiano, 2008; Baeza, 2014), others linked to the greater vulnerability and exposure to contagious diseases faced by migrant women due to their new living conditions (Goldberg, 2014), the difficulties associated with access to and the use of health systems (Cerrutti, 2011), and the process by which rights are recognized or denied based on the easing or tightening of laws (Caggiano, 2008). In this vein, emphasis has also been placed on the agency of migrant women to salvage cultural practices linked, in particular, to self-care and community networks as a strategy that can help migrants to overcome the various obstacles they encounter in accessing health care in a restrictive context, such as the need for national documentation, payment for services, ethnic and gender discrimination, and the geographical distances separating them from health services (Aizenberg & Baeza, 2017; Otero-García, Goicolea, Geasánchez, & Sanz-Barbero, 2013).

Although culture may play a major role in health care, the way it has been used in migration has helped to perpetuate imaginaries and culturalized representations of migrant women that negatively influence their health care. These images not only fail to account for the complex and changing realities experienced by migrant women with respect to their health (Gregorio Gil, 2015) but also limit the ability to analyze the different barriers migrants face in exercising their rights.

This article seeks to open up the *black box* in the use of the notion of *culture* in research on migrant health. To this end, it analyzes health care teams' perceptions of Bolivian migrant women as power relations and mechanisms that construct a given type of body and sexuality (Foucault, 1992) and are expressed in the historical construction of migrant women, where they take on particular relevance (Gregorio Gil, 2010).

I understand that an analysis of how biomedical discourse operates on migrant women, from a perspective that takes into account the various mechanisms that give rise to situations of inequality, is key to gaining a more comprehensive insight into health outcomes.

The analysis aims to reveal the *cultural reductionism* that pervades the health care teams' perceptions of the image of Bolivian women. This reductionism has tended to reduce the *problem* of migrant health to a single cause or form of social sorting on the basis of an idea of culture founded on essentializing, biological and static representations, which historically have pervaded discourse and power practices in medicine, especially in maternal and reproductive health, where women's role has been relegated to procreation and reproduction of the home (Esteban, 2006).

With this objective in mind, the approach taken by this study employs the theory of intersectionality, scarcely used in migrant health, to analyze the discourse of health professionals treating Bolivian migrant women in the provinces of Córdoba and Mendoza. This is done on the understanding that an intersectionality-based perspective helps to explore, understand, and challenge the discursive mechanisms used to construct a health care team's perceptions of the culture of Bolivian women and the intersections –of class, gender, nationality, and ethnicity or race– that pervade their opinions, judgments, and practices.

The aim of this study is to gain an insight into and analyze health care teams' perceptions of Bolivian migrant women from the perspective of the theory of intersectionality. First of all, this work will discuss methodological aspects, and then go on to show the limitations of a culture-centered perspective to analyze and explain the problems of migrant health. Then a theoretical approach to intersectionality will be presented as a basis to provide an empirical explanation of the importance of taking a deeper look at the way professionals' discourse is constructed in relation to *culture* in health care for Bolivian migrant women and the implications for health care practices. The aim is for an analysis of these narratives to serve as a starting point to open up the *black box* that is the idea of *culture* to increase the visibility of the production/reproduction of the many intertwined social inequalities ubiquitous in the health care given to women from this group in Argentina.

For the most part, South American immigration in Argentina has been characterized by low levels of education, poor housing conditions, and scant access to basic infrastructure services, which has a negative impact on the health of immigrants and their families (Cerrutti, 2009). Although migrants from bordering countries have always accounted for between two and three per cent of the population, in recent decades the characteristics of migrants have gradually changed in terms of composition by country of origin, area of settlement, and composition by sex (INDEC, 2010).

Today, most migrants from Latin American countries to Argentina were born in Bolivia, Paraguay, Chile, and Peru, and arrived in the country as a result of the adverse economic conditions in their countries of origin, job opportunities, and the favorable exchange rate established in Argentina from the 1990s (Cerrutti, 2011). The crisis in regional economies and the urbanization process recorded have led to a significant drop in the number of migrants having settled in border areas, and an increase in migrants going to live in major urban areas like the cities of Córdoba and Mendoza. According to the National Population and Housing Census of 2010, Mendoza received 8% of all Bolivian migrants arriving in the country, with Bolivians making up the main immigrant group in the province. In Córdoba, Bolivians accounted for about 7% of the total Bolivian population in the country, and are the second largest immigrant group. Bolivians in Córdoba and Mendoza come mostly from rural Andean areas of Bolivia, mainly

departments like La Paz, Potosí, Tarija, and Cochabamba, which define themselves –on the basis of their ethnic origin– as Quechua and Aymara.

