Migraciones
INTERNACIONALES
El Colegio de la Frontera Norte

MIGRACIONES INTERNACIONALES, VOL. 11, ART. 10, 2020
e-ISSN 2594-0279 https://doi.org/10.33679/rmi.v1i1.1855

# Recent Status of Sexual and Reproductive Rights of Migrant Women Residing in the City of Buenos Aires

# Estado reciente de los derechos sexuales y reproductivos de mujeres migrantes que residen en la Ciudad de Buenos Aires

Javiera Verónica Fanta Garrido[1]

ABSTRACT

Sexual and reproductive rights of migrant women are a subject of growing interest due to the difficulties in accessing sexual and reproductive health services and supplies, along with constraints inherent to the health care system. This article analyzes the status of some sexual and reproductive rights of immigrant women from neighboring countries and Peru residing in the city of Buenos Aires, Argentina. Using secondary data and interviews with key informants, this research examines adolescent reproduction, access to preventive care, and the predominant characteristics the in sexual and reproductive health care of this population group.

*Keywords*: 1. international migration, 2. gender, 3. sexual rights, 4. sexual and reproductive health, 5. city of Buenos Aires.

RESUMEN

Los derechos sexuales y reproductivos de mujeres migrantes constituyen un tema de interés creciente debido a las dificultades de acceso a los servicios y a suplementos de salud sexual y reproductiva, sumado esto a los obstáculos propios de las instituciones sanitarias. Este trabajo analiza el estado de algunos derechos sexuales y reproductivos de inmigrantes provenientes de países limítrofes y del Perú que residen en la Ciudad de Buenos Aires, Argentina. Mediante datos secundarios y entrevistas a informantes clave, se examina la reproducción adolescente, el acceso a los cuidados preventivos y las características que priman en la atención a la salud sexual y reproductiva de este grupo poblacional.

*Palabras clave*: 1. migración internacional, 2. género, 3. derechos sexuales; 4. salud sexual y reproductiva; 5. Ciudad de Buenos Aires.

Date received: February 28, 2018
Date accepted: May 15, 2019
Published online: July 1, 2020

[1]Gino Germani Research Institute-UBA/Conicet, Argentina, javiera.fanta@gmail.com, https://orcid.org/0000-0001-6176-1776

Migraciones Internacionales es una revista digital anual editada por El Colegio de la Frontera Norte. https://migracionesinternacionales.colef.mx

## INTRODUCTION

The dynamism and feminization that global migratory movements have undergone has brought increasingly growing attention to the Sexual and Reproductive Health (SRH) of migrant women in the public agenda and specialized literature. Side by side with this, the very concept of SRH has become wider and more complex in the last decades, transcending the solely reproductive aspects of sexuality and the idea of lack of illness, encompassing now physical, mental, and social well-being as it relates to sexuality and reproduction (Smith & LeVoy, 2016). As a matter of fact, the definition accepted by the International Conference on Population and Development in Cairo (1994) sets forth that SRH "implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (United Nations, 1995, p. 37). Due to its agreed convention nature, this definition has opened the door to a series of universal guarantees, contained in different international instruments within the scope of Sexual and Reproductive Rights (SRR).

The work presented hereby offers a view on the study of the recent state of some of the SRR of migrant women original to countries neighboring Argentina and Peru, living in the Autonomous City of Buenos Aires (CABA, for its acronym in Spanish). It specifically examines the situation of women between the ages of 14 to 19 years who were born in Bolivia, Paraguay, and Peru, due to the dynamism that these collective groups reached in the last 30 to 40 years.

By the wide array of acknowledged SRR, we decided to classify these rights as those pertaining: (i) reproduction, (ii) no reproduction (contraception and abortion), and (iii) the free exercise of sexuality (Monte & Gavernet, 2012). This work addresses the two first dimensions from a plural methodological approach. The levels of fertility and maternity of teenage migrant women are analyzed, on the basis that this component represents an expression of reproductive inequality; the main characteristics of the SRR system that either hinders or enable access to it are also analyzed. Likewise, the actual access to preventive care in women SRR matters in recent times is assessed, and a brief exposition on the delivery care received by the women involved is presented. To achieve these goals, secondary data sources and in-depth interviews were considered. For the first, the 2010 National Census of Population, Households, and Housing (INDEC, 2015) and the Migration, Fertility, and Family Survey (EMFF, for its acronym in Spanish) (Dirección Nacional de Población, 2011) were analyzed on a non-probabilistic sample of migrants concurrent to the National Migration Office.

In turn, four key informants were interviewed in December 2015 and January 2016: one professional of the Health and Migration Group of CABA's Training and Teaching Directorate of the Ministry of Health, the coordinator of the Argentine Committee for Refugees and Migrants (CAREF, for its acronym in Spanish) and head of the Bolivian

Migrant Women and Youngsters Access to SRR project, an obstetrics practitioner member of the Respected Delivery team of a CABA public hospital, and a representative of the Obstetric Violence Observatory (*Observatorio de Violencia Obstétrica*). On the other hand, this study considered six semi-structured interviews with migrant women of reproductive age (15 to 49 years old) born respectively in the studied countries and residing in the CABA, with children born alive in Argentina to inquire about their experiences on giving birth in the local context.

The importance of studying the SRRs of the female migrant population is based on several reasons. First, migrant girls and women are more likely to experience sexual violence, especially when transiting (United Nations, 2016). The evidence indeed shows that within the context of certain migration circuits (as is the case of Central American migration transiting through Mexico towards the U.S.), the risk of rape is accepted and acknowledged as part of the journey (Infante, Silván, Caballero, & Campero, 2013).

Additionally, migration is associated with a greater risk of getting a sexually transmitted disease (STD) due to greater exposition of the population in transit to forced, occasional, and unsafe sexual intercourse (UNAIDS, 2013). In this sense, women face an additional challenge by fearing possible stigmatization or by the fear and shame of having been victims of sexual violence, factors that may hinder and delay their visit to health service centers in case of getting an STD (Agu, Lobo, Crawford, & Chigwada, 2016). Certain background information pertaining mother and child health (Haour-Knipe & Grondin, 2003; Carballo, 2006; Heaman et al., 2013; Chiavarini et al., 2016) shows that migrant women are less likely to partake of pre- and post-natal nursing and that they generally take longer to attend their first pregnancy follow-up consultation. On the other hand, given that Latin America and the Caribbean is the region with the largest number of unsafe abortions in the world (Sedgh et al., 2016), it can be expected that migrant women are more likely to avoid or delay visiting health service centers in case of possible aggravated medical conditions. All the circumstances described are deepened in conditions of migratory irregularity and recent migrants (PNUD, 2008), and while it is true that the characteristics vary among the different migration groups and destination societies, it is consensually agreed that migrant women deserve special attention when it comes to assessing the SRR conditions of the population.

