Chapter X

Reproductive Health of Migrant Women in Chile: Barriers to Healthcare and Contraception

10.1 Introduction

Contraception is a critical issue for migrant women. Often, in host societies, migrant women face various limitations in accessing effective and culturally sensitive family planning services. These limitations contribute to reproductive health risks. Furthermore, in the absence of a suitable social or institutional support network for child caring, pregnancy most often compromises women’s involvement in the labour market, bringing an additional burden to their already difficult economic subsistence. In addition, migrant women are not entirely autonomous in their reproductive decisions. Family members influence most often women’s decision-making. Their position within their (transnational) families subjects them to a double set of power relations, both in their country of origin, as well as in the host country. In view of its importance in migrant women’s lives and reproductive rights, the issue of contraception is examined here in its various dimensions.

Overall, this chapter discusses existent barriers that especially women migrants must deal with in order to access reproductive healthcare in Chile. Specifically, it looks at the economic, practical, and cultural barriers which either prevent women from using family planning services or discourage them from using the contraceptive methods offered by the Chilean healthcare system.

The first section provides an overview of women’s actual use of contraceptives in Chile, by looking at use, preferences and knowledge of the contraceptive used as well as their attendance to medical check ups.

The second section examines the barriers of access to healthcare. Some of the existent barriers to healthcare access relate to situations of exclusion and discrimination generally affecting all migrants but most often, apply to women in particular.

The third section delves into cultural dimensions which have an influence in women’s use of contraceptives and more generally influence women’s decision-making in the reproductive sphere. The analysis pays special attention to women’s embodied cognitions and practices regarding their own sexuality and reproduction and explores the extent to which these dimensions interfere with their use of these contraceptive methods. Secondly it discusses prevalent gender and power relations involving the control over women’s own sexuality and reproduction relevant to understanding women’s reproductive decisions and use of contraceptives while living as migrants in Chile.
Lastly, this chapter presents the strategies women use to avoid pregnancy in the context of the existent barriers of access to healthcare and to modern contraceptive methods.

10.2 Gender, migration and reproductive health

The study of the reproductive health of migrant women must depart from taking into account women anchoring in two spheres of activities, the productive and reproductive sphere. Within this double focus, it is crucial to attend to the patriarchal system which determines and defines migrant women’s lives and their reproductive sphere in their society of origin. In addition, in the context of transnational migration, a double set of power relationships may be at play. These are the power relations women maintain with their families of origin as well as relations which are set up or reassembled in the receiving society. Power relations framed in the patriarchal order acting upon migrant women’s reproduction and sexuality should therefore be especially noted.

The spaces that open up to migrant women in the receiving society must also be critically examined. While often the new society broadens women’s spaces, providing them with greater autonomy, the contrary may also happen. Indeed, new life circumstances in the receiving country may place women in a more vulnerable position and without social support. The complexities of women’s reproductive lives, at the crossroad of their double anchoring, will be explored further in this chapter.

In light of what has just been stated, providing some additional contextual information around the circumstances associated with an unwanted pregnancy, a common development among Peruvian migrant women will help to understand the series of conflicts and tensions women face in such situations.

Pregnancy in all cases compromises migrant women’s involvement in the labour market. As such, it jeopardises their own – as well as their dependents – means of survival. In that sense, pregnancy goes against the main purpose of the migration endeavour. In spite of this, when confronted with an unwanted pregnancy, as Catholic women, they would not consider termination. In almost all cases they would have their babies. This has been confirmed by healthcare providers in family planning services. In addition, abortion is not an option as in all circumstances it is illegal in Chile.

Once the child is born – and in the absence of a dependable social network to rely upon – the woman would have to completely assume the responsibility for child-caring. It is a given that a Peruvian woman would typically not trust her child to a Chilean child-care institution. This is a valid sign of their general mistrust of Chilean society.

Quitting their jobs and staying on in Chile may be one viable alternative when women have a supportive partner. Without such a support system, women are forced to return to Peru with the newborn baby. Moreover, pregnancy may cause serious conflict with the women’s families in Peru. This is particularly true in circumstances where a baby has been conceived in a non-socially legitimate relationship, such as the cases of single women or married women who already have other children and a partner living in Peru.
The information presented in this chapter aims at shedding light on the factors that can lead women into an unwanted pregnancy, and particularly on those related to the condition of being migrants. The next section provides an overview of women’s actual use of contraceptives in Chile. It identifies existent barriers to contraception as well as more generally, barriers to reproductive healthcare. While these barriers may be similar to what women experience in Peru, additional factors which respond to the condition of being migrants are specifically addressed here.

