


# “Mom... you have homework”: an ethnographic approach to policies focused on health. Follow-up, intervention and control over practices of migrant women

“Mamá, tenés tarea”: una aproximación etnográfica a las políticas focalizadas en salud. Seguimiento, intervención y control sobre prácticas de mujeres migrantes

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## Abstract

This work reviews the particularities of the daily management of health policy in a city in the Argentine Patagonia, where a focused and non-explicit policy on migrant women from rural areas of Bolivia is evident. In a perspective of ethnographic knowledge and participant observation in different spaces of the public health system, the way in which health teams identify risk factors and implement monitoring, intervention and control logics is evidenced. In the meetings between migrant women and health workers, tensions over health practices are evident in a context crossed by multiple forms of inequality. In some situations, conceptions of risk emerge as a category that awards rights, where priorities for access to healthcare are evaluated according to the interpretation of health effectors. In this sense, the strategies of community workers in these meetings and in their labor relations, where they must respond with statistically evident results, are reviewed. Here migrant women organize ways to build health in contexts of inequality.

**Keywords:** Health Policy; Risk; Primary healthcare; Migration; Control.

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## Resumen

En este trabajo analizo las particularidades que adquiere la gestión cotidiana de política sanitaria en una ciudad de la Patagonia argentina, donde se evidencia una política focalizada y no explicitada sobre las mujeres migrantes provenientes de zonas rurales de Bolivia. A partir de una perspectiva de conocimiento etnográfica y la observación participante en diferentes espacios del sistema público de salud se evidencia el modo en que los equipos sanitarios identifican los factores de riesgo e instrumentan lógicas de seguimiento, intervención y control. En los encuentros entre las mujeres migrantes y las trabajadoras de salud se evidencian tensiones sobre las prácticas de salud en un contexto atravesado por múltiples formas de desigualdad. En algunas situaciones, las concepciones de riesgo emergen como una categoría dadora de derechos, en la que se evalúan prioridades para el acceso a la atención sanitaria según interpretación de las efectoras de salud. En este sentido analizo las estrategias de trabajadoras comunitarias en estos encuentros y en sus relaciones laborales, en las cuales deben responder con resultados evidenciables estadísticamente. Aquí las mujeres migrantes agencian modos de construir salud en contextos de desigualdad.

**Palabras clave:** Política de salud; Riesgo; Atención primaria de salud; Migración; Control.

## Introduction

This paper is part of an ethnography of the daily management of health policy in the city of Comodoro Rivadavia, Argentina. The management of public health policy that targets migrant women in their care processes, as well as its effects, experiences and practices related to these, is characterized herein. This article particularly analyzes the non-explicit policy focused on migrant women from rural areas of Bolivia. Based on the identification of risk factors linked to “non-care” in health teams, control, follow-up and intervention logics on migrant practices are orchestrated. It describes a series of relationships and encounters between migrant women and community health workers in the field<sup>1</sup> (hereinafter community workers) that occur through periodic home visits, in which some tensions on health practices are evidenced. Other studies have shown how interpretations of risk on the practices of migrant women veil a generalized, social class, ethnicized and generational view, which tends to appeal to the culture of migrants, particularly women of “reproductive age” and mothers, who bear the responsibilities of care (Baeza; Aizenberg; Barria Oyarzo, 2019; Barria Oyarzo, 2020).

Different studies have shown the links between discrimination and the migrant population coming from Bolivia in Argentina, evidencing the difficulties experienced by migrants when accessing the health system (Aizenberg; Rodriguez; Carbonetti, 2015; Baeza, 2013; Caggiano, 2007; Cerruti, 2010; Jelin; Grimson; Zamberlin, 2006; among others). In contrast to the idea of “barriers in access to health” or conflict over the exercise of rights that has been emphasized by part of the literature, this study accounts for a hypervisibilization of the migrant population. Here we found an unexplained and tutelary policy focused on women in particular, their gynecological-obstetric care, and their responsibility as mothers in the care of their children.

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1 This figure is constituted as a member of the health teams in the province of Chubut since 2006 based on the proposal of professionalization of the figure of “health agents”. They are all female workers who, in primary healthcare teams, serve as a link between the community and the health system. They work mainly through the monitoring of health indicators and medical controls of family groups at “socio-health risk” and with “unmet basic needs” in order to reduce “barriers in the implementation of the health sector’s own programs” (Argentina, 2009).