## CHARACTERISTICS OF THE MIGRATION FLOW COMING FROM PERU AND NEIGHBORING COUNTRIES WITH ARGENTINA

Strictly speaking, migration seen as bordering from the scope of this study refers to those immigration collectives originating from countries that share the border with Argentina. However, today the term "bordering" implies, more than a mere geospatial point of reference, a series of sociodemographic characteristics shared by these migrants, placing them within a specific social group. We deal with a racialized migration (Magliano, 2015)

—which means that the ethnic-racial factor is an enclave that determines the position of this group within the social structure—, overrepresented in certain labor niches, subject to precarious and irregular labor conditions, and driven by subsistence and social mobility projects. Given this, the specialized literature available on the matter tends to include within the concept of bordering migration those individuals born in Peru, even if this country does not share geographic borderlines with Argentina (Cerruti, 2009).

According to data of the 2010 National Population, Household and Housing Survey 90,000 females of reproductive age born in Bolivia, Paraguay, and Peru reside in the CABA (Instituto Nacional de Estadística y Censos, 2010). Although the reasons for migration are diverse, the main driver of mobilization among migrant women from neighboring countries is labor opportunity (Cerrutti, 2009). Their insertion in the labor market mainly falls within a few occupations, housekeeping standing out as the main activity, and to a lesser extent retail sales and agricultural activities (ibid.).

As for the background in terms of the general health care of these migrant collectives, the construction of stereotypes regarding their origin has been noted as a limiting factor to access and permanence in the system. Jelin, Grimson, and Zamberlin (2006) noticed how medical practitioners from health institutions of the country's capital and the 24 parties that constitute the Greater Buenos Aires region (GBA)[2] make distinctions between migrant women from Paraguay and Peru, on the one hand, and the Bolivian collective on the other, in terms of their level of adaptability to the local culture. In the latter case, health professionals and administrators identify a broader cultural gap, which is attributed to the lower average education level of Bolivian migrant women, in turn, expressed in the interpretation of medical indications and how closely they follow them. The authors state that in the case of the hospital system, this gap results in processes of inferiorization of the other, whereas in primary care systems those cultural differences tend to be relativized and perceived as a communication problem.

In turn, the work by Cerrutti (2010) regarding Bolivian women in the border region, in the Province of Buenos Aires, and the CABA showed that health professionals and administrators do agree in pointing out that migrant women of this origin display little autonomy in reproductive decision making, and that they are not well disposed towards control and follow-up; this happens with the recommended prenatal monitoring, for example.

In her exhaustive research on migrant women from Paraguay in the GBA, Wang (2010) showed how certain population sectors in Paraguay consider it superfluous and even useless to visit health institutions if there is no illness to justify a consultation. Moreover, many of

[2]The GBA is the large metropolitan area constituted by the CABA and the parties of the Buenos Aires suburban area, the latter corresponding to 24 administrative jurisdictions.

these migrant women contact the health system only upon the time of giving birth, and their visits are oftentimes limited to this event, being interrupted once the delivery and the immediate postpartum process is done with. When it comes to contraceptive practices, the author brings to attention the fact that migration represents a milestone in the lives of these women, by enabling their access to contraception methods (CCM) and promoting consultation in SRR services.

*Argentinian Policy for the Protection of Sexual and Reproductive Rights*

In 2003, two years after one of the harshest economic crises ever to hit Argentina, the country entered a new stage in terms of social models, characterized by the implementation of actions from the State intended to strengthen inclusion processes. Under this perspective, the National Congress passed in 2004 law No. 25.871 on Migration, according to which the right to free transit of people throughout the national territory is guaranteed. Particularly when it comes to the right to health, the law sets forth in its Article 8 that the right to health (including social assistance and healthcare) may not be denied nor restricted to any foreigner who needs it, regardless of their migration status. Moreover, it delegates to the authorities of health and education institutions the responsibility of providing orientation and advice on the corresponding procedures required to regularize migration statuses.

In line with this political approach of greater observance and respect towards the fundamental rights of the people, in 2002 law No. 25.673 was passed, which brought about the creation of the National Plan of Sexual Health and Responsible Procreation (PNSSyPR, for the acronym in Spanish for *Programa Nacional de Salud Sexual y Procreación Responsable)* under the Ministry of Health. This program is intended for the general population and its aims are essentially preventive for the most part. Among its goals are the reduction of mother and child morbidity and mortality, the prevention of unwanted pregnancies, and the prevention and early detection of sexually transmitted diseases, HIV/AIDS, and genital and breast pathologies (Article No. 2 of the law).

Also, in Argentina, there is law No. 25.929 on Respected Delivery, passed in 2004 and regulated in 2015 by means of the 2035/15 decree. This regulation protects the rights of the mother and the newborn in the stage of delivery and the rights of the woman in relation to the pregnancy. Among them, the right to treatment that is dignified and respectful of cultural standards, the right to be informed on the evolution of the delivery and the possible interventions that could take place in the different stages of the process, and the protection of the bodily bond between the mother and the newborn (Article 2 of the regulatory decree).

One of the novelty aspects of this law is that it addresses a type of gender violence usually not made visible: that of obstetrics violence understood as that which is imposed by the health staff on the body and the reproductive processes of pregnant bodies. Although this type of violence is considered under law No. 26.485 on the integral protection of women,

the law on respected delivery sets forth specific guarantees concerning the autonomy of will and the respect for human dignity during pregnancy and birth processes. Another relevant aspect is that it also includes a flexible perspective on how the delivery and pregnancy processes can be approached. As an example, article 2 of the regulatory decree sets forth that every person has the right to choose the place and way in which labor will take place, as well as the way of birth. Article 2 also points out that regarding pregnancy, labor, delivery, and the postpartum period, all women have the right of being treated with respect and dignity, and to not be discriminated against because of their culture, ethnicity, preferences, or any other factor. From the optics of interculturality, this law calls into question the use of standardized protocols for safe deliveries and provides a regulatory framework that is wide enough to ensure a dynamic approach towards the cultural processes associated with pregnancy and birth.