### 10.3 Use of contraceptive methods among migrant women

This section discusses the use of contraceptives among Peruvian migrant women in Chile. It also discusses their attitudes towards modern contraceptive methods and assesses the extent to which they correctly use the various methods. In addition, it inquires into women’s attendance to medical checks-ups in Chile.

The information presented here is based on a survey that concentrated on the use of contraceptive methods conducted among migrant women in their community. The goals of the survey were to gather the biological and social profile of a group of Peruvian migrants in their fertile age and to determine their mode of use of contraceptive methods. This information offers an initial picture of the factors which may lead to an unwanted pregnancy among migrant women, including the nature of the barriers affecting efficient contraceptive use.

#### 10.3.1 Demographic profile of respondents

The sample in this survey was composed of 64 women in their reproductive age (15-45 years old); who were sexually active and users of contraceptive methods. The average age of these women is 31 years; 95% of them have partners and an active sexual life. On average, migrant women have 1.52 children, which is actually lower than the average of children per woman in Peru. This confirms that migration reduces the possibility of larger families.

The majority of these women have a good educational level – primary and secondary education (73%) and tertiary education (27%). The majority have been living in Chile for 2 to 4 years. Nine out of ten women are economically active; a status which matches with them being of relatively young age. The majority of these women originally came from urbanised areas in Peru. Typically, they are from the city of Lima and the Northern Coast, which coincides with characteristics of the population of the first household survey conducted.133

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132 The survey was conducted by undergraduate students under the researcher’s supervision as part of their thesis to graduate as midwives from the Universidad de Santiago Daniela Guerrero and Andrea Torres.

133 The population selected for this second survey may overlap to some extent with the first survey population as the geographical residential area selected in both cases was the same. However, factors introducing variability of the samples’ composition were that people were randomly chosen. Also during the one-year time frame between both the surveys, migrants moved in and out of the area. The similar characteristics of the population’s places of origin can be explained by the networks through which migrants move. These networks originate in specific cities of Peru and are localised also in specific geographical areas of Santiago.
10.3.2 Contraceptive methods used

The contraceptive methods considered in the survey were natural methods, barrier methods, hormonal methods and intrauterine devices (IUD). These methods were grouped in traditional and modern methods according to the medical classification. Among the modern methods are oral contraceptives, injections and IUDs. Traditional methods were classified as the ‘calendar’ method, coitus interruptus, and the use of condoms.

Table X-2 Contraceptive methods used in Chile by Peruvian women

<table>
<thead>
<tr>
<th>Methods Used</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptives</td>
<td>33%</td>
</tr>
<tr>
<td>Calendar</td>
<td>20%</td>
</tr>
<tr>
<td>IUD</td>
<td>17%</td>
</tr>
<tr>
<td>Condom</td>
<td>14%</td>
</tr>
<tr>
<td>Injection</td>
<td>8%</td>
</tr>
<tr>
<td>Other (Coitus interruptus, Lactational amenorrhea method LAM)</td>
<td>8%</td>
</tr>
</tbody>
</table>

The most often used contraceptive methods among migrant women in Chile are the modern ones. Oral contraceptives occupy first place, followed by a traditional calendar method and in third place, the IUD. At least 24% of women use some kind of traditional contraceptive methods. Modern contraceptive methods are used by at least 72% of the women in the sample.

The figures presented above should be compared with corresponding statistics in Peru. The use of contraceptives among Peruvians is distributed in the following way:

Table X-3 Use of contraceptive methods in Peru in 2006

<table>
<thead>
<tr>
<th>Methods Used</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coitus interruptus</td>
<td>4,3%</td>
</tr>
<tr>
<td>Periodical abstinence or calendar</td>
<td>17,6%</td>
</tr>
<tr>
<td>Condom</td>
<td>8,7%</td>
</tr>
<tr>
<td>Injections</td>
<td>13%</td>
</tr>
<tr>
<td>Female sterilisation</td>
<td>10,6%</td>
</tr>
<tr>
<td>Male sterilisation</td>
<td>0,4%</td>
</tr>
<tr>
<td>IUD</td>
<td>6,1%</td>
</tr>
<tr>
<td>Pills</td>
<td>7,1%</td>
</tr>
<tr>
<td>Other</td>
<td>2,8%</td>
</tr>
</tbody>
</table>

Over and above all methods, modern or traditional, the calendar system continues to be most used in Peru. As for modern contraceptive methods, the most commonly used is the tri-monthly injection, followed by female sterilisation, the pill and the IUD.

