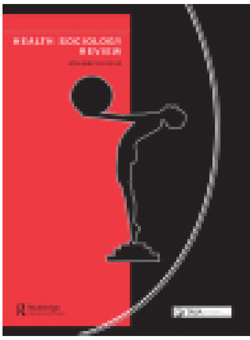

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Reproductive health and Bolivian migration in restrictive contexts of access to the health system in Córdoba, Argentina

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ABSTRACT
Although issues of health have been thoroughly analysed in the field of migration studies, there are still very few studies that seek to understand the reproductive health of women in migratory processes. This article analyses the reproductive health of Bolivian migrant women living in the city of Córdoba, Argentina, through an analysis focused on the community assets that migrants deploy in the health-disease-care process within restrictive contexts of access to the health system. The research consisted of an exploratory study using in-depth interviews with Bolivian migrant women and health professionals through the implementation of semi-structured guidelines. The work shows that, in an environment characterised by a health system that acts to exclude, migrant women develop a series of rational strategies where they draw on community assets embodied in forms of self-care of the body and in community networks. Based on a process of reframing memories related to health practices in the Andean world, these women incorporate these assets and more easily confront the obstacles that they must overcome as migrants in different stages of their reproductive health.

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Reproductive health; Bolivian migration; gender; community assets; Argentina

Introduction

Although the understanding of the relationship between health and migration has increased in the academic literature since the mid-1980s, there is still limited understanding of the relationship regarding migration and reproductive health globally and, especially, in the Latin American region. The knowledge about the impact of migration on the health of Latin American migrant women of reproductive age, and on how the latter experience health and the care of their bodies in migratory contexts, is still scarce. Currently, the issue of reproductive health and migration deserves particular attention given the high degree of feminisation that characterises the Latin American migrant population, the high proportion of migrant women who are of reproductive age, and the challenge for the health services of the host countries to adequately address their health problems (Aizenberg, Rodríguez, & Carbonetti, 2015; Cerrutti, 2011). This article aims

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to fill the existing gaps in the Latin American literature from the perspective of Bolivian female migrants, coming mostly from the rural sector, and health providers that have contact with them in their host cities.

Latin America was the first region in the developing world to reach parity in the number of male and female migrants (Martínez Pizarro, 2003). Currently, of the almost 30 million people living outside their country of birth in the region, almost half are women, which represents a significant change: from predominantly men migrating at the beginning of the twentieth century, towards a gender balance in the early twenty-first century (Martínez Pizarro, Cano, & Soffia, 2014). Variations in migration flows are related to the degree of complementarity between the labour markets in the countries, labour demand in service activities, the effects of social networks and the modalities of family reunification (Martínez Pizarro et al., 2014). This international migration in Latin America has contributed to highlighting how feminisation is a salient feature of migratory processes, yet the literature has not analysed in depth the effects of migration on women's health. Until the 1990s, migrant women's experiences were invisible because analyses were often carried out from an associational perspective, women were understood as passive actors who accompanied men, which left analyses women's experiences in the migratory processes as a secondary consideration (Ariza, 2002). Nevertheless, the increasing participation of women in migration processes, the growing tendency to incorporate gender approaches in the social sciences and the conceptual opening to the figure of the migrant woman (Oso, 1998), have shown that migration processes are social phenomena shaped considerably by gender relations (Pessar & Mahler, 2003). Furthermore, in the last few years, social sciences have highlighted the need to approach the dynamic intersection between the different components present in the historical structures of domination (Lugones, 2008; Stolke, 2004). Social science analyses have demonstrated the value of the intersectionality of gender dimensions, ethnicity, social class and national origin in migration studies (Donato, Gabaccia, Holdaway, Manalasan, & Pessar, 2006), and the outcomes of the interactions (Cole, 2009) of the categories which, in the case of female migrants are placed in the social periphery. This has led to a growing attention to the relationships between migration, intra-family dynamic, the social contexts of women, impacts of displacement on gender roles and migration outcomes on the quality of life of women, including their sexual and reproductive health (Mora, 2002).