*Teenage Reproduction Among Migrant Women from Neighboring Countries in the City of Buenos Aires*

Analyzing teenage reproduction is an exercise not without difficulties, particularly when such analysis covers migrant populations. In the first place, there is the widely known difficulty of undisclosed childbirth among girls and teenagers, likely attributed to the negative connotations that pregnancy and maternity at a young age are associated with. On the other hand, analyzing this factor among migrant women is also difficult as it implies identifying the actual place wherein pregnancy and childbirth took place. There also are differences between births taking place at premature (14 years) and early (15-17 years) of teenage, and those happening at later ages (18-19 years), due to both physiological and contextual factors. In this sense, maternal morbidity and mortality rates in early ages is comparatively greater to that of later ages, and in certain contexts being a mother can be socially acceptable or desirable from 17 years of age and on. Taking the latter into account, premature, early, and late teenage maternity (under the assumption that having a child before 18 years of age is usually undesirable regardless of the country of origin), as well as the fertility rate for teenagers from 15 to 19 years, was analyzed.

The results show that the groups of migrants from Peru and neighboring countries display a greatly larger teenage motherhood (14 to 19 years) percentage than that of the native population (Table 1). The differentials found in premature and early ages of teens are particularly steep, the specific fertility rates of migrants from neighboring countries from ages 15 to 19 show noticeable differentials per country of origin, exceeding in the different instances the level displayed by women born in Argentina (Table 2).

Table 1. Percentage of Premature (14 Years), Early (15-17 Years) and Late (18-19 Years) Teenage Mothers, per Country of Origin. Autonomous City of Buenos Aires, 2010

| Country of origin | Teenage mothers (%) | | |
|---|---|---|---|
| | 14 years | 15-17 years | 18-19 years |
| Argentina | 1.6 | 7.2 | 21.6 |
| Bolivia | 4.7 | 13.1 | 31.7 |
| Paraguay | 4.0 | 10.8 | 28.3 |
| Peru | 4.4 | 8.6 | 19.2 |
| *Total of migrant women from Peru and neighboring countries* | 4.3 | 11.2 | 27.9 |

Source: 2010 National Census of Population, Households, and Housing. Extended Questionnaire (Instituto Nacional de Estadística y Censos, 2010).

Table 2. Specific Rate of Fertility (TEF, for its Acronym in Spanish), 15 to 19 Years, per Country of Origin. Migrant Women from Peru and Neighboring Countries, and Argentinian Women. Autonomous City of Buenos Aires, 2010

| Country of origin | TEF $_{15-19}$ (in thousands) |
|---|---|
| Argentina | 26.5 |
| Bolivia | 81.2 |
| Paraguay | 86.9 |
| Peru | 64.1 |
| *Total of migrant women from Peru and neighboring countries* | 77.9 |

Source: 2010 National Census of Population, Households, and Housing. Extended Questionnaire (Instituto Nacional de Estadística y Censos, 2015).

It could be argued that the results presented are not the manifestation of a healthy cultural heterogeneity, but rather represent worrisome gaps that reflect unequal access to resources and rights (including a life free of violence and to make decisions about their bodies, to mention a few).

*Access to Contraception Methods*

As already stated, the analysis on the use of CCMs and how they are linked to the right of women to decide about their reproductive processes should also consider an essential aspect pertaining to body autonomy: this is, the actual willingness of women to make use of these methods, or otherwise to express their desire to defer maternity, as well as to conclude/prevent reproduction.

As a first step, this section presents a characterization of the sample analyzed by the EMFF, emphasizing migrant women residing in the CABA. Next, the number of children born alive is compared against the stated ideal number of children to get to know to what extent does the fertility trajectory matches the reproductive aspirations of the surveyed

women. To obtain the latter information, the EMFF included the question "What is the ideal number of children a woman should have according to you?" Regarding this, it should be noted that there might be a trend to state a figure no lesser than the actual number of living children and that in some instances unquantifiable answers were given ("the number God be willing," for example). Taking this into account, as well as the influence of the variables of child mortality and mortality throughout life, the unquantifiable cases, and those that declared the death of a child were respectively discarded. Finally, the current use of CCMs by migrants who did not want to have more children or wanted to postpone the next or a first pregnancy was analyzed.

The analyzed sample consists of 451 migrant women, out of which 171 were born in Bolivia, 173 in Paraguay, and 107 in Peru. The age of the surveyed women ranged from 18 to 49 years, the average age being 32 years. Approximately half of the women (48%) arrived in Argentina at ages 20 to 29 years, and only a lesser percentage (16%) migrated after the age of 30. About three-quarters have lived in Argentina for five years or more (296 women), so this is a sample composed mainly of former migrant women. At the time of the survey, most women had attended or were attending the formal education system, being the collective from Paraguay, one with the highest educational level (an average of 4.6 years), followed by Peruvian and Bolivian migrants, whose average level reaches 3.9 years of education. Regarding marital status, 70% of the surveyed women (318 migrant women) are currently in a relationship, out of which more than half live with their spouse (274 women). Also, about 70% (317 women) is or has been a mother.

Upon analyzing the ideal number of children reported by the migrant women from neighboring countries, the data showed that the prevailing aspiration was the two children model (55%), regardless of the migration origin. This preference was mainly stated by women who had not yet started their reproductive trajectory at the time of the survey. The fact stands out that none of the surveyed women aspires to nulliparity. In terms of the number of children born alive per female, the average ranges from 1.4 among Peruvian migrant women and 1.8 among Bolivians, whereas among migrant women from Paraguay, the average is 1.5 children. These results, which express a low rate of fertility, are likely to be because the sample was comprised of young women who are yet to conclude their reproductive phase.

To compare the reproductive aspirations with the fertility trajectory of the surveyed migrant women, Table 3 shows the ideal number of children declared according to the number of children born alive, expressed in percentages (%). From there, we derive that family planning would imply greater deficiencies among those who have a greater number of children. If we take as reference those migrant women who had four or more children, for example, we can see that only a small fraction of that group considers that amount to be ideal.

Table 3. Migrant Women from Peru and Neighboring Countries (18-49 Years) per Ideal Number of Children, per Number of Children Born Alive (CBA) (%)

| CBA | Ideal number of children (%) | | | | Total | *N* |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4+ | | |
| 0 | 3 | 62 | 27 | 8 | 100 | 133 |
| 1 | 8 | 60 | 24 | 8 | 100 | 108 |
| 2 | 3 | 59 | 28 | 10 | 100 | 96 |
| 3 | - | 29 | 50 | 21 | 100 | 66 |
| 4+ | - | 57 | 34 | 9 | 100 | 44 |

Source: 2011 Migration, Fertility, and Family Survey (Dirección Nacional de Población, 2011).