This study takes on an anthropological perspective of the State, in which public policies can be construed in terms of their effects, the relationships they build, and the broader systems of thought in which they are embedded (Sharma; Gupta, 2006; Shore, 2010). The critical anthropology of health allows us to investigate the particularities of the construction of health, disease, attention and care, and their different forms of organization, notably in biomedicine and health policy (Martínez Hernández, 2008; Fassin, 2004).

The fieldwork was conducted between 2015 and 2019 in different public health institutions of the city, based on participant observation in the accompaniment of healthcare providers, and in the relationship with migrant women in two peri-urban neighborhoods of the city of Comodoro Rivadavia. The observation rooms are made up by the daily life of two Primary healthcare Centers (CAPS) and home visits, accompanying healthcare providers, where the author participates in these relationships.

## Home visits: Monitoring, intervention and control

Community workers are presented in Primary healthcare (PHC) teams as those who “bridge the gap” between health teams and the population. Their task is mainly made up by “field trips,” walks to the neighborhood areas where they visit each “head of the household,” generally in the areas where the population considered at risk lives, mostly migrant population. During these visits, they generally establish a link with the women, since they are the ones who are at home during the day, who are sought as referents of the family groups, and on whom the responsibility for healthcare falls.

The type of home visit made by the community workers always varies, depending on the link they have established with family members, their personal style of work, and the characteristics of those who receive them. Each meeting may take place in a public or private space, and may vary from a more administrative visit, in which the worker asks for

health records and collects data through specific questions, to a more relaxed dialogue, in which they talk about different topics. In all cases, the follow-up and insistence on gynecological controls, birth controls, children, and the use of contraceptive methods are of fundamental relevance for migrant women from rural areas of Bolivia. These practices, as previously explained, are based on the perspective of healthcare providers on the “non-care” of these women, which are built in the heart of health policy programs at the national and local levels, which are formed in the daily interaction between migrant women and community workers. It is with the home visits to the “head of the household” that follow-ups, controls, and interventions are implemented on those considered to be at risk. For the community workers, a “household head” implies the responsibility of monitoring statistical health indicators and their improvement.

In one of the field trips with Susana, a community worker, she goes to Eladia’s house to ask her how she is doing, and quickly asks her if she has had a PAP (cervical cytology test). Eladia, looking down, says no with a nod of her head. The worker emphatically tells her that she has to go, that it is important to have the PAP done. Eladia nods and Susana asks her what day she can come to the CAPS, arranging a visit for next week. Eladia is 44 years old, Quechua-speaking and speaks Spanish with difficulty. When Susana and the author leave to continue with the visits, Susana comments that Eladia has not had her PAP since last year. For workers, “being covered by the PAP” implies having had the exam at least in the last two years (July 2016). Eladia’s embarrassed attitude in face of the health provider’s demand, reveals an asymmetrical relationship. In some cases, the workers stop to explain to women what is the PAP and what the procedure is like, but in others they take for granted the knowledge of these medical techniques. This situation is often reiterated during home visits in relation to gynecological check-ups and having the PAP. In the “family forms”<sup>2</sup> each community worker should record the

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<sup>2</sup> The family forms are cards on which the community workers record health indicators for each household. They collect socio-demographic data and a series of categories that evaluate the risk of the respondents, which are linked to vaccinations; control of children from o

follow-up of pregnancies, deliveries, responsible procreation and Pap smears, with the month and year of the procedure.

Community workers develop some strategies to foster gynecological consultations, such as “community activities.” These activities are workshops in CAPS waiting rooms aiming at the promotion of these controls or campaigns to take medical visits. In March 2017 in both CAPS, a campaign was held to alleviate the low number of gynecological controls and “Pap smear a day” by the women who visit the CAPS. There, workers make leaflets, like invitations, to advertise the activities they carry out and, days before the event, they distribute them at the homes of those they visit. In one of the leaflets, a phrase can be seen as a title and in large letters that says ‘Mom... you have homework!’ and the image of a hand holding a pencil on top of a sheet of paper with lines, on which the text of the leaflet is written. This invitation is addressed to “women mothers,” who are challenged through a school metaphor, “You have homework.” The image also refers to the school environment. The tone of obligatory nature is reinforced and is clear in the first sentence: “If you are between 15 and 64 years old, have a Pap smear.” This enunciation imperatively states that the study must be carried out for mothers in the age range detailed. These invitations are delivered on an agreed day and time, between which the activity is carried out, in which women commit themselves to have a Pap smear.