UN studies in Latin America have shown that, compared to their native counterparts, migrant women experience a higher number of unwanted pregnancies, report lower use of contraceptives and a lower propensity to attend reproductive health services (UNFPA, 2006, p. 24). In Argentina, different comparative studies (Cerrutti, 2011; INDEC, 2013) show that the average amount of prenatal care for Bolivian puerperal women is lower than for Argentine women, and that six out of ten Bolivian women have unwanted pregnancies, a situation that reveals the unmet demand for family planning services. In this sense, migration has been identified as a risk factor, showing that the confluence of gender, ethnicity, nationality and the lack of official citizenship documents can lead to the most extreme human rights violations, including sexual abuse, deterioration of reproductive health and threats to physical integrity (Martinez Pizarro & y Reboiras Finardi, 2010). Thus far, the academic approaches developed in Argentina have emphasised the different barriers that Latin American migrant women face in reproductive health. These include considerable vulnerability and exposure to diseases from living conditions

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in their new homes (Goldberg, 2014); the difficulties associated with access to and use of health systems (Aizenberg et al., 2015; Cerrutti, 2011); the multiple cultural processes involved with care practices and communication with the health personnel (Baeza, 2014; Jelin, Grimson, & Zamberlin, 2006), and the processes of recognition and denial of legal rights (Caggiano, 2008).

Understanding how Bolivian migrant women experience their reproductive health in Cordoba, Argentina, is of particular relevance considering the particularities of migration today. Although the presence of migrants from neighbouring countries in Argentina has always been between two and three percent of the population, in the last decades this has changed (INDEC, 2010). Currently, migration from Latin American countries to Argentina consist primarily of people born in Bolivia, Paraguay, Chile and Peru who came to Argentina as a consequence of the disadvantageous economic conditions in their countries, and the work opportunities and other favourable circumstances established in Argentina since 1990 (Cerrutti, 2011). The crisis in economies in the region and the urbanisation that has taken place has led to a decrease in the number of migrants settling in the border areas and an increase in migrants living in large urban centres, such as Cordoba. According to the 2008 provincial census, Bolivian migration is concentrated in the province's capital and the *Gran Córdoba* area and it represents 51% of the total population from bordering countries. The Bolivian people in Cordoba have typically occupied precarious and informal jobs, available in labour niches. Bolivian women tend to work in horticulture, floriculture or brick making jobs in rural or peri-urban areas, while others work in care, domestic service, textiles or sale-related activities at markets in urban areas.

In Argentina, studies have shown that South American migrants living in the country are exposed to high levels of vulnerability, bad living conditions and limited access to health services. The vast majority of South American migrants in Argentina are characterised by low levels of education, unfavourable housing conditions and scarce access to basic infrastructure services, which negatively influence their health and that of their families (Pantelides & Moreno, 2009). Furthermore, many migrants are at risk of serious diseases as result of extremely precarious working conditions or working in hazardous environments (Goldberg, 2014). In the specific case of women, migrants are even more exposed to encountering obstacles to health care services. In addition to the difficulties they have as migrants, women face obstacles due to factors associated with their social class, gender, and ethnic-cultural background (Cerrutti, 2011; Jelin et al., 2006). Thus far, those studies that have analysed the role of culture in the health of migrant women, have highlighted how cultural differences between migrant populations and the health system have generated relationships based on distrust amongst professionals and users, lack of access to modern health systems by migrant populations, low performance in women's health care, and difficulty to exercise their right to health, etc (Aizenberg et al., 2015; Baeza, 2014; Goldberg, 2014).