Bolivian migrants have taken up precarious, informal jobs in vacant niches, entering the workforce as part of a family production process (Magliano, 2009). In the case of Córdoba, migrants' participation in production processes has mostly consisted in the manufacture and sale of bricks on the city's outskirts, together with work in local stores and domestic labor in urban areas close to their homes. In Mendoza, labor market insertion has centered on wine, fruit and vegetable production, which during harvest periods requires substantial labor, provided by entire rural families. Men and women all perform agricultural work at some point in their lives and at all ages (Balán, 1990).

THE POTENTIAL OF THE THEORY OF INTERSECTIONALITY IN MIGRANT HEALTH

In recent years, the social sciences have raised the need to address the dynamic intersection between the different components in historical structures of dominance, stressing the intersectionality of the dimensions of gender, ethnicity, social class, and national origin in studies on migration (Donato, Gabaccia, Holdaway, Manalasan, & Pessar, 2006) and the outcomes of interactions of categories that, in the case of migrant women, are located in the social periphery (Cole, 2009). Drawing on black feminist theory, the development of intersectionality has found that gender, ethnic/racial origin, and social class, among other social classifications, interact and intertwine with the social and material realities of women's lives, shaping certain power relations and producing/reproducing multiple interwoven social inequalities and social dominance relations (Stolke, 2004; Lugones, 2008).

In general terms, the perspective of intersectionality, which emerges as a theoretical and methodological attempt to understand social power relations and the contexts in which social inequalities occur, has enabled a *complex* analysis of the reality experienced by subjects by addressing different stances and social, historical, and contextually situated classifications. This has entailed a growing interest in the relationships between migration, intra-family dynamics, women's social status, ethnic/racial background, the repercussions of displacement on gender roles, and the impact of migration on women's quality of life, among other aspects (Martínez Pizarro, 2003).

Despite its relevance in studies on migration and gender, the theory of intersectionality is virtually nonexistent in studies on health and migration. Although the link between migration, health, and gender is still in its early days, studies have focused particularly on culture as a way of showing how cultural barriers between providers and migrants influence the health care migrants receive and their access to such care. An overemphasis on viewing migrant health –especially in the case of women– from the lens of culture has

detracted from a more comprehensive analysis on how other social categories that female migrants simultaneously fall under influence their health care, access to medical services, and the response given by health care providers.

This paper aims to review and contribute to this field of study, problematizing what *culture* means for those involved in the health system and how these meanings influence their practices from an intersectionality approach. In particular, intersectionality is a theoretical framework of particular relevance in analyzing the various forms of inequalities affecting migrant women's health in restrictive contexts. In international migration, classifications based on gender, social class, national origin, race/ethnicity, immigration status and health policies are, without a doubt, aspects that directly influence the health trajectories and experiences of migrant women and the way they access medical services, and the obstacles and facilitators in their health care (Martínez Pizarro, Cano, & Soffia, 2014).

Thus, intersectionality is a relevant theoretical tool to examine the senses and implications of migration in health care for migrants and the power relations between health providers and female users. In this sense, the theoretical and methodological challenge undertaken by this study is to analyze, from an intersectionality approach, the perceptions of health professionals regarding Bolivian migrant women in Córdoba and Mendoza, on the premise that empirical research from this perspective means selecting certain classifications and categories based on the acknowledgment of a specific social, spatial, and historical framework. In this particular case, gender, social class, ethnicity, national origin, and immigration status emerge as major social classifications, producing an intersection of different views on migrant women in health services and their health practices.