Having the Pap smear as one of the concerns of the community workers is part of the guidelines of the Sexual and Reproductive Health Program and the Sumar Program that takes shape through the CAPS teams and particularly in the work of the community health teams. One of the main objectives of these national and provincial programs is to reduce uterine cancer, seeking early detection of its presence through these biomedical techniques. Particularly, during home visits, community workers

carry out personalized follow-up on the gynecological check-ups of migrant women, encouraging them to go to the health center. In some cases, tensions arise over other healthcare practices that are not considered or are proscribed by healthcare providers (Barria Oyarzo, 2020).

Another concern of healthcare providers is the use of contraceptive methods by migrant women. Through home visits, the workers promote the use of hormonal and surgical devices, such as contraceptive pills, IUDs (intrauterine devices), injectable contraceptives, and, in some cases, “tubal ligation”<sup>3</sup> to avoid unplanned pregnancies. In a meeting with two community workers, they mentioned that the use of contraceptives depends a lot on the origin of the women; generally those who come from the city, speak Spanish and attended school know about contraceptive methods. On the other hand, women from rural areas “do not take care of themselves”; most of them do not know about contraceptive methods. In the “responsible procreation” section of the family form, each worker should record whether or not the women request information on contraceptive methods and whether or not they are provided with information about them. Whenever applicable, they should record the type of method they use.

Regarding obstetric controls, community workers periodically visit women in the process of pregnancy, which is based on the scarce controls and the tensions that occur in the interaction with healthcare providers. Despite this perception by healthcare providers, the experiences of women during pregnancy and childbirth are diverse, in many cases depending on their age, origin, and relationship with healthcare providers. In some cases the way women seek to avoid medical intervention during childbirth was observed.

During home visits there is also control over vaccinations and pediatric care. One of the community workers comments that every time

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to 5 years of age; control of pregnancies, childbirths, up-to-date Pap smears (done at least within the last two years); “responsible procreation” (follow-up on the use of contraceptive methods); environmental health; tuberculosis, hypertension and diabetes; violent injuries; substance use; and disabilities. The fact of considering a family group to be at “socio-health risk” implies that it does not meet three or more of these expected indicators.

3 Also known as “tubal sterilization” is a permanent and surgical contraceptive, in which the fallopian tubes are cut, tied or blocked to prevent pregnancy.

they see children they try to lure them into “being responsible” for the family. During each home visit, it is usual to check health records, where vaccinations, “healthy child” pediatric checkups and, eventually, pathologies are recorded. “Healthy child” checkups are periodic medical visits to monitor children’s growth. In these visits, children are measured and weighed to evaluate their physical development, possible diseases and to accompany mothers and fathers in the care and feeding of their children. Also, in these instances, the corresponding vaccinations are administered according to the National Health Ministry’s schedule<sup>4</sup>.

In the encounters between community workers and migrant women, different difficulties related to communication and the understanding of the health workers’ requirements, as well as indications of other ways of conceiving healthcare, which are not taken into account by the health personnel, become visible. Likewise, migrant women may find themselves in situations of vulnerability, since the scarcity of economic resources and the lack of support networks hinder healthcare expected from the health system, and situations of suffering reported by the migrant women.

## Special appointments: Risk assessment and guarantee of rights

The concept of non-care on the part of migrant women, particularly from rural areas of Bolivia, functions as a “rights awarder,” as it guarantees access to gynecological-obstetric and pediatric check-ups in a health system that at times appears restrictive or with difficulties to meet the population’s demand. The socio-sanitary risk categories justify a tailored follow-up of migrant women regarding their and their children’s healthcare, leading to strategies for access to devices, medical practices and women’s “awareness” of these forms of healthcare.