This article aims to analyse the way in which Bolivian migrant women in Cordoba experience the care of their reproductive health in a context of multiple barriers to the health system, favouring an analysis focused on the community assets that women deploy in the migratory experience. It is based on the conceptual assumption that Bolivian women are active agents who develop strategies and build preventive health care practices using cultural knowledge and practices that they bring from their places of origin. Particular features of the Andean culture are at play here, based in reciprocity between members of the community

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(Michaux, 2004) and concepts of health and disease that are natural and holistic, which help women to navigate the different obstacles they face. Thus, this work does not seek to focus on the barriers that Bolivian migrant women must face, but rather it seeks to place women within their broader contexts where they navigate their pathways through the health-disease-care process. The literature on migration and health has focused predominantly on identifying the different obstacles that influence the access and health care of migrant women (Aizenberg et al., 2015; Baeza, 2014; Caggiano, 2008; Goldberg, 2014), without paying enough attention to how they manage to develop strategies to overcome such barriers and look after their bodies. This work incorporates a new look at the field of migration and health in Argentina, highlighting the importance of taking the migration process as an opportunity to redefine the identities of women and describe their assets as a way of coping with the difficulties encountered in the health-disease-care in their places of destination. The paper incorporates the concept of social agency as a key axis, which conceives of women as social agents and privileges their roles in, and capacities in reproducing and transmitting cultural knowledge and community networks as sources of mutual support for their health care (Anthias, 2006). In contexts of mobilities, memories are activated, certain components of the memory regarding how to care for the body in pregnancy or delivery are forcibly forgotten or silenced. Migrant women are not alone, in an intersubjective way, they are linked to families, country men and women, neighbours with whom they share experiences and affections. It is in these relationships where the practice of telling histories, news, memories concerning what was left behind in the territory of origin, where time and space overlap in a complex and dynamic way, takes place. Trigo (2011) argues that the spatial materialisation of memories becomes necessary in contexts of listening or sharing. It is in the 'lands of memory' where migrant women find the information and generationally transmitted knowledge that allows them to self-care during the pregnancy process, delivery and puerperium (Trigo, 2011, p. 11).

Focusing the study on community assets departs from the biologist approach of health as a process isolated from the social world (Good, 2003). It also departs from the neoclassic perspective of migration as an exclusively individual process (Borjas, 1989). In other words, looking at strategies that women deploy seeks to analyse the health-disease-care of migrants from a historical perspective where continuity and the resignification that Bolivian women give to traditional knowledge and practices play a key role. In this sense, this work recovers the multiplicity of spaces where women experience the bond with their bodies and their health care which are not only focused on the interpersonal relationships with doctors but located in a variety of individual and collective circumstances, recovering the explanations of the social, cultural or political causes behind the health, disease and care processes (Menéndez, 1985).

Methodological approach

The research consisted of an exploratory and descriptive study that relied on a qualitative methodology, combining in-depth interviews carried out predominantly in one of the suburbs with a large Bolivian population in the capital of Cordoba, situated in the city's periphery. Six Bolivian women were interviewed. Half of the sample were women from rural regions of La Paz and Potosí. The remaining three were women from urban centres from La Paz and Cochabamba, and members of the Andean community in

Cordoba involved in the cause of migrant rights. At the time of the interview, four women were of reproductive age (one in the 20–25 years old range, and three in the 25–35 range), had an average of two-to-three children and were users of maternal-child health services of the city's public health centres. While these migrants defined themselves primarily as Bolivians, they consider themselves in relation to their *quechua* or *aymara* ethnic origin. Seven health professionals were also interviewed (2 female doctors, 3 social workers, and 2 gynaecologist-obstetricians) working at the health centres in that suburb and general hospitals in the city of Cordoba. The information presented here is part of the field work carried out between June 2013 and December 2016. In interviews with women, the goal was to describe their trajectories and experiences with respect to their health care, especially regarding their reproductive health, as well as in specific situations such as pregnancy and childbirth. Interviews with health personnel gathered their perceptions regarding migrant populations in general, and the Bolivian flow in particular, as well as the existing barriers and facilitators in the access to and use of reproductive health services by migrant women. Although the narratives of health personnel was not exempt from the representations of the biomedical model to which they belong, in all cases they were staff who were involved in the neighbourhoods where the migrant population were based, and they carried out health practices from a perspective that reflects the trajectories of women and their needs. The project did not have the backing of any ethics committee because the funding organism did not require it. Interviewees were informed of the purpose of the interview and the voluntary nature of their participation, as well as the anonymity of the information they provided. The interviews were conducted by social researchers belonging to the university, who were presented as external and independent from health institutions. Participants were recruited through the 'snow-ball' technique. In the case of health professionals, interviews were carried out in the health services, and in the case of migrant women, in their own homes. All were recorded with consent from the interviewee and then transcribed for later processing and analysis.