As observed, if compared with Peru there is an increase in the use of modern contraceptives in Chile and among them, of oral contraceptives. This can be explained

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134 According to a latest survey conducted by Endes -continua 2006. The study sample was composed of urban and rural sexually active women between 15 and 49 years old. http://www.mesadeconcertacion.org.pe/documentos/documentos/doc_00529.pdf
as its use replaces the three months injection, not available in the country. However 8% of women in the migrant sample were users of the one-month injection available in pharmacies and some primary health clinics in Chile. Also, as described in interviews further on, some women had received the tri-monthly injection during a recent trip to Peru.

10.3.3 Preferred method

Consulted about what method is the most preferred, women stated their first choice was the oral contraceptive. In second place was the IUD, followed very closely by the Tri-monthly injection.

<table>
<thead>
<tr>
<th>Preferred method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC</td>
<td>30%</td>
</tr>
<tr>
<td>IUD</td>
<td>20%</td>
</tr>
<tr>
<td>Tri-monthly injection</td>
<td>19%</td>
</tr>
<tr>
<td>Calendar</td>
<td>11%</td>
</tr>
<tr>
<td>Others</td>
<td>11%</td>
</tr>
<tr>
<td>Unsure</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Comparing methods used and those preferred by women in the migrant community, we observe that a total of 38% of users of various methods are either dissatisfied with the method used – as they are not using the ones they prefer – or are unsure of the method preferred. Among contraceptive methods, the tri-monthly injection is the one with highest disparity between preference and its actual use. 11% of those women who would have liked to use this method were not using it. A second place, in the degree of disparity, is found among the users of the calendar method which has 9% more users than who would prefer it. This information leads to the question regarding the extent to which migrant women in Chile are using a contraceptive method contrary to their preferences. The manner, in which decisions around what contraceptive to choose are taken, is explored in the second part of this chapter as well as in more detail in the next chapter.

The question about why women still prefer traditional methods over modern ones needs to be addressed as they involve the cultural perceptions and notions which are ultimately guiding women’s behaviour and interfere with their acceptance of the

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In Chile, the tri-monthly injection was not available to the public within primary healthcare until recently. The reason for its non-availability in Chile was not clear. Even the healthcare providers interviewed had no definite answers. Some postulated that this method caused undesirable health side effects as it caused the suspension of periods in some users. As part of the new official Ministry of Health policy regulating reproductive healthcare in Chile and launched in 2007, there is now a larger availability of contraceptive methods in primary health clinics, including the 3-month injection (AMPD, Depoprodasone 15).
methods offered to them in Chile. These perceptions are often not addressed or considered by healthcare providers, during medical consultations. Female users of traditional methods (calendar, coitus interruptus, and condoms) in our survey choose not to use modern contraceptive methods for various reasons which include negative side effects on their health; a negative social connotation associated with the use of these methods and beliefs that these methods are not suitable for younger women. As can be asserted from the survey findings, these perceptions seem to be shared by migrant women independently of variables such as age, educational level and the length of time living in Chile. These factors showed to not have any influence on the kind of contraceptive method chosen (modern or traditional).

10.3.4 Actual use of contraceptive methods

Incorrect use of contraceptive methods was detected in the majority of migrant women. 61% of women used their contraceptive method wrongly.136 Women users of modern contraceptive methods use them more correctly than users of traditional methods. 88% of users of modern contraceptive methods use them correctly. Specifically, it was found that all users of the calendar method were using it incorrectly, whereas the contraceptive injection was used correctly for all its users. This indicates why the possibility of an unwanted pregnancy is very high among women following the calendar method. Furthermore, this actually challenges perceptions regarding migrant women who become pregnant voluntarily in order to gain optimal access to their visas in Chile.