The shortage of medical appointments in health centers is common given the population’s demand and the scarcity of health personnel. It tends to

generate conflicts and discontent in users and health teams. Although the health system seeks to reach as many people as possible, health personnel are scarce for the population. In this context, community workers develop some strategies that seek to guarantee differential access to medical visits by the population considered to be at social and health risk. In this sense, there is a provision of “special appointments” managed by the community workers and, in some cases, personal mediation with medical specialists.

Both CAPS offer the so-called “protected” or “special” appointments, which are between five and ten monthly gynecological and pediatric medical consultations that each community worker has available to offer to the women they visit. These appointments, according to an internal agreement in the work teams, should be delivered considering the women’s risk or need. They are delivered in special cases, when it is difficult for a woman to go to the health center to have an appointment or needs an urgent appointment. In many cases these appointments are delivered conditioned to visiting the health center, highlighting their cost and importance.

On a field trip, Carolina—a community worker—and the author visited Francisca, a 30-year-old woman from Bolivia, who was supposed to attend a check-up visit for her two children, aged 1 and 3, but she failed to attend. When they arrived at the house, Carolina asked Francisca, who speaks only a little Spanish, why she did not go to the pediatrician’s appointment, to which she replied, quietly and slowly, that she had lost the paper for the appointment and had forgotten. Carolina tells her that she is going to arrange another appointment, a “special appointment,” so that she can take the children, since they are failing to attend their follow-up. Carolina emphasizes that Francisca should not miss it, since the other time the pediatrician was waiting for her, stressing how important appointments are, and explaining that there are people who queue up very early in the morning to get a visit. Carolina speaks to Francisca loudly and stressing each word

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4 National vaccination schedule. Retrieved from: <<http://www.msar.gov.ar/images/stories/ryc/graficos/0000001013cnt-2017-01-01-calendario-vacunacion.pdf>> Accessed on: February 07 2022.

as if she were making an effort to make herself understood. Francisca nods her head, smiles and receives the paper Carolina gives her. Carolina has Francisca read the paper, making sure she understands the day and time of the appointment for next week. Carolina tells her to stick the paper on the refrigerator or keep it safe, repeating that it is very important the control: “For the health of your little children.”

In some cases women, knowing how the protected appointments work, demand them appealing for special consideration from the community workers. On one of the rounds the author was accompanying Danila, a community worker. They were on their way back to the health center when Sabina called. Sabina told Danila that she wanted an appointment, because she was supposed to take her youngest child, who was one year old, for a follow-up visit last month. Danila asks her why she didn't go to the health center. She explains: “Because I have to go very early, and it is always crowded,” laughing and sticking out her tongue, with a mischievous expression. Danila exclaims: “Oh God... this woman” as she laughs. Diana asks for the children's healthcare booklet, and provides her one of the appointments she has assigned for the month. Sabina knows about the “special appointments” and asks for them to the worker with whom she has a relationship of trust.

In other instances, the community workers mediate with medical specialists in the health system to ensure access to consultations for the women they visit. Thus, depending on the links that the community workers establish with different healthcare providers, they can arrange appointments for the women they are taking care, avoiding the cumbersome process of getting an appointment for a medical specialty at the CAPS or the hospital. On one of the walks through the neighborhood, Carolina told the author that, jointly with the team of community workers, they bet on networking through contacts with other professionals in the public sector.

“Being in charge” of a family implies, for the community workers, a responsibility with their supervisors in the health system and with the women they visit; they must answer to the health system with improvements that are visible in the statistical surveys. The objective of the visits is to

improve health indicators, and it is expected that after three years, at the most, a family will no longer be followed-up because it is considered to be out of socio-health risk. Each family, and in particular each woman, is a “burden” of responsibility for the providers, for whom they must represent and do everything possible to achieve the expected patterns of care for them and their children under their responsibility. In some cases, migrant women demand female workers and negotiate their position with what the latter can offer them.

This restrictive context for access to the benefits that the health system can provide coexists with the hypervisibilization of migrant women, particularly from rural areas of Bolivia, where the guarantee of rights is at stake. In a context where the scarcity of resources prevails in the health system, which at times appears excluding for migrant women, we can also observe the visibilization of this group, which as a group at socio-health risk is the object of different strategies to achieve the healthcare expected by the health system.