Results

Although the health processes of each participants were narrativised as personal decisions of each social actors and their specific circumstances, the focus on community assets allowed the analysis of health not as an isolated 'fact' but as an historical-spatial continuity between the community to which it belongs, the country of origin and destination. The historical perspective has not been sufficiently problematised in studies of migration and health, which in their vast majority have taken migrants' stories using a static view, once they are settled in their host nation, isolating them from broader historical-social processes where they have shaped their practices and representations around their health. The historical approach invites us to take the characteristics of the health-disease-care process in the places of origin as an essential guide to highlight the diverse practices assumed by migrant groups in their places of destination. In all societies, forms of care are based on conceptions and knowledge that underlie the intervention of suffering. As Menéndez (2009) points out, the economic, political, religious, ethnic and scientific-technological development conditions that characterise a given society constitute the framework in which the different possibilities of care develop and exist. He also highlights that, even when we think of an antagonistic vision among health

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systems, there is a tendency, at the level of practices, to complement each other with different knowledges and forms of care, the choice of which is based on the presumptive diagnosis made by people, as of the objective conditions that go through them.

Hence, the health and disease phenomenon occurs under a codified frame of reference, giving rise to practices and behaviours that are based on myths, ingrained believes and customs, as well as obstacles and facilitators that the subjects find along the way. As an interviewee pointed out:

> Bolivian women, have less accessibility to go to a hospital, take their children and move elsewhere to attend a second level of care … then they seek alternatives to follow up and there is a lot of self-care of the body that they bring from Bolivia when they don't access a (health) system … They are more careful and worried about their health and the baby inside them than Argentine (women) … more mindful of their body. There are health care and preventive attitudes by Bolivian women that Argentines do not have. In the case of breast feeding, for example, almost one-hundred percent exclusively breast feed, which Argentines do not. They have other type of habits: the majority do not smoke, do not drink alcohol during pregnancy, in that sense, [Bolivian women] have healthier attitudes than Argentine women … (Julieta, Doctor, interview conducted in Cordoba, 7/2015).

This account points out the way in which self-care operates in the therapeutic itineraries of Bolivian migrant women as a way to counter the barriers to access the health system. According to Menéndez, self-care includes the actions developed by individuals to prevent the development of certain conditions and to favour certain aspects of health that aim to reduce risk behaviours, being the domestic group where the actions of detection, diagnosis, care and healing activities of the disease are initiated (Menéndez, 2009).

The indigenous communities maintain their own perceptions of health, disease, prevention and healing of the individual and collective health. For many of those communities, health is understood as the result of harmonious relationships with oneself, family, community and nature, which result from compliance with norms of social behaviour and respect for the forces of nature and the elements that compose it (OPS, 2003). Within this system and as a product of the socialization and gender division, women assume the role of carer, mainly care that have to do with daily life, food and healthy body, as a symbol of the feminine figure in harmony with nature (Álvarez, Moncada, Arias, Rojas, & Contreras, 2007, p. 681). Likewise, women have played a key role as generators and reproducers of social networks, carriers and transmitters of collective memory, of knowledge and culture, including the use of traditional medicine. In the interstices of the medical domain and in the face of generating greater possibilities to bring together the 'abandoned' and new territories, migrant women strongly assume the shelter of memory. By telling family histories, linking both territories through consultations, questions, returns, comings and goings, memories are activated in the construction of a complex plot where the intention is to recover everything that can help to cope with the transit of migration, but in a context in which it is necessary at times to also hide, silence and in other cases forget (Baeza, 2014). These connections between the territory of origin and the new territory, as opposed to generating ruptures generate a series of approaches, contacts and new territorial ties that strengthen links and can generate new ways of knowledge transfer regarding the self-care of the body.