On this basis, this article aims to question the notion of *culture* found in health discourse on migration to bring to light the various class, nationality, gender and ethnic/racial biases masked by such a perspective. I argue that an intersectionality approach complexifies studies on migrant health that have viewed culture as a causal element of health outcomes, as a way of subsuming the *problem* into a single form of social classification while calling into question the way other forms of social dominance operate in the perceptions and practices of health professionals who work with migrant women. This work aims to report the meanings that underpin ideas and opinions concerning female Bolivian migrants in order to reflect upon the significance of representations associated with reproductive/domestic care. This will serve as a basis to highlight the different forms of inequality that underpin the notion of culture and enable the production or reproduction of reproductive or family health care models based on condemning logics that extend throughout women's lives regarding the division of labor and forms of family organization in the context of migration (Gregorio Gil, 2006).

METHODOLOGICAL ASPECTS

The research consisted in an exploratory descriptive study that employed a qualitative methodology centered on semi-structured interviews conducted with health professionals both in downtown Córdoba and a rural settlement in the center of the province of Mendoza. Across both locations, interviews were carried out with one male and eight female health professionals from health centers (primary care) and major general hospitals (tertiary care): one health worker and two female nurses from health centers and two female nurses, two social workers, and two obstetrician-gynecologists from hospitals. All interviewees were working in public health services at the time of the interview and were contacted using the snowball technique. All names were changed to ensure the anonymity of the interviewees and the places visited.

The final sample of professionals was finalized when the information revealed was sufficient to reach theoretical saturation. The information presented in this paper is part of fieldwork conducted between June 2013 and February 2017. The semi-structured interviewing technique is centered around a conversation based on a thematic outline on the subject to be discussed with the informant. The interview includes open-ended questions that seek to encourage the interviewee to express his or her opinions and may deviate from the outline prepared by the researcher initially (Denzin & Lincoln, 2005). The interview guide or thematic outline sought to ascertain the opinions of medical staff with respect to the Bolivian migrant population and focused on three main areas: a) social representations regarding the Bolivian migrant population in general and in the health services; b) the identification and opinion of the barriers and facilitators that exist for migrant women in their access to and use of reproductive health services; and c) the identification and opinion of health care for migrant women both within and outside the health services.

In accordance with international standards of ethics and national standards published by the National Scientific and Technical Research Council (Resolution 1806/04), interviewees were informed of the purpose of the interview and the voluntary nature of their participation. They were also informed that both they and the institution would remain anonymous. The interviews lasted between two and three hours and were conducted by social researchers from the university, who presented themselves as external and independent of the health institutions. In the case of health professionals, interviews were conducted in a health service setting. All interviews were recorded with the consent of the interviewee and then transcribed for subsequent processing and analysis. The interviews were coded and an analysis conducted manually by the leading researcher, taking into account the main topics used to construct the problem under analysis:

- a) Social representations of Bolivian women in general and in the health services (characteristics, differences compared to other social groups, main health needs).

- b) Facilitators and obstacles for Bolivian migrants seeking health care (communication barriers, the doctor-patient relationship, economic barriers, compatibility between health care and women's needs).
- c) Health care practices that target migrant women (intramural and extramural health care, main problems addressed, health care programs).

The data collected was analyzed through a narrative analysis, taking into account the fact that the individuals are active social beings that construct personal and social realities through stories and narratives (Somers, 1994).

RESULTS

Culture in Relation to the Characteristics of Bolivian Women in the Health Services

In the national literature, of all migrants arriving at the health services, it is Bolivian migrants who emerge as the most differentiated *Other*, with their own characteristics (language, clothing, customs) and certain phenotypic traits different to those of Argentines (Jelin et al., 2006). In this context, women carry particular weight in professionals' narratives on Bolivians, largely explicable by the type of services examined, which for the most part were associated with reproductive health.

The interviews conducted in the city of Córdoba reveal conflictive relationships between migrants and the health system, as a result of the cultural differences observed in health care by professionals. Culture is put forward as an umbrella explanation for migrants' health behaviors and failings in health practices. The representations of Bolivian women are associated with the traditional submissive and docile role attributed to Bolivians, and especially Bolivian women, in Argentine society (Magliano, 2009). "The difference compared to Argentine women is the level of education: Bolivian women are submissive and mostly simple; that's a cultural characteristic, they don't speak much and we can't understand them" (Gabriela, psychologist, tertiary care, interview, Córdoba, 2013).