Now, what happens with those migrant women who have fulfilled their reproductive aspirations? Are those women of bordering origin who currently have a couple making use of CCMs to prevent pregnancy? The information analyzed reveals that out of the total of surveyed migrant women, 40% of them (128 women) fulfilled their reproductive preference, that is, the number of children they have equals or exceeds the ideal number of children stated. Out of them, 65% use some CCM (86 women), and 32% (41 surveyed women) do not use any contraception method, even if they already reached the number of children, they deem ideal. Following these results, the data found shows that when asked, "Would you like to have more children?" 34% of migrant women who have a couple and wish to conclude their reproductive phase (50 cases) do not use any contraceptive method.

The points mentioned before lead to the belief that a large number of the surveyed women lack full access to family planning services or lack information on how to use the CCM that are distributed. Even in those cases where the reason for those women willing to conclude their reproductive phase (or postpone pregnancy) not to use CCMs is due to fear of secondary effects, that which is failing is access to the information on CCMs and their alternative options.

*Preventive Care in Reproductive Health*

Women tend to leave six to eight years longer than men; however, this difference is not indicative of their health needs being effectively covered. The World Health Organization states that inequality between sexes in terms of their exposure to risks and their vulnerability before them is a limiting factor for their access to health care and information, which in turn negatively impacts the health of women (OMS, 2009).

Likewise, when it comes to the coverage of health services, this international organization recognizes that certain health services are more likely to be available, such as pregnancy care, than others, such as the treatment for cervical cancer. This specific type of cancer is the most frequent one after breast cancer in women from

developing regions, and particularly in Argentina. There, the mortality rate from cervical cancer reaches 8.3 out of 100,000 women, which equals to 1,800 deaths annually, whereas breast cancer is the cause of death for 5,600 women annually at the national level (International Agency for Research on Cancer, 2012).

Cervical cancer reflects the severe social inequality that still prevails in the field of women's health, as it is a disease that is almost entirely preventable in the light of current knowledge and technologies. The Nation’s Ministry of Health has acknowledged that this disease affects primarily low-income women who, due to various social barriers, cannot access screening services (Zamberlin, Thouvaret, & Arrossi, 2011). In view of this, screening tests are essential to detect precancerous or cancerous tissue, thus decreasing the mortality rate of this disease. Conventional mammography and cytology (Papanicolau, commonly referred as PAP) are tests that are commonly used to detect breast and cervical cancer, respectively.

The question arises: to what extent do bordering migrants of reproductive age attend gynecology service centers? The specialized literature available on the matter shows that the attendance to health centers in general, and particularly those of SRH, is closely related to the number of years migrant women been living in the destination country (Chen et al., 2001; Carballo, 2006); that is to say, the likelihood of them visiting health service centers increases as the number of years living in the destination increases. Taking this into account, Table 4 shows the percentage of migrants from neighboring countries who have had at least one gynecology consultation in Argentina, in relation to the number of years they have been living in the country. The results show that more than three-quarters of these women attended the gynecologist at least once (86%), thus reinforcing the idea that there is a relationship between the number of years after migrating and the attendance to this type of health service. Among migrant women living in Argentina for more than 10 years, only a small fraction did never visit a gynecologist (6%), whereas, among those women living there for less than three years, this percentage is as high as 46%. Contrastingly, the results do not vary to any relevant extent when analyzed in terms of their country of origin.

Table 4. Migrant Women from Peru and Neighboring Countries (18-49 Years) Living in the CABA who Visited a Gynecologist in Argentina, per Years of Living in the Country (%)

| Years living in Argentina | Visited a gynecologist in Argentina (%) | | | *N* |
|---|---|---|---|---|
| | Yes | No | Total | |
| Less than 3 years | 54 | 46 | 100 | 50 |
| 3 to 5 years | 81 | 19 | 100 | 104 |
| 6 to 10 years | 90 | 10 | 100 | 100 |

| | | | | |
|---|---|---|---|---|
| More than 10 years | 94 | 6 | 100 | 196 |
| *Total* | 86 | 14 | 100 | 450 |

Source: 2011 Migration, Fertility, and Family Survey (Dirección Nacional de Población, 2011).

Table 5 shows the percentage of neighboring countries and Peruvian migrants between and 49 years who have ever had a mammography performed in Argentina and a PAP in the last years, arranged by years of migration. The data do not allow to point out the time of the last breast care screening, and so it only includes the carrying out of the examination at least once in their time living in Argentina, as a measuring of the attendance to SRH preventive care by migrant women.

The results that the percentage of surveyed women who ever had a mammography in Argentina increases with their years of residence. An exception to this trend can be seen in the most recent migration group. Apart from this variation, it is quite noticeable that an average of more than half of the migrant women has never had this test carried out on them during their stay in Argentina, despite the medical recommendations established for women in this age group. Conversely, the relative frequency of the PAP during the last year is significantly greater when compared to the previous indicator. An average of 68% of migrant women between the ages of 30 and 49 underwent a PAP test in the year before this survey. Likewise, the results show that this percentage does not increase with the years after migration, as it does happen in the previous case.

Table 5. Migrant Women from Peru and Neighboring Countries (18-49 Years) Living in the CABA who had a Mammography in Argentina and a PAP in the Last Year, per Years of Living in the Country (%)

| Years living in Argentina | Mammography in Argentina (%) | | | | PAP in the last year (%) | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Total | *N* | Yes | No | Total | *N* |
| Less than 3 year | 40 | 60 | 100 | 15 | 67 | 33 | 100 | 15 |
| 3 to 5 years | 35 | 65 | 100 | 29 | 72 | 28 | 100 | 29 |
| 6 to 10 years | 38 | 62 | 100 | 48 | 67 | 33 | 100 | 48 |
| More than 10 years | 47 | 53 | 100 | 151 | 67 | 33 | 100 | 151 |
| *Total* | 43 | 57 | 100 | 243 | 68 | 32 | 100 | 243 |

Source: 2011 Migration, Fertility and Family Survey (Dirección Nacional de Población, 2011).