Thus, women resort to diverse practices for their own care, which allows them to learn their own experience, initiate themselves in the empirical knowledge in its habitat and

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provide self-care, a practice that they carry out to maintain their own life, health and well-being based on the knowledge they possess (Álvarez et al., 2007, p. 681).

> In Bolivia there is a very strong recognition of natural medicine and for nature, and we resort to medicinal plants that are natural to heal us because it is from earth where we are born and we heal … in the *Pachamama* (mother earth) … we believe that earth is not an object but a subject. Hence, *Pachamama* is a living being, we treat her as our mother, therefore, maternity and what arises from it, we live it as part of that nature and everything starts from that basis (Jacinta, Bolivian, interview conducted in Cordoba, 7/2015).

In this narrative, it is possible to observe the way in which the Andean worldview is reconstituted within the framework of urban life, as a way of addressing the health problems that arise in a migratory context.

These alternatives are also acknowledged by some medical professionals as valid for healing, who refer to the healing effects of plants, ointments and other elements that are part of the Andean perspectives of health. In this sense, an interviewed physician stated:

> We see here the topic of *fajar* (wrapping) the child to tighten the chest, and we ask ourselves, why? How do they look after the infant's health when they do not access the system? And we saw that the (children's) thorax was tightened with a rigid cloth because the problem (fever) was in the belly and was so that (the fever) did not go up, or the subject of urine when the child has fever, you must bath them with the mother's urine … (Julieta, Doctor, interview conducted in Cordoba, 6/2015).

The notion that self-care is an expression of the link between individual-nature health offers interesting explanations to account for the reasons underlying women's decisions when using, or not, the health system during pregnancy. In particular, the notion of self-care and understandings of pregnancy 'as something natural, as part of life', allows us to look at women's practices as resulting not only from their living conditions but as part of rational decisions, in this case based on understandings of health that go beyond the merely biological:

> Argentine (women) are more careless in many ways during pregnancy, the risk factors to which they are exposed are many. They are less respectful of their own health and that of the baby. Bolivian (women) are much more careful, naturalize the pregnancy more than an Argentine woman. (The latter) feels that pregnancy is a pathological situation, but for Bolivians pregnancy is natural, is part of life. (Carolina, Doctor, interview conducted in Cordoba, 7/2015).

Looking at migrant reproductive health from a social-historical perspective shows the dynamic-collective process that underlies women's health trajectories and allows us to account for women's ability to generate strategies according to how they interpret the context they live in and respond to it.

These situations refer to the way in which women construct their identities in line with the social fabric in which they exist, and where they bring interculturality to their various practices (Rivera Cusicanqui, 2010). As mothers, merchants, cooks, ritualists, and referents, participants health practices were built through by the similar practices that come from their place of origin and the learnings that arose from their new contexts.

> We saw and learned that there is a lot of resistance to our medical practices that had to do with a different conception of health and illness, a different healing process, and I noticed that it makes it very normal for people not to reach the health service … it is not due to

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> negligence but I saw that the explanations regarding disease had nothing to do with the biological but with matters regarding the wind, the abandonment, the bad of the community … (Ana, social worker, interview conducted in Cordoba 9/2015).

The previous interview shows how the decision to use health services during pregnancy was based in a conscious reflection regarding women's own conception of the body and health, more than a deviation of values, obstacles or 'negligence', as it could be interpreted from the view of some health professionals. As we pointed out, the works that have addressed culture in the Bolivian migrant populations tended to look at it from the deficits that it generates. Nevertheless, as Ann Swidler points out, culture influences the actions of individuals because it provides the individual with tools, a vocabulary of meanings, symbols and repertories with which they organise their practices (Swidler, 1986).