Cultural barriers associated with doctor-patient communication emerge in the narratives as one of the most distinguishing features of relationships with patients. Of particular note is the frustration caused by the difficulty conversing with women during consultations and ensuring the information provided has been understood and taken in by patients.

Generally speaking, the health team's perception [of Bolivians] has to do with hygiene, which is a major cause of rejection. The other thing is language, idiomatic aspects. The rhythms are different. They're quieter and speak at a slower pace; they don't ask many questions or they wait around; they don't have the courage to ask if they need something. This leads to a huge sense of

helplessness when we're talking and have no idea what's happening on the other end (Juana, obstetrician-gynecologist, tertiary care, interview, Córdoba, 2013).

You don't know if they understand, you can't read by their faces how the message is being received... Both parties really have to strain to communicate. I'm left with the sense they have no expression; you don't know if they've really understood the message. That isn't so much the case with Argentine women; Argentine women are more inquisitive, but as far as Bolivian women are concerned, everything is always just fine (Laura, obstetrician-gynecologist, tertiary care, interview, Córdoba, 2013).

The naturalization and reproduction of stereotyped views of Bolivian –and Argentine– women as part of a homogeneous group should be read as the product of the reification of culture, which has led to inappropriate stereotypes in the care provided to patients who are homogenized or pigeonholed, almost by force, on the basis of their ethnic or cultural affiliation (Caggiano, 2008). Indigenous identity negotiation and reconstruction in migration takes place within a complex context. While in the place of origin indigenous self-recognition is growing, in the place of destination immigrants face homogenization from the host society and an ambiguous attitude from the state: the backwash of decades-long invisibilization of the indigenous population (Caggiano, 2008).

Following on from Caggiano's work, it is interesting to note, in the following account, how the biomedical model gives rise to situations where women are placed in roles that, while presented as coming *naturally*, hide social, gender, and ethnic inequalities, leading to the reproduction of cultural stereotypes of passive women subject to male domination.

People that come from there [Bolivia] use language that makes it difficult to communicate at times, and their culture is very deeply-rooted; they have a very strong culture. For example, in their culture, everything goes through the husbands to their wives. Simply by the language, it seems that men are better equipped or able to handle the situation and women are very subdued, there's submission. At the beginning they're very timid; they have a very particular culture... (Marianela, nurse, tertiary care, interview, Mendoza, 2016)

Thus, culture –as a static and universal category– is used to justify not only unequal gender relations within a couple, but also the adoption of a stance of resignation by health professionals in situations understood to be inherent to the group in question.

Using the Culture of the Other as a Disciplinary Mechanism in Medicine

Even though for some professionals, *culture* and *cultural aspects* are placed within the sphere of the Other, as are the shortcomings in care resulting from such demands

(Mariano, 2008), for others, this diversity opens up important questions on medical practice:

These are women who work in the fields and their concern –which is one of their [Bolivian women's] particularities– is they always request a natural birth because if they have an operation, a Cesarean, they'll be out of the fields for longer. That's why I say there's a problem with machismo, male authoritarianism. For example, there have been cases where women have had multiple pregnancies and a difficult labor, and the doctors wanted to perform a C-section but generally the women refused until the husband came (Marianela, nurse, tertiary care, interview, Mendoza, 2016).

As seen here, a critical view of the health system acknowledges that this system *questions* families that must adapt to intra-family and social care arrangements. Here, the nurse interviewed references the penalty imposed by the health system on the basis of what is interpreted as a *deviation* from domestic expectations, which entails various kinds of questions and reflections on the health system and its ability to channel diversity. At the same time, this account again shows the naturalization of pervasive passive, submissive stereotypes in the image of women as the companions of men and reproducers of the household as part of an eminently biological model.

At this point, it is also interesting to observe the disciplinary mechanisms that operate in the way the health system presents itself to Bolivian migrant women in its eagerness to change *native* habits and customs, shaping new ones that fall within the parameters expected by the Argentine system. In particular, the biomedical system presents itself as a sort of social control mechanism for women who deviate from a norm that favors a reproductive and caring role over a productive one, disciplining those who have chosen to belong to both the domestic and public worlds. This perspective not only hides working women from view but helps to strengthen the rupture between domestic and public life and the type of family organization in place among migrants.