Another finding that reflects the results obtained, in consonance with the bibliographic background on the matter, relates to the low percentage of Bolivian migrants who have had the recommended tests carried out on them to prevent breast and cervical cancer, compared to the women of the Paraguayan and Peruvian collective. The EMFF data pertaining migrant women ages 30 to 49 years living in the CABA shows that 53% of the Paraguayan (90

women) and 41% of the Peruvian (59 women) migrant women underwent a mammography in Argentina at least once, yet among Bolivian women, this figure reaches only to 35% (94 women). Similarly, yet not so markedly so, the percentage of migrant women born in Bolivia who had a PAP test done in the last year reaches 63%, compared to 74% and 66% of those born in Paraguay and Peru, respectively.

The results showed so far force us to think of migration as an intersectional phenomenon, according to which the very definition of bordering migration would be too limited to explain the different access to SRH services and preventive care. According to this, both the years of residence after migration and the country of origin of the migrant women would represent factors impacting access. Considering that preventive tests and screening are necessary for the SRH of all women and the fact that they are priority points for the effective implementation of the PNSSyPR, it could be said that the groups with the characteristics mentioned previously are more exposed to vulnerabilities in this area of their health.

*Characteristics of the Sexual and Reproductive Health Care of Migrants from Peru and Neighboring Countries, Emphasizing Childbirth Care*

Given that there is consensus on the fact that the migrant population represents a group of particular interest in SRH matters, the questions should be asked: How does the biomedical system work in taking care of the health of migrant women in terms of identifying the bordering migrant collective as a social group and the practices implemented for such identification? (Aizenberg & Maure, 2017) How is the current policy in terms of SRR thought of and implemented? What are the main obstacles and enablers impacting the effective compliance of these rights?

One of the first questions arising within the frame of the SRR of migrant women points back at the feasibility and how an intercultural approach to the SRH system can be incorporated, particularly when it comes to childbirth care. From this starting point, we ask ourselves, what is it that we mean by *cultural integration* to the SRH sector, and what culture are we referring to? Two main lines can be identified regarding this (Comelles, 2004): one that aims at comprehending culture as an ethnic taxonomy, and the other approaching it as meaning, that is, as a wider subjective dimension that, in the case of SRH, is associated to being a woman, to working, to being indigenous (or not), to speaking a certain language, etcetera, and from that basis being acknowledged as a holder of rights. In its part, *culture*, as understood from ethnicity, tends to go hand in hand with the exoticization of the foreigner, which implies the risk of falling into stereotypical categorizations of what it means to communicate with and addressing the needs of the *other*.

> Peculiar as it is, those who are more sensitive toward migration matters find it harder to notice violence against women. That is in part sometimes due to cultural relativism, that culturalist vision of respecting both the culture of the

> other and being unable to notice this that, according to some, cultural relativism ends when human rights are violated [...], they say "I don't want to impose my ideas, because I'm white." [...] For example, a professional who without prejudice tells a woman, "well, you can plan your pregnancies," and maybe that woman has 12 brothers and only had one child, and that change took place from one generation to the next. I think we know very little about that [...] Subjectively, what happened to that woman? (Laura, Health and Migration Group of the Ministry of Health of the CABA; personal communication, December 28, 2015).

When health professionals and administrators focus on "what is traditional" or "what is indigenous" and put aside complementary aspects that make up the subjectivity of the individual making use of health services, difficulties may arise in this care service. They range from suppressing information that affects the optimization of the SRH services (for example, not knowing what is the target population on which to emphasize the family planning methods) to even impacting rights and human dignity, for example, by rendering invisible situations of violence.

On the opposite side, when culture is understood as a constitutive part of subjectivity (as an episteme), the necessary conditions for an equal exchange among the different cultural sensitivities arise (Fernández Juárez, 2011). This view, characteristic of the intercultural approach, demands the deconstruction of monolithic thinking and essentialization, of the retreat into oneself and of the disregard for "the other" (ibid.), all of these being characteristics of the hegemonic biomedical system. This view is intended to incorporate the Respected Delivery equipment of a CABA Public Hospital through the implementation of a delivery care model that echoes the law No. 25.929:

> We use straps, balls, we have this stool, the salt lamp, essential oils. They [the ones giving birth] decide, and we also assess that they can stand it. They deliver with a bath, in showers in they want, with the person they want. Sometimes the people with them take turns because they are tired or because it takes many hours. And then they can deliver there on the dilator, or if they prefer, they can be taken to a gurney so they can push more easily or whatever they need along the way. What is more important, I believe, is that they can choose and have someone with them. [...] We also try to provide as much comfort as possible for a public place. The main thing is to always treat them well, the smile, the eye-to-eye look [...] Look for what your body is asking you for (Adriana, obstetrics practitioner of a Public Hospital of the CABA, personal communication, January 6, 2016).

Upon implementing this initiative, the cultural dimension is reflected in the possibility of choosing, that is, by understanding that not all women can or wish to go through delivery and childbirth in the same way; moreover, it is about choosing among different options that were thought of from the experience of taking care of different bodies.

From this perspective, being a migrant is not ignored, but rather it is pointed to an articulation of the different aspects that constitute women, migrant women, workers, and indigenous; all of these fields on which the transgression of rights also operates.

This intersectional approach is particularly useful when analyzing the phenomenon of obstetrics violence in the context of the SRR of women. Among other aspects, this type of violence implies physical or verbal abuse, the lack of care or consideration towards women, unjustified medical interventions, and not asking for informed consent. Even if all women who go through a process of labor, delivery, and postpartum in health institutions find themselves exposed it, being a migrant implies an additional axis of vulnerability that tends to reinforce unequal interactions in this field:

> As a migrant, you are facing something entirely unknown. You will experience a truly asymmetrical relationship in most instances, and you come from a different country on top of that. And if the color of your skin and your features stand out... Right there and then, you are more disadvantaged than someone born there (Marina, Obstetric Violence Observatory, personal communication, December 14, 2015).

In this way, gender would not be the only dimension involved in determining the effective exercise of SRRs, as such is also conditioned by the other categories also involved, such as migration, race, sexual orientation, among others. Wherefrom should we approach this “additional vulnerability”? Does it imply segmenting the demands of SRR compliance? Given that this a transversal phenomenon, the answers to these questions given by our informants point at upholding the construction of guarantee practices not only from *being a migrant* but also from being a *woman*, acknowledging from this global frame that exclusion, discrimination, and oppression situations mainly affect women under additional axes of subordination.

When it comes to the main characteristics of the migrants’ SRH care, it can be noted that although the informants are aware of the hegemonic model of biomedical care, they also notice gaps and obstacles that upon manifesting make health professionals a highly heterogeneous group. That is why it would not be precise to talk of a single collective of health professionals.