As per Swidler (1986) we can consider the previously presented accounts to show how culture, which has usually been read as an obstacle, can be understood as part of the deliberate strategies that women rationally implement. Far from being barriers, traditional knowledge such as self-care, are facilitators to overcome the barriers faced as migrants in the health field. Two participants offered eloquent narratives in this sense, explaining how their health problems were addressed through knowledge and practices common to the Andean worldview, despite the difficulties they encountered in health services:

> We go when we cannot do anything here anymore […] When (regarding their children) they have a stomach ache we give them a herb that is called *manzanilla* (chamomile), which we bring from Bolivia, we have good herbs, there is a tree over there for all those pains, like eucalyptus, that is what we use. And if [the child] already has fever we bath them with eucalyptus, we boil the eucalyptus and with that water we wash their body. And also with urine, in Bolivia when you live in the country side, urine is very good for us. If it is a boy (the one with fever), it must be female urine and if it is a woman (the one with fever), boy's urine, and for the babies the urine must be from their mother and we rub it with a piece of cloth. We also put potatoes and we moist it with water and potato, we cover (the body) with that … We go to the health centre when we do not have the herbs but we only use the herbs we bring … (Roxana, Bolivian woman, interview conducted in Cordoba, 12/2015).

> […] I don't like going (to the hospital) […] they start at 8:30 (am) but you have to wake up at 5 or 6 in the morning to take a number and you won't have an appointment until 12:30 or 1 (pm) and then you have no time to do things at home … And in the morning I have to take the children to school and every day I wait for my children, then, when they get out of school I cook or I go and pick them up … When they have fever I make them urinate. If my boy gets sick I urinate or bath him in urine, if it is my daughter I make her father urinate and rub it all over her body. If the temperature does not go down, I put ice over the head and [if the fever does not come down] well, we must go to the [health centre] (Mariela, Bolivian woman, interview conducted in Cordoba, 12/2016).

These testimonies show us how pain relief in the sick body is first sought using the knowledge passed through generations where the meaning acquired by the body is fundamental to think not only of the illness but the cure. The remedy comes from the body, and in this way, they intertwine with each other, oriented towards the healing.

Drawing on views of health in these cultural terms also allows us to understand that individual health is produced by historical processes that take place in a framework of social ties with characteristics specific to the migratory processes. Addressing Bolivian reproductive health from this perspective requires a closer look at the characteristics of the Bolivian migration flow in Argentina. Although Bolivian women have always been

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involved in the migratory processes towards Argentina, their relocation occurred within a context of family migration, unlike, for example, Peruvian women who have usually migrated alone (Magliano, Perissinotti, & Zenklusen, 2014). In migration to Argentina, the family and social networks of Bolivian migrants assume characteristics continuity and reinforcement reflecting the social bonds in the country of origin. According to Michaux, the social structure in the Andean Bolivian context is made up of 'family relations, intra-family economic and political relations, and intra-community relations that correspond to particular structures of reciprocity' (Michaux, 2004, p. 109).

The following testimony shows how the community value embedded in the system of reciprocity is part of the migrants' everyday life:

> Here there is an Andean cultural value within Bolivian collective, it is the value of the community in general … In my family, for example, cultural diffusion is an obligation because we understand ourselves as a community, not as individuals, and that is a very [important] value. So, we must help each other because one of our inclusive values is reciprocity … you help because at some point in life the other will help you, or you will need the other. (Noemi, Bolivian woman, interview conducted in Cordoba, 10, 2014).

This reciprocity system is fundamental for gaining access to and satisfactory transit through the health care system. As pointed out by one of the interviewees, families who had been in Argentina for longer became the "ones in charge" of transferring the information to new arrivals, including information about the health services available and the places providing the best quality care:

> The families that have been here for many years have the obligation of telling those who just arrived not only the migratory process but also where to access care … Thus, it is for that reason that the families that have been here longer, give the information to the new ones. (Jenny, Bolivian woman, interview conducted in Cordoba, 4/2014).

The following accounts show how this reciprocity system allows women access to a support network that helps to develop care behaviours during pregnancy and childbirth, as well as information about how to overcome the geographical and economic obstacles that are present during prenatal care.