The women interviewed again acknowledge this in the following quotes when they discuss the disciplinary/controlling perspective of the health system with respect to the women's working lives. In this sense, the following excerpt shows that when the generic, hygienist dominance of the hegemonic medical model intersects with ethnicity and migration, Bolivian migrant women become part of an authoritarian relationship that passes judgment on their behavior based on a stereotyped perspective that interprets their figure as being disinterested or disconnected from child-rearing and domestic life.

I (interviewer): And how do you think they view their own health?

P (Paola): It seems to me that they associate health with work. Being sick prevents them from working, getting food, and securing the services they need to survive; that's why we mentioned the Cesarean, they don't want it and will flatly refuse, and there are times the doctors are explaining to them that the baby is badly positioned, that they absolutely have to perform a Cesarean, and they'll say, "Let's wait a little longer because I have to go and work." So it's as if what matters most to them is not so much their health, their well-being, but work. They prefer to have the baby as soon as possible, go out to work, and not have a Cesarean that's going to prevent them from working. I think [working] does affect them. Women come aged twenty-five, thirty, with four or five kids; they've been constantly working their whole lives and they look wrecked, they neglect their teeth and appearance, everything [...] They're outdoors, they work on the farm, then they come and do the housework at midday and go back out to the farm, and then the farm's —or the employer's, let's say— transport system comes to pick them up... and I'm told they leave the children, who go to school on their own, and then they leave one person in charge of all the kids (Paola, nurse, tertiary care, interview, Mendoza, 2016).

This type of conduct, associated with what can be understood as an *alignment/acculturation* of Bolivian patients to the expectations of the Argentine medical system, is clearly observed in the explanations offered by health workers who go round rural settlements home to a considerable number of Bolivian families. The figure of the health worker is of particular significance in understanding the type of discipline found in migrant women's health care, which is geared toward prioritizing their reproductive role as mothers responsible for feeding and the hygiene and well-being of others.

As a way of extending the primary health care strategy, health workers are responsible for health promotion and preventive work through visits to each family home, establishing themselves as a link between families and the health services. One of their key roles is to *teach health habits* from a grid of pre-established *risk factors* on a form used by health workers to determine the *criticality* level of at-risk groups based on the number of *factors* detected, while establishing the strategies and aspects that will constitute the focus of their *advice* and *recommendations* (Lorenzetti, 2012). Although supposedly *neutral*, the health workers' interventions with the *at-risk group* are plagued by strong gender, class, and ethnic biases that result in a web of discipline and control practices aimed at channeling and *acculturating* mothers into a certain type of patient and woman in line with a desired health model.

Gradually they're getting used to the pace of the health system but it's tough. Often you have to tell them, "Look honey, tell your husband you can't work because the baby's almost here," but it's cultural, and culturally, what can you do? There are other cultures, let's just say, they were born like that... who

knows, there are things we won't be able to change... (José, health promoter, primary care, interview, Mendoza, 2016).

Thus, it was found that the health worker's discourse reproduces the roles expected of Bolivian women in looking after their own health, but above all in looking after those under their care. Certain actions and strategies used to reconcile health care and paid labor are also frowned upon. Below it is possible to see how culture crops up repeatedly in explanations for female migrants' poor health, but from a class-based perspective that subsumes them into material living conditions – the result of migrants' collective habits or values. In this sense, the health care standards alluded to by the health worker –and the reproduction of gender stereotypes associated with traditional domestic care roles– demonstrate a significant regulatory bias that presupposes the existence of expected family living conditions. Also noticeable is how the health worker reduces the explanations of Bolivian women's behavior to culture, while reinforcing the idea that the woman-mother-caregiver relationship is a given. This leads to a *culturalization* of social inequality, which, by disregarding material living conditions, detracts from the responsibility of the health system in the reproduction of inequalities and the roles it should play to prevent this happening.

The “Acculturation” of Health Habits and Behaviors

Bodies are not biological products: societies and health systems construct notions of the body and sexuality that are closely connected to gender, class, and ethnicity (Foucault, 2003). Although this construction affects various social groups, women –regardless of their nationality or immigration status, when viewed under the lens of migration from Bolivia– take on specific particularities as the target of mechanisms aimed at constructing docile, malleable bodies, or in other words, bodies able to adapt to the parameters expected by the Argentine health system.