While age has some influence on the manner of use of the method (indicators suggest older women use their contraceptive methods more incorrectly than younger women) level of education does not seem to have an influence in the mode of use of contraceptive methods.

Additionally, it is interesting to observe that the duration of residence in Chile does not seem to have an influence on the correct or incorrect mode of use of contraceptive methods. This finding suggests that information on the right use of contraceptives has either not been transferred at all or less effectively to these women by local healthcare providers.

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136 Correct use of contraceptive methods refers to those conditions which allow the adequate use of the method. The definition of correct use of a contraceptive varies according to each type a) Calendar or Knaus-Ogino Method: to find the estimated length of the pre-ovulatory infertile phase, nineteen (19) is subtracted from the length of the woman's shortest cycle. To find the estimated start of the post-ovulatory infertile phase, ten (10) is subtracted from the length of the woman's longest cycle. b) Lactational Amenorrhea Method or LAM: women who are exclusively or almost exclusively breastfeeding; have not had menses since giving birth and are less than six months postpartum c) Coitus-interruptus: the man must remove his penis from inside the vagina when ejaculation is imminent. Men must ejaculate away from the woman’s vagina. d) Condom: the condom must be worn as soon as the man’s penis is hard (erect) and before any sexual contact. Before putting it on, air must be squeezed out of the tip of the condom to leave room for the semen after ejaculation. Oils, creams or lubricants must not be used. e) Oral contraceptives: the pill must be taken everyday at the same time. When a pill is missed, it must be taken as soon as possible, and continue with the same scheme but with other additional methods or else maintain abstinence for seven days. f) Injected method: this method should be administered every 1, 2 or 3 months according to the type, always the same day via intramuscular. g) Intrauterine dispositive (IUD): women must observe the amount of blood expelled in their menstrual cycle. The IUD must be controlled periodically, once a year.
agents. This occurs regardless of the length of time these women have lived in Chile. As will be discussed in the next chapter, problems in the transference of information are issues at stake. Women complain that they often don’t understand the explanations given to them by the Chilean healthcare providers.

10.3.5 Attendance to medical check-ups

A large segment of migrant women do not attend medical check-ups or family planning programs. Only 38% of the women surveyed went regularly for medical check-ups while 63% did not. The most common reason for not seeking medical check-ups was lack of time (58%) and difficulties getting time off from their employers (23%) which points at the limitation posed by the working conditions of migrant women. However, many felt it was not necessary to regularly consult with a doctor.

The survey also determined that women obtained their contraceptives mostly from pharmacies (51%). They can also obtain them from healthcare institutions (49%). In most cases (56%), the person who recommended the contraceptive method was somebody who was not a healthcare professional. These findings render it possible to assert that the majority of migrant women are not resolving their contraceptive needs in the Chilean healthcare system. Unfortunately we don’t have comparable information of Peru, however this information poses questions regarding the nature of the barriers of access migrant women are facing in Chile. Indeed, a healthcare practitioner was involved in only 44% of cases in selecting the contraceptive method. Women’s reliance on people other than healthcare practitioners reveals the particular dynamic involved in their decision making process.

10.4 Discrimination, exclusion and barriers to access of medical care

The various barriers of access to healthcare affecting migrants are examined here. However, some of these barriers affect women in particular, for example the restricted workplace rights of women working as domestic workers. A barrier related to previous experiences of discrimination and the way in which this is affecting migrant’s health seeking behaviour is also discussed here.

The information presented is based on semi-structured interviews conducted among women who participated in the survey who, at the time of the interview, were not attending medical check ups. It also includes interviews and focus groups with migrant women consulting family planning programs and antenatal care conducted inside the healthcare system.

137 In Chile, as well as in Peru, it is possible to buy the pill over the counter without a medical prescription.
10.4.1 Economic and legal barriers

When holding a temporary residence permit, migrants in Chile are given an ID number. This allows them access to the national public health insurance system, FONASA, and with that, to the public healthcare system. Not having an ID excludes migrants from public healthcare, with the exception of pregnancy control and birth. Being illegal, unemployed or informally employed also excludes them from FONASA.