> Some have a special sensitivity for this matter, people who have been working with migrants for several years and who are crafty about interculturality; that is, in the lack of policies, they are crafty finding out, learning, and incorporating words in their language, they translate, they make signs [...]. It is up to each one, of the standing of that health center, of that service, on its administration (Laura, Health and Migration Group of the Ministry of Health of the CABA; personal communication, December 28, 2015).

Two important questions arise from this. First, while State policies with an intercultural focus aim at expanding and improving SRH care, these often tend to be insufficient and only cover a small fraction of care services. Secondly, and as a result, many of the strategies

alternative to the traditional biomedical model implemented from the health system depend on the willpower of those able to apply them. As a matter of fact, and in terms of the latter, a practitioner member of the Respected Delivery team of a Public Hospital of the CABA explains:

> We buy everything ourselves. The ball, the straps, the net where we put the tennis ball and the big one, where we hang the straps. ADOM, which is the Association of Municipal Obstetrics Clinics, donated the stool. They designed this stool and donated it to hospitals that work as we do (Adriana, obstetrics practitioner of a Public Hospital of the CABA; personal communication, January 6, 2016).

One of the main obstacles when trying to widen the coverage of the strategies aimed at incorporating *cultural* concerns into health practice, or at making more flexible the standardized care model, is the fact that they depend to a large extent on the willpower of health professionals and administrators. That is why this type of initiatives tend to be an exception and not the rule. At a macro level, we find the next reflection, complementary to the voluntarist character analyzed:

> Everything [the system] works as an emergency. Everything that has to do with thinking seriously on long term follow up involves a more interdisciplinary way of working, that can consider other aspects besides the merely biomedical ones oriented to solving emergencies (Laura, Health and Migration Group of the Ministry of Health of the CABA; personal communication, December 28, 2015).

When inquiring on the main obstacles emerging when trying to incorporate strategies that guarantee the rights of migrant women within the scope of SRH, and particularly in the field of delivery care, we noticed that the infrastructure arises as an "objective" argument to distancing from the commitment of ensuring those rights:

> Before adapting the dilator for this type of deliveries [respected deliveries], our patients were always accompanied by someone. We cannot put it in the room as the room is a shared space and they could be with someone, but it had to be women, the husbands stayed outside [...] What does the law say? That the patient has to be accompanied by someone and all else, always that there is room for such, and we have the delivery rooms all completely apart from each other. There are hospitals where they are only divided by curtains. Then you have the father of one patient caressing her head, and right in front you, have another one, right there (Adriana, obstetrics practitioner of a Public Hospital of the CABA; personal communication, January 6, 2016).

From this description, we may ask to which extent is it possible to address the argument pertaining to material conditions when that which is at stake is guaranteeing the rights protecting the users of the SRH system; where is the limit that determines the point at which

said conditions prevent complying with a basic right such as having someone with you during delivery and childbirth? On that matter, one of the interviewed informants ponders:

> There are places where they tell you […] that respected delivery cannot be implemented because the facilities would not allow for it. They say, "well, first we would have to modify the facilities, change places, because there are many women in one single room, there is no intimacy, the delivery cannot take place as such." You hear that a lot. It is as if any innovation in terms of user rights are resisted with different arguments […] So, how motivated can the health teams be to modify the practices in terms of the rights of users? How right are they? (Laura, Health and Migration Group of the Ministry of Health of the CABA; personal communication, December 28, 2015).

Yet another obstacle that arises in the process of intercultural communication relates to linguistic and idiomatic differences. This is particularly true when it comes to naming parts of the body and describing its physiological processes, aspects that are profoundly immersed in the culture. In this sense, one of our key informants warns of the differences arising in the field of the SRH of migrants from neighboring countries:

> Sometimes there were ways to name parts of the body or diseases that they would have a hard time understanding because they called them differently in their home countries. For example, for the campaign, we talked about sexually transmitted diseases, and the health teams went mad at us. If I talk about sexually transmitted diseases, this lady will not understand a thing. If I put up the sexually transmitted diseases spot, then she will understand. There we have a misunderstanding. There are constant misunderstandings in the dialog. What we have to do is making that dialog possible from different positions (María, CAREF; personal communication, January 14, 2016).

Finally, from the interviews, we come to understand that one of the main challenges in matters of intercultural health is overcoming the idea that health is an individual task instead of recognizing it as a collective participation system. This is particularly relevant when it comes to SRH, wherein the focus of responsibility tends to be upon the user:

> Something that happens a lot is that the users are blamed for their illnesses, because they came here late, because they came here too early […] Not reading about inequalities and taking health as a matter of individual responsibility […] Professionals will tell you "this is not a matter of being a migrant or not, it is a matter of mothers caring for the health of their children or not." That moralizing way of talking that blames and personally makes the migrant woman responsible for not coming here at 5 in the morning to take a turn for her child, just to end up having to come the day after […] impacts on that person coming back again or not (Laura, Health

> and Migration Group of the Ministry of Health of the CABA; personal communication, December 28, 2015).

Pertaining to the perceptions of the interviewed migrant women coming from neighboring countries and Peru, the question arises: to which extent do these women have actual access to SRH services, and what is the quality of the care they receive from local health centers, according to their own experiences? A common characteristic is the positive assessment of access and quality of services in Argentina, particularly at CABA. The interviewees highlighted as positive the cost-free nature of the care they receive and how diverse is the scope of preventive care, especially in terms of pregnancy, delivery, and care for the newborn. Contrastingly, the SRH services in the countries of origin are perceived as precarious, hard to access, and not sufficient in satisfactorily addressing their demands. Likewise, they notice how in their contexts of origin the matters involving female sexuality are taboo territory. The latter is related to the fact that for the greater part of their lives in their original societies these women had limited and informal access to methods to prevent pregnancy, care to avoid sexually transmitted diseases, or the need to carry out periodic preventive checks.

> Regarding sexuality, I found that the government here gives out condoms, contraceptives, besides health being free. If you have doubts about some sexually transmitted disease, you can get checked directly. There are no taboos here […], and that's not the case in Paraguay; they don't have that (Elsa, Paraguay, 24 years old; personal communication, December 12, 2015).

Along the same line, Antonia (Bolivia, 43 years old) stated:

> Over there in Bolivia, I wouldn't stay in a hospital, at least not in the border where I am from [Villazón], because there are doctors but not very professional. I'm sure there are in the city, but not in small towns, no (personal communication, January 14, 2016).