> It is very different when a Bolivian woman that has been here for a long time arrives, you see all her family outside, in the corridors waiting for the birth. They bring *mate* (traditional South American tea) and blankets to her, they help her with the baby. It is a family moment that help the woman to recover from childbirth … the family can better support the baby and look after the mother. (Gabriela, social worker, interview conducted in Cordoba, 6/2013).

Incorporating a view that forefronts the cultural value of health for migrant Bolivian women allows us to understand that health is a historical and collective process in which the web of social bonds that are deployed become particularly relevant in the strategies that women generate. Once again, reconfiguring culture as an obstacle rather than a barrier permits a view of women's agency and their capabilities as active agents within the community contexts they live.

Here health trajectories are not analysed from the perspective of the individual but from the way women reshape the social structures and meanings present in their Andean culture and take advantage of reciprocal ties as a way to achieve a more satisfactory

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outcome in the sometimes hostile scenario present during specific moments of their reproductive health, such as pregnancy, childbirth and puerperium.

Conclusions

This paper aimed to observe the way in which Bolivian migrant women in Cordoba, Argentina, experienced their reproductive health and cared for their bodies in contexts characterised by multiple barriers to the health system. By focussing on the community assets of women, the article intends to contribute new perspectives on the way in which migrant health is addressed in restrictive health contexts. The study has shown that, in an environment characterised by a health system that acts to exclude, Bolivian migrant women rationally deploy a series of strategies to draw on their community assets, embodied in the networks of reciprocity of families and members of the Bolivian migrant community, as well as to the meanings of health as a natural and holistic process. The possibility of "taking advantage" of these assets leads to the development of preventive and care behaviours allowing them to more easily face the difficulties they encounter as migrants with regards to their health. In this sense, the analysis has shown, together with Menédez, that the way in which each woman experiences the health-disease-care process varies according to the knowledge and practices related to their own understandings of health, as well as the obstacles and health facilitators encountered in the search for care. The opportunity to observe the health practices of women from this perspective highlighted that the decision to use health services is often based on a conscious reflection regarding their own understanding of the body and health, as well as an evaluation of the barriers to access the health system. The article contributes to the knowledge offered by existing studies that have sought to understand the relationship of migrant women to health services, and have tended to look at women's health deficits as well as barriers to reproductive health. Despite their vulnerability, women are able to develop strategies using the resources available through their culture to mitigate the impact of barriers in the care of their body. Women choose to draw on knowledge and practices from their Andean culture, despite that they are constituted as alternatives, to avoid using health services, or to use them in combination with these knowledges and practices. Therefore, we consider that the notion of intersectionality not only contributes to understanding how women develop strategies to overcome multiple barriers, but that it should be considered for health policies designed for migration populations, to deepen understanding of different medical practices–such as some of the ones we present here–focusing on diversities (Duarte Hidalgo, 2013).

We cannot state whether migration experiences contribute to the making of flexible gender models ord the renegotiation of norms and practices concerning sexuality and reproduction. However the study critically sheds light on the way in which researchers have observed Bolivian migrant women in relation to their health, which has focused largely on how social structure impacts on health, rather than how they manage to build strategies to overcome it. We were interested in considering the way in which migrant women from Bolivia not only rely on ancestral knowledge related to healing, but in how these knowledges allow them to position themselves as agential in defence of their rights as migrants. The strengthening of reciprocal ties between members of the Bolivian community, especially amongst women, results in a dynamic exchange strengthening their capacity to face the conditions presented by the health system. This paper lies

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together with other studies in the field of gender and health in the region to emphasise the importance of taking the migration process as an opportunity to for women to redefine their identities in accordance with their cultural context of origin (Ariza, 2002; Pessar, 1986). To conclude, emphasis is given to the importance of incorporating a historical-political and cultural perspective in the care of migrant women that takes adequate account of their particular trajectories, the assets they possess and deploy in the host nation, and their specific needs with respect to access to health care and their cultural practices. This is a line of analysis that we will continue to deepen in future investigations.

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