However, unemployed and uninsured legal migrants are entitled to receive free primary healthcare in any public clinic if they can demonstrate their state of indigence to the social worker. Typically, indigent cards are given to migrants for a one-month period, after which, they must apply for it again. Many times, this right to healthcare is denied to uninsured migrants even when they are in the country legally. Often, migrants’ lack of information about their rights leads them to not exert these rights when they are rejected at public healthcare institutions. Many migrants would merely accept such rejection and would not assert their rights.

This has been Irina’s experience. She had been informally employed as a domestic worker without contract and was thus uninsured. When she got pregnant, she had to stop working. Close to her seventh month of pregnancy on a Sunday, she was in pain and losing fluids, so decided to go to the emergency ward of the local Hospital. As she had no medical insurance, she was told that she had to go back to the primary clinic on the following Monday morning to request a referral. Only then would she be accepted as an emergency patient in the Hospital. Fortunately the delay in getting care did not have irreversible consequences for her baby. However, she is now uncertain about healthcare for her forthcoming birth. While healthcare for giving birth is free in situations in which pregnant women are indigent – as in Irina’s case – this information may not be clearly communicated by healthcare providers until the very last minute.

I: The social worker told me that it (her right to free healthcare as an indigent person) is only for one month, that it does not cover birth. You see? Even that is very expensive, so I was also considering going to Peru to have my baby. Because I asked in San Borja (local Hospital), as supposedly mine is a caesarean section birth and they told me that is more than 640.000 Chilean pesos (more than 1000 USD). So, for me, that is too expensive.

L: Did you discuss this with the social worker?
I: Yes I told her. And, she said “no, we will have to see you, after this month and that… (the social worker said) we would see, we would talk later about it,” because they had given me (right to free healthcare) only for pregnancy controls, not for the birth care.

Carmen Luz in turn, says she cannot afford to attend consultations at the clinic once a month as she had casual jobs and was very low paid. She did not have money to pay for transportation. In addition, she did not know how the system worked. Now she is pregnant and wonders whether she will be able to attend her check-ups. She looks after a baby and her employer ‘works’. She says she cannot quit her job, because if she did, nobody will want to hire her while she is pregnant.

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138 This involves an interview with a social worker, to fill in a socio-economic questionnaire, to accredit residence with the local police, and a visit by the social worker to the migrant home.
10.4.2 Fear and mistrust

When women are in the country illegally, they often experience fear of being asked for their papers or are reprimanded because they are pregnant.

Rosa Maria Castañeda did not attend any medical consultations for the four years she had been illegally living in Chile until she became pregnant. Only in her 4th month of pregnancy did she visit the doctor.

RM: I was afraid. I said maybe they will ask me for my papers, I did not know that they could give one care, just like that. (She becomes nervous, fearful.) …I don’t know, I thought for my papers… I said maybe they would reprimand me. They would ask me why did you get pregnant?

L: Have you heard of anyone who had been told that?
RM: Well, sometimes the girls would tell me uyyy no. Let's say the girls tell me. They would tell me that when they gave birth, they scream at them, and this and that. So that is why I was scared.

L: They scream at them? And what do they tell them?
RM: Yes, that is why they scream out! That you should not have your child. No, but I have never, never gone to a hospital, I have always been afraid of hospitals. I have always been scared. When I was about to go for a check-up, the nerves would attack me.

Erika had not had a medical check-up in four years. She only came in for her first medical check-up in her fifth month of pregnancy. During her interview, Erika initially attributed her lack of continuity to a variety of reasons. These included having moved to another neighbourhood and being careless with her own health. She finally expressed an additional – and likely most valid – reason for having suspended her medical check-ups for all these years.

E: Like now, I have come with fear. You can imagine, I am close to being in the 5th month (of pregnancy) and only now I have done the first (test).
L: Why didn’t you come earlier?
E: Ahh, it is because in the year 2000 that I came (to this same healthcare clinic). They treated me very bad here. So that is why I had fear.
L: Why did they treat you bad? What did they tell you?
E: Maybe it was because I am a foreigner. So I don’t know, it was not like now. Now they have treated me very good!
L: Tell me why did they treat you bad before?
E: I came here with signs of miscarriage … I did not know that I was pregnant either… And they started to tell me that if… That how I had left so much time pass by… at the third month I came (to the clinic)… They did not treat me as a patient should be treated. Well, not only did they not treat me kindly but all what it was, was screaming at me! … It was as if I was humiliating myself in front of the lady.
L: Did that make you delay coming in for a check up now?
E: Yes, what has happened to me, (is that) I have been scared.
L: How were you feeling when you came in today?
E: You will not believe me. That all night or all these days I have been. The only thing, I prayed to God that things would work out OK; that was all.
10.4.3 Practical barriers and the lack of workers’ rights