One additional aspect coming from the discourse of our interviewees is the apparent relationship there is between living in Argentina and their access level to the SRH services, and the extent to which they can demand the SRR that correspond to them. Maria, born in Paraguay (35 years old), who was pregnant at the time of her migration, narrates this:

> When I just arrived, everything was new. As I didn't have the precariousness paper [a document crediting proving one's temporary residence in Argentina] I didn't have any pregnancy checks [for her third child]. Only by the end of my pregnancy as I was in so much pain. […] They treated me well and didn't ask me for the paper. […] Now [pregnant with a fourth child] I began to get checks since I found out about it (personal communication, January 6, 2016).

In general, the interviewees did not find in the pregnancy and delivery process between their country of origin and the place that received them, except that the service is not entirely free in their original country as it is in Argentina.

> It's the same thing, they demand checks from you but because of the risks, in case the baby comes horizontally, in case they have to perform a c-section. In Paraguay, it is quite normal [to give birth] at home. Now less so. Now there are small clinics and from there they take you to larger hospitals (Inés, 28 years old, Paraguay; personal communication, January 6, 2016).

> The midwife, your mom, or your husband, there are differences. Not so in the hospital, no; you go to nurses or obstetrics practitioners. […] Over there, if a doctor treats you, that same doctor will take care of the delivery. He will lead you through the process (Fernanda, 42 years old, Peru; personal communication, January 6, 2016).

Access to clear, complete, and factual information by the comprehensive health team is one of the fundamental principles of National Law No. 26.529 of Patient Rights and the National Law 25.929 for Respected Delivery. Among the guarantees set forth in the last legislation are the right of all women to be informed on the different medical interventions that might take place during delivery and postpartum, as well as to actively participate in the decision making on the different intervention alternatives. Among the different delivery experiences narrated by the interviewed migrants, the transgression against their right to information is a constant:

> Interviewer: Did you have an episiotomy?

> Paula: Yes. I was anesthetized but I did notice when they cut me open […] it didn't hurt. I asked the obstetrics practitioner how large the cut was, how many stitches, and she told me, "we don't release that information here" (Paula, 30 years old, Paraguay; personal communication, December 3, 2015).

Summarizing, and under the light of the goals set by the PNSSyPR, the interviews carried out allow us to state that migrants perceive their demands in this field as properly covered, particularly when it comes to care during pregnancy and delivery. It is overall agreed that the health system in Argentina, and specifically in the CABA, can provide an effective response to the needs that arise in the field of SRH. However, when asking about the elements that make up this perception, the answer is not so encouraging, that perception mainly comes from comparing own experiences with SRH services in Argentina with those in their country of origin.

## CONCLUSIONS

SRR represents a wide range of guarantees directly linked to the dignity, equality, and autonomy of people. Implementing the measures required to ensure their full exercise for the entire population is a task involving a deeper understanding and a reinforcement of human rights. The present analysis pertaining to the reproductive and non-reproductive dimensions of SRR is an effort towards this direction, aiming at making visible aspects that

either have received very little attention in academic and public policy circles (as in the case of teenage fertility among migrants) or that tend to be analyzed from a position on rights dissociated from multicultural perspectives. The following points summarize the main findings and conclusions derived from this work:

- In matters of teenage fertility, the analyzed migrant collectives show alarming results that require timely action by State agencies, specifically in the areas of health and child protection. Future research should analyze the representation of teenage migrants in terms of their reproductive aspirations, and on the other hand, assess if the high percentages of teen maternity among immigrant collectives are due to situations of sexual abuse. Justifying these results with the argument that migrant women "come with" a particular reproductive level and calendar from their country of origin is nothing but exoticizing immigration and not knowing that abusing adults are hiding behind girls and mothers.
- Rather than the country of origin of migrants, the time after migration appears to be a factor that conditions access to SRH services, including the access to preventive care tests. Although the gaps existing in the percentages of care between recent and former migrant women are not huge (they are encouraging), attention should be paid to the first group to generate strategies that contribute to decreasing said gaps.
- In the CABA, there is no small number of migrants living in couples and not making use CCMs, despite having already fulfilled their reproductive aspirations. This might suggest that there is still work to be done in terms of preventing unwanted pregnancies. It should be noted that family planning campaigns tend to put on women the responsibility of preventing pregnancies. At the social level, both the pill and the intrauterine device are valued over other CCMs. In this sense, the campaigns in this field should emphasize vasectomy and the use of male condoms as alternate family planning methods.
- When it comes to incorporating the intercultural dimension in the field of SRH, it can be noticed that "crafty strategies in interculturality" have been implemented in the wide array of professionals and administrators making up the health system; these strategies allow to reinforce the promotion and protection of certain SRR of migrant women and the general population. Although the current regulations do incorporate and tend to reinforce this guideline, as they are crafty strategies, it is concluded that a gap persists between the existing laws and their implementation in the health system. Likewise, obstacles and setbacks of old remain, limiting the understanding

of culture as a constitutive aspect of the migrant individual. The question about what actual opportunity health professionals and administrators have to thinking of culture as a wide subjective dimension, and about what other alternatives exist to bring this about, besides the on-field craftiness already mentioned, remains to be revolved.

- The analysis presented here on the state of the SRR of migrant women from neighboring countries living in the CABA should be considered as an exploratory and brief approach to the subject matter. Some further research alternatives that may contribute to examine this field to greater depth are the applicability of law No. 25.929 on Humane Delivery and Childbirth from the view of migrant women themselves, the phenomenon of induced abortion in migrant collectives, the update of data on the trafficking of migrants for sexual exploitation, the state of things on the SRR of the LGBTI population, among others.

Translation: Fernando Llanas

REFERENCES

Agu, J., Lobo, R., Crawford, G., & Chigwada, B. (2016). Migrant Sexual Health Help-Seeking and Experiences of Stigmatization and Discrimination in Perth, Western Australia: Exploring Barriers and Enablers. *International Journal of Environmental Research and Public Health*, *13*(5), 1-22. https://www.mdpi.com/1660-4601/13/5/485/htm; https://doi.org/10.3390/ijerph13050485

Aizenberg, L., & Maure, G. (2017). Migración, salud y género: abordajes de proveedores de salud en la atención de mujeres migrantes bolivianas en la provincia de Mendoza, Argentina, *REMHU: Revista Interdisciplinar da Mobilidade Humana*, *25*(51), 149-164.