The following conversation with a nurse from Mendoza shows how culture is again cited as the main reason for Bolivians' self-consciousness during gynecology consultations, along with the idea that this culture can be changed as women begin to break away from the native culture and incorporate new norms and habits developed during their stay in Argentina. Indeed, the relationship between country of origin, culture, and behavior is clearly shown as it is thought that second-generation migrants born in Argentina are more aware of their rights. In other words, they are no longer docile, malleable, passive bodies –like those having come straight from Bolivia– and become individuals with rights, having acquired cultural habits similar to those of Argentines.

E: And generally speaking, what is their relationship with their body like? How do you see it?

M: I've often noticed that they're very timid and uncomfortable about opening up for you to help them or examine them, they're always careful not to show themselves or let you approach them. Approaching them is difficult; they feel violated, in a sense. For example, you go to examine them and they close their legs, cover themselves with their clothes, you know what I mean? They feel uncomfortable with anything like that... that's what I mean about people who are true natives; with those who have been here a long time or the children of Bolivians it's different, it changes a lot. You can approach them, they're better at defending themselves, they know their rights, all those kinds of things. So they come and lay down the rules and say, "no, you treated me badly, you're discriminating against me, you discriminate against us, that's why you're treating us like this" and things like that (Marisela, nurse, tertiary care, interview, Mendoza, 2016).

The way the health system constructs the image of Bolivian women as docile, malleable patients exhibits significant similarities to work by Ezquerra (2007), who shows how the state uses various policies to attempt to construct the bodies of female Filipino workers as docile bodies, devoid of sexual desire and responsible for securing the well-being of their families and, by extension, their country. This case shows how the health worker, within a context of dominance and subordination that has historically characterized the hegemonic medical model, produces discourse and health practices riddled with gendered and nationalized biases that task women with preventing disease transmission within families and, consequently, within the Bolivian population.

This conduct should be read from an eminently discriminatory perspective in which the health professional plays the role of natural protector of the native population from the potential threat posed by foreigners, especially Bolivians. The following remarks by the health worker show how Bolivian women and their family group become *suspects* in the transmission of infectious diseases like tuberculosis, and how women are once again held responsible for looking after themselves and their family to prevent the spread of a potential disease. In this sense, disciplinary practices associated with reproductive and caregiving roles emerge once again as a way to protect the native population from a potential threat.

You're responsible for referring a woman to the hospital or some place for not taking the kid to check-ups, for not going to pregnancy check-ups, or if tuberculosis is suspected. Whenever people go [to the hospital], when you refer a woman and she goes, that's a source of satisfaction. So... for example [this woman] was pregnant, so I went and made her an appointment. So long as they show up, I'm happy (José, health promoter, primary care, interview, Mendoza, 2016).

CONCLUDING REFLECTIONS

The objective of this study was to gain insight into and analyze health care teams' perceptions of Bolivian migrant women from the perspective of the theory of intersectionality. The study sought to determine how health professionals construct the culture of the Other in relation to the health practices of migrant women and the way this construction affects health care. With interviews used as the source of information, the discourse and narratives of those interviewed were full of everyday meanings, judgments, values, and opinions, along with expectations regarding the interview and interviewer. The literature on migration and health has mostly focused on identifying the various cultural barriers that affect migrant women's health care and access to such care (Virruel-Fuentes, Miranda, & Abdulrahim, 2012; Caramés, 2004; Comelles et al., 2009; Gou & Phillips, 2006).

In Argentina, this approach has been widely employed in studies on Bolivian migration and health, but with insufficient emphasis placed on how the notion of culture is constructed and functions in health care as provided to women from this particular group. This work incorporates a new perspective into the field of Bolivian migration and health in Argentina, employing an intersectionality approach with the goal of complexifying approaches that have tended to diminish migrant women's experiences under the lens of a single category or social classification. This serves as the basis to uncover the different forms of inequality that underpin the notion of culture and have an adverse effect on the production/reproduction of inequities in health.