Provision of family planning care in public healthcare is based on the need to optimise use of professional resources. With that purpose, the regular procedure is that women with an appointment must be at the clinics as early as 7:00 or 8:00 in the morning to receive a “waiting list” number. On average, women can spend 4 hours, an entire morning, sitting in waiting rooms to be called upon. Furthermore, the provision of contraceptive pills is structured so that women have to be present at primary health clinics on a certain day every month, to collect their contraceptive supply for the coming month. For women who work, to have to go to consultation rooms on specific dates is not always feasible. To do so, means their employers would have to allow them half a working day each month so that they could collect their contraceptives.

As I tell you here, I would have the option to change to the pills, but like the (appointment) dates, sometimes one does not get permission. It is better to have a check-up for the T because there you have more of an ample space (to get some time off and attend the check ups). (Juanita Quevedo)

Attending healthcare is very time-consuming, making it difficult for working women to visit the clinics. Marcela who was unemployed at the time reflected on this. If I had been working, I would not be able to come (to the clinic) because, generally, there is a lot of delay in (providing) care. Like all the women using oral pills, she must visit the clinic every month on a fixed day to collect them. These appointments cannot be changed.

Interviews showed that the majority of the Peruvian women who have check ups in family planning and pregnancy controls are those who are not working; do not have a steady job or work only a few days a week. Often women lose their jobs when they get pregnant. This happens especially if they do not have a contract or they voluntarily resign, to look after their baby.

As seen in the interviews conducted among women in the community and at the primary health clinics, various barriers to accessing healthcare were detected. While some relate to migrants’ general situation of exclusion, others are linked to previous experiences of discrimination in the Chilean healthcare system. Such incidents had caused fear and mistrust towards healthcare providers. Healthcare providers act as gatekeepers, restricting migrants in their access to healthcare. This is done by not providing the necessary information to migrants to make use of their rights to

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139 The idea is that the earliest person to arrive at the clinic gets the first numbers and therefore, gets the earliest attention. However this system does not work in practice. This is because everyone goes to the clinic early to get early numbers and all numbers are distributed at the same time. A woman can end up with a very last number even though she arrived just as early as everyone else. Even so, midwives and doctors only begin to see their patients at around 9:00 in the morning.

140 The logic of this system is to closely monitor women’s use of contraceptives and prevent the misuse of resources. This may occur as women are given doses, perhaps for three months, which may not be used completely or at all.

141 Some of these barriers have also been found in a small scale study conducted by Instituto de la Mujer (2007) in Santiago where evidence was found that undocumented pregnant women did not attend to primary healthcare clinics for fear of being reported and deported or because they are unaware of the existing norm that states that care should be provided to them irrespective of their legal status. While the current amnesty erases –at least temporarily – illegality as a barrier for accessing healthcare, other barriers still remain.
healthcare. For migrant women especially, these various kinds of barriers mount up. Often while working as domestic workers, they are more limited and restricted in accessing health-care when compared to their male counterparts.

10.5 Cultural barriers to contraception

Women’s decision-making regarding their use of contraceptive methods is, to a large extent, influenced by their cultural perceptions. These perceptions inform their practices and guide their behaviour.

Two spheres in which cultural perceptions are influential on women’s behaviour are analysed here. The first sphere is existing gender notions and relations which legitimise the role of men and older women in younger women’s decision-making processes regarding reproduction and contraceptives. The second sphere analysed is existent cultural and embodied representations of women’s anatomy. Far from being cognitive representations, these are embodied perceptions which ultimately influence women’s experiences with modern contraceptive methods. In turn, this has a strong bearing upon their rejection or acceptance of these methods. The sphere of gender positions and decision-making will be explored next.

Gender power relations influencing women’s (non-)use of contraceptives

Gender influences reproductive behaviour. These cultural constructions involve ideas and values regarding sexuality, contraception, and reproduction which are defined differently for men and women.