Carballo, M. (2006). Female Migrants, Reproductive Health, HIV/AIDS and the Rights of Women, UNFPA-IOM. Retrieved from http://legeforeningen.no/Fagmed/Norsk-gynekologisk-forening/Nyheter/20061/female-migrants-reproductive-health-hivaids-the-rights-of-women/

Cerrutti, M. (2009). *Diagnóstico de las poblaciones de inmigrantes en la Argentina*, Serie de Documentos de la Dirección Nacional de Población, 2. Buenos Aires: Dirección Nacional de Población.

Cerrutti, M. (2010). *Salud y migración internacional: mujeres bolivianas en la Argentina*. Buenos Aires: Fondo de Población de las Naciones Unidas/ Centro de Estudios de Población.

Chen, M., Rosero, L., Brenes, G., León, M., González, M. I., & Vanegas, J. C. (2001). *Salud reproductiva y migración nicaragüense en Costa Rica 1999-2000: Resultados de una Encuesta Nacional de Salud Reproductiva*. San José, Costa Rica: Universidad de Costa Rica.

Chiavarini, M., Lanari, D., Minelli, L., Pieroni, L., & Salmasi, L. (2016). Immigrant mothers and access to prenatal care: evidence from a regional population study in Italy. *British Medical Journal Open*, *6*(2), 1-9.

Comelles, J. (2004). El regreso de las culturas. Diversidad y práctica médica en el S. XXI. In G. Fernández Juárez (Coord.), *Salud e interculturalidad en América Latina. Perspectivas antropológicas* (pp. 6-21). Quito: Abya Yala.

Dirección Nacional de Población. (2011). Encuesta sobre Migración, Fecundidad y Familia 2011. Retrieved from https://argentina.unfpa.org/es/publicaciones/encuesta-migraci%C3%B3n-familia-y-fecundidad-emff

Fernández Juárez, G. (2011). Claroscuros de la salud intercultural en América Latina. *Nuevo Mundo Mundos Nuevos*. Débats, (s/n). Retrieved from http://journals.openedition.org/nuevomundo/61188; doi.org/10.4000/nuevomundo.61188

Haour-Knipe, M., & Grondin, D. (2003). Sexual health of mobile and migrant populations. *Sexual Health Exchanges*, 2, 1-3.

Heaman, M., Bayrampour, H., Kingston, D., Blondel, B., Gissler, M., Roth, C., […] Gagnon, A. (2013). Migrant women's utilization of prenatal care: a systematic review. *Maternal and child health journal*, *17*(5), 816-836.

Infante, C., Silván, R., Caballero, M., & Campero, L. (2013). Sexualidad del migrante: experiencias y derechos sexuales de centroamericanos en tránsito a los Estados Unidos. *Salud pública Méx*, *55*(1), 58-64.

International Agency for Research on Cancer (IARC). (2012). Base de datos IARC53. Retrieved from http://p53.iarc.fr/TP53GeneVariations.aspx

Instituto Nacional de Estadística y Censos (INDEC). (2015). Censo Nacional de Población, Hogares y Viviendas 2010. Retrieved from https://redatam.indec.gob.ar/argbin/RpWebEngine.exe/PortalAction?&MODE=MAIN&BASE=CPV2010A&MAIN=WebServerMain.inl

Jelin, E., Grimson, A., & Zamberlin, N. (2006). Los pacientes extranjeros en la mira. In E. Jelin (Ed.), *Salud y migración regional. Ciudadanía, discriminación y comunicación intercultural* (pp. 47-56). Buenos Aires: Instituto de Desarrollo Económico y Social.

Magliano, M. J. (2015). Interseccionalidad y migraciones: potencialidades y desafíos. *Revista Estudos Feministas*, *23*(3), 691-712.

Monte, M. E., & Gavernet, L. (2012). La incorporación de los derechos sexuales y reproductivos en las constituciones de Argentina, Venezuela, Ecuador y Bolivia. In J. M. Morán Faúndes, M. C. Sgró Ruatay, & J. M. Vaggione (Eds.), *Sexualidades, desigualdades y derechos. Reflexiones en torno a los derechos sexuales y reproductivos* (pp. 157-189). Córdoba, Argentina: Ciencia, Derecho y Sociedad.

Organización de las Naciones Unidas. (2016). *Situación de los migrantes en tránsito. Informe de la Oficina del Alto Comisionado de las Naciones Unidas para los Derechos Humanos*, Annual report of the United Nations High Commissioner for Human Right, 31st sesssion. Retrieved from https://www.acnur.org/fileadmin/Documentos/BDL/2016/10356.pdf

Organización de las Naciones Unidas. (1995). *Informe de la Conferencia Internacional sobre la Población y el Desarrollo*, El Cairo, 5-13 September, 1994. Retrieved from https://www.unfpa.org/sites/default/files/pub-pdf/icpd_spa.pdf

Programa Conjunto de las Naciones Unidas sobre el VIH/Sida (ONUSIDA). (2013). *Global report: UNAIDS report on the global AIDS epidemic 2013*. Retrieved from https://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf

Organización Mundial de la Salud (OMS). (2009). *Women and health: today's evidence tomorrow's agenda*. Geneva: Organización Mundial de la Salud.

Programa de las Naciones Unidas para el Desarrolla (PNUD). (2008). *HIV vulnerabilities faced by women migrants: from Asia to the Arab States*. Colombo: Programa de las Naciones Unidas para el Desarrollo.

Sedgh, G., Bearak, J., Singh, S., Bankole, A., Popinchalk, A., Ganatra, B., […] Alkema, L. (2016). Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *The Lancet*, *388*(10041), 258-267.

Smith, A., & LeVoy, M. (2016). *Los derechos sexuales y reproductivos de los migrantes en situación administrativa irregular cerrando la brecha entre sus derechos y la realidad en la Unión Europea.* Retrieved from http://picum.org/wp-content/uploads/2017/11/Sexual-and-Reproductive-Health-Rights_ES.pdf

Wang, L. (2010). Ideas y prácticas en torno a la Salud Sexual y Reproductiva en jóvenes migrantes paraguayas que se trasladan a la Argentina. *Eä Revista de Humanidades Médicas & Estudios Sociales de la Ciencia y la Tecnología*, *2*(2), 65-94.

Zamberlin, N., Thouyaret, L., & Arrossi, S. (2011). *Lo que piensan las mujeres: conocimientos y percepciones sobre cáncer de cuello de útero y realización de PAP*. Buenos Aires: Ministerio de Salud de la Nación/UNICEF/Organización Panamericana de la Salud.