## Targeted policies and subordinate inclusion

In this context, there is evidence of a health policy targeted and tutelary to migrant women from rural areas of Bolivia. This policy is not explicit as such, but is made visible in the daily practice of community workers according to social and health risk assessment. They seek to channel the health care practices of these women to the biomedical model based on a health structure particularly focused on gynecological-obstetric and pediatric controls. In this sense, migrant women appear as those with whom they have to work, particularly because of their lack of care. Community workers play a fundamental role in monitoring and controlling health indicators and intervening in those practices that need to be promoted.

In many cases, community workers are torn between a work attentive to the complexities of the social determinants of health and the demands of the health system. The supervision of community health teams within each CAPS requires results that should be statistically evidenced. They have to support 120

under their care, visiting them at least once a month, and show statistical improvements at the end of each round, in the reports drafted every three months. These reports should include the number of women visited who had PAP testing per day, “healthy child” follow-up, vaccinations, pregnancy follow-up and women using contraceptive methods.

Non-explicit targeted policy is understood a series of systematic actions by the state organization on a given social group or a problem that is not explicitly defined. In contrast to the notion of public policy, according to which the State assumes an active and explicit role (Tobar, 2012), this context unveils a series of actions that take shape based on the interpretations of healthcare providers that veil a generalized, class-based, ethnicized, and generational view. Following Shore (2010), this paper proposes that public health policies take shape through the codification of public health logics that go beyond this space in a context crossed by different forms of inequality. In this context, the daily management of the work of community workers makes evident a policy focused on the health of migrant women from rural areas of Bolivia, of reproductive age and mothers, especially those considered at socio-health risks, challenging their gynecological-obstetric and pediatric care practices for their daughters and sons.

Recovering classic contributions by Foucault (2002) on disciplinary techniques, control of bodies and their coercive function, one could say that these have historically been modeled *par excellence* on the army, the prison, the school and the hospital. Here it is observed how the logic of hospital and biomedical control expands in a field of actions and logics that become visible in the work of community workers towards migrant women. Surveillance, monitoring, intervention, and control over the bodies and the ways of taking care of them, in this case, are expanded in the urban territory, in the neighborhood extensions, invading the domestic spaces of migrant women. Based on their links with these women, the workers seek “awareness raising,” “taking on responsibility for care,” which is part of a process of subjectivation in which they seek to engage women in their care.

The notion of risk applied particularly to “Bolivian women” justifies a role of guardianship and protection for these women, seeking to channel their practices to a prefixed model of care, in many cases making the women responsible for the causes of their health problems. Here one finds an interpretation of risk that takes into consideration housing conditions, the lack of urban resources and basic services. However, the actions of public policy through the work of community workers are especially focused on gynecological-obstetric care, the use of contraceptive methods, and the control of children and their vaccination, in many cases naturalizing the precarious conditions of life.

Risk is a category inherent to epidemiology, in this case quantifiable in population terms and observable in individual cases by means of the survey of community workers. In the words by Suarez, Beltran and Sanchez (2006), risk in public health makes it possible to determine which aspects of the environment or lifestyle of individuals or a group should be transformed or controlled to reduce the risks present. Thus, risk is presented as a property of people that is in causal association with a harm, adverse effect or disease. For the case under study, the risk is particularly focused on the lack of gynecological, obstetric, and pediatric follow-up and of the use of contraceptive methods, seeking the accountability of migrant women. In this way, other conditions of inequality, such as socioeconomic inequality, are not taken into account, even though they are disclosed. Consequently, it is up to the sensitivity and willingness of each community worker to manage resources and means to improve living conditions within the parameters of the women. This also happens with listening and dialogue about other forms of healthcare that, as seen in some cases, are proscribed or neglected.

In his ethnographic work in the city of Potosi, Bolivia, Ramirez Hita (2010) states that popular knowledge for the biomedical sector appears as “non-knowledge” to achieve good health. In this sense, the prevention and problem-solving strategies proposed are usually focused on the individual and not on the collective subject. Thus the “ignorance of risks” is built into the axis of health practice, leading to the proposal of vertical preventive

actions, in which the problem is posed in terms of moral responsibility or ignorance of the actors. In this context, the way in which community workers manage resources and strategies to “help women to take care of themselves” and “become aware” of the “proper” ways of care in a context marked by multiple inequalities can be observed.