This study's contribution draws from the wealth of the link between the theory of intersectionality and migrant health, making it possible to challenge the notion of culture used by professionals to reveal the various forms of dominance –in terms of class, gender, nationality, and ethnicity or race– that constitute the basis upon which the health system deploys disciplinary mechanisms to channel (or acculturate) migrants within the parameters desired by the Argentine health system, and in particular, parameters that reinforce reproductive and family health care norms based on a disregard for productive endeavors and the various family organization dynamics in place among migrants. Thus, the bodies of migrant women are generalized, ethnicized, and deterritorialized from the particularities of their places of origin and the specific context in which women's life trajectories are played out in the migration process.

As noted by Parella (2003), in the migration process, caregiving responsibilities in migrant populations and the social construction of the maternal role are affected, in many cases, by the way in which productive and reproductive roles are reconfigured. In other words, even though for migrant women these processes may reshape caregiving roles based on support received from family members, or entail the superimposition of the productive and reproductive worlds as a continuous flow and not so much a radical

division of separate experiences (Parella, 2003), these practices are seen by the health system as a departure from the norm. As stated, the generic and ethnocentric dominance of the doctor-patient relationship can be applied to all women regardless of nationality or immigration status. However, in the case of Bolivian women, this takes on specific particularities as they become the target of mechanisms aimed at constructing docile, malleable bodies based on cultural reproductions that perpetuate stereotyped images associated with passivity and submission.

The care provided to Bolivian women should be read based on the positivist paradigm that has characterized the biomedical system from an eminently biological perspective in which social aspects –in this case linked to women's participation in the workforce– are disregarded. The particularity of this paradigm in Bolivian migrant women's health care should be discussed on the basis of the notions that underpin the conceptualization of the culture of the Bolivian Other as a negative aspect of the group as a whole, but also and in particular, of individual traits. As mentioned, this particular interpretation of culture is found –not by chance– to be consistent with cultural interpretations of poverty associated with *blaming victims* for their own fate, with social notions subsumed into individual interpretations on the assumption that people can break out of poverty *if they change culture* (Ramírez Hita, 2006).

An intersectional perspective, therefore, sheds light on the way these women are immersed in a complex power mechanism in the doctor-patient relationship, in which they simultaneously endure multiple forms of pressure from discriminatory structures. In this sense, it can be noted that for Bolivian migrant women, social inequalities in the health sector are exacerbated as different forms of discrimination intersect, including variables associated with race/ethnicity, nationality, sex, and social class, together with age, given that these women are of childbearing age. However, rather than just a sum total of forms of discrimination and a long list of inequalities, it is important to contextualize the way in which these inequalities are embodied by the current Argentine health system, in which heterogeneous health practices are also employed. Indeed, while some interviews more clearly reveal the reproduction of discipline and control mechanisms on the basis of perceptions loaded with negative imaginaries, others seek to challenge this conduct as a way of highlighting the limitations of the biomedical model in providing care and responding to the specific needs of migrant women. Although this study did not aim to identify differences between professionals working in health centers and hospitals, and those working interdisciplinarily, it would be interesting to consider a more conspicuous standardization process involving the implementation of security mechanisms/regulatory techniques that target individuals (Foucault, 2006) for professionals working directly on site, as is the case with health workers.

Thus, this study reveals different types of approaches in migrant health care, with more empathetic views of the realities of Bolivian women, mainly among psychosocial health

workers (social workers and psychologists), coexisting with other perspectives that reproduce representations and practices imposing greater discipline and control, reflected mostly in professionals in biomedical fields like obstetrician-gynecologists, health workers, and nurses.

Furthermore, the interviews showed that in an exclusionary health system, migrants emerge as *scapegoats* for failings or limitations in health care and the system's poor organization in providing care for migrants. In this sense, despite a migration law in Argentina that promotes migrants' access to health, there is a lack of health policies and programs targeting migrants' general health care and specific needs. So it is that the possibility of opening up the notion of culture enables a better understanding of the construction processes of health inequities, going beyond cultural barriers or interpersonal relationships between patients and care providers, and demonstrating that changes in these processes call for transformations that involve broader structural aspects.

This study's limitations are mostly centered on the fact that the research lacks a control case study that provides insight into the perceptions of professionals not in contact with migrants, in order to identify the differences between the health care given to Bolivian women and Argentine women. Future research focusing on the perspective of migrant women and exploring how they challenge and resist the different logics of oppression within the health system will be useful to complement the information presented here.

Translator: Joshua Parker

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