Viaña (2009) has coined the notion of “subordinated inclusion” to account for the way in which state policies, from an instrumental and “intercultural” perspective, include ethnic diversities under the parameters of neoliberal states and international organizations, neglecting a deep and structural questioning of their principles. Other authors have worked on this notion in the educational and migration context, which refers to the ways in which the mandate of integration to the national-Argentinean is produced, ignoring previous trajectories, knowledge and belongings (Novaro; Diez, 2011). In this case, extrapolating this notion, one can affirm the existence of a particular mode of inclusion of migrant women under the parameters of the biomedical model in a context in which health and its programs are perceived as a right of citizenship. In this sense, women who do not adhere to the biomedical care guidelines appear in some cases as those who do not allow to be helped or are unaware of the correct ways to take care of themselves. Thus, the subordinate inclusion in the field of health is made visible through the disavowal of women in their care processes, the proscription, silencing or dismissal of non-biomedical practices as a condition for being part of the health policy. One could affirm that the State, as an organization for the management of public resources, expands in the territory guaranteeing rights and expanding its coverage under the parameters of biomedicine.

It is also necessary to account for the conditions of socioeconomic inequality in which one finds the migrant population living in the neighborhoods visited by the community workers. The possibilities of access to material and economic goods, the fact of speaking Spanish, knowing how to read and write and having a network of links in the migratory context are presented as a condition to be able to sustain the care expected by the public health system. One can say, from an intersectional

perspective (Viveros Vigoya, 2016), that the relations of power and inequality that take shape through gender, social class, nationality and ethnic-racial configure a space in which migrant women are taking positions and building their particular ways of caring for health. Within this framework, women take differential action, in their relationship with community workers and the access to resources that these can offer them, to make decisions about their ways of caring for their health, which may or may not be related to the biomedical model.

In this context, community workers develop strategies through which they seek the care expected by migrant women. Special appointments or mediations with other health professionals are presented as a modality of management of the scarce resources that, as observed, are available in the public health system. Considering the problem of access to medical visits, workers have special appointments for women in “at risk” conditions. Depending on the sensitivity of community workers to the precariousness of life, resources are made available and decisions are made about them, what we could call, following Fassin (2003) “pathetic decisions.” The author studies in the French context the way in which public policy enforcers make decisions on the regularization of migrants for “humanitarian reasons,” in which the body, suffering or illness serve as resources to claim a right, depending on the “politics of pity,” in which feelings are mobilized to assign rights (Fassin, 2003). In our context, access to a right, a medical visit, is subordinated to the suffering or risk interpreted by community workers. In some cases, it is the women are the ones who request this resource by claiming personal difficulties.

## Final considerations

The targeted, non-explicit and tutelary policy on migrant women from rural areas of Bolivia is produced by the identification of risk factors linked to “non-care” in health teams that implement logics of follow-up, intervention and control. These actions challenge gynecological-obstetric and pediatric care practices that are considered “risky.” Primary Health Care unveils a series of relationships and devices



through which the practices of Bolivian migrant women are channeled to a type of care practices expected by the public health system. Particularly, in the meetings between migrant women and health workers, tensions over health practices are evident in a context crossed by multiple forms of inequality. Here we observe a subordinated mode of inclusion through the disempowerment of women in their care processes, in which the State expands in the territory guaranteeing rights and expanding its coverage under the parameters of biomedicine.

Health policy takes shape through the codification of public health logics by health care providers, which goes beyond this space. In this context, conceptions of risk emerge as a rights-awarding category, in which priorities for access to health care are evaluated according to the interpretation of health care providers. The study observed strategies of community workers in home visits and in their work relationships that should respond with statistically evident results. "Being in charge" of a family implies, for the community workers, a responsibility with the superior personnel in the hierarchy of the health system and with the women they visit. In this sense, there are different ways in which female community workers and migrant women act towards constructing health from their positions in contexts of inequality.

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### Author's contribution

The author has carried out all the instances of elaboration of the article, from the fieldwork, between 2015 and 2019, to conception, data analysis, elaboration of the manuscript, drafting and revision.

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