In a patriarchal society such as the Peruvian, women are not expected to openly exert control over their own bodies and sexuality. If they do so, it must be done covertly. Control over a woman’s sexuality and reproduction is often held either by the men in her life or by other older women in their families – their own mothers, mothers-in-law or aunts. This control is exerted from a distance. Indeed even while migrant women may be far away from home this control continues to exist. This plays a role in the negotiation around the use of contraceptives and displays how, as transnational migrants, women are subjected to a double set of power relations. Thus, in spite of having gained more spaces of freedom in the host society women are still limited to exert control over their own reproduction to avoid pregnancies.

He made me pregnant! (Cultural legitimacy of women’s lack of knowledge)

The cultural legitimacy of women’s lack of sexual experience is manifested, for example, in the expression women use: he made me pregnant! This is specific language used by women to describe the course of events that led them to an unwanted pregnancy at a young age. Underlying is the idea that men are experienced; the ones who know and decide. Nevertheless this expression may also be interpreted as women’s desire to exempt themselves from responsibility for their own pregnancy, which in fact is the other side of assigning the legitimacy of knowledge and decision exclusively to men. The meaning of the notion can be confirmed in the fact that the first pregnancy of the majority of the 30 women interviewed was unplanned.
The majority of women interviewed began to use contraceptives or *cuidarse*, literally *to look after oneself* as they express it, only after their first baby or after subsequent pregnancies when no more children were wanted. As the survey conducted showed, single women with no children who use contraceptives accounted for only 13%. Not only are they in the minority, but also as the case presented next illustrates, these women do not openly exert control over their own reproduction and bodies.

Vilma is a 23-year-old woman. She lives with her boyfriend, Marco. I met both of them in the building on Bandera Street. One day while we were talking about her health issues, I asked Vilma about the contraceptive method she was using. She responded that she did not use any method. After I had shown my surprise, she confessed she actually was using a method and asked me to switch off the recording machine so she could talk about this. She then told me she initially used the tri-monthly injection. She got this medication from her sister, who also lived in Santiago. The sister had injected it into her, as she had some nursing training. Vilma then travelled to Peru where a friend advised her to use an IUD. This is a birth control method she believed only to be used by women who had already given birth. Finally, she was convinced she could use it and this is the method she uses now. Vilma did not want Marco to know about the IUD because if he found out, he would think that by having the ‘T,’ she could more easily be unfaithful.

While Vilma exerts a covert control over her own body she fears to openly challenge her partner’s need for control.

Hilda is 25 years old and has a one-year-old baby. She is attending family planning programs and acknowledges she did not know anything about contraceptive methods when she was single and began her first relationship in Chile.

(I knew) nothing, because I had not lived with a man in Peru before. So, I didn’t know … anything (about sexuality and contraceptives). And my partner (in Chile) was the first I was with …

Indira did not know anything about contraception before she got pregnant.

L: When you came to Chile did you use any contraceptive method?
I: I did not use any methods. I used to think that only married women... (could access contraceptives) that I had no… I did know that one could *cuidarse* (to use a contraceptive method), but I used to feel embarrassed. And I did not want to go to bed with anybody who was not going to be my husband. So I just left it, my parents reared me like that.

The control exerted by parents and adult women over young, single women in Peru aims to prevent an early pregnancy. For the family to keep young women and teenagers inside the family home and not be seen in the street is a public proof of the woman’s

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142 I knew the couple so it was easy for me to have access to an interview and to Vilma’s personal experience. There was, however, also the fear that I could talk to anyone else and maybe share the information given to me. Vilma feared that I would disclose this information to her mother-in-law whom I also knew and this would damage her partner relationship. The time that I spent among the community of migrants convinced them that they could trust me. However their fear to be exposed to other members of the community remained. It was not possible for me to record on tape their experiences about sexuality or other sensitive issues when these cropped up in casual conversation. This was contrary to what happened with the women interviewed in the clinics, who felt more protected by the fact that I did not know them and felt freer to talk about private matters.
chastity and of her moral quality. This protects the woman’s reputation throughout her 
life. Ana, for example recalls an argument she had with her husband who migrated to 
Chile and left her in Peru. He heard rumours about her being unfaithful but Ana made it 
clear to him that he did not have the right to doubt her fidelity. She said to him: You did 
not meet me in the street (Family planning).

The greater freedom young women enjoy in Chile runs counter to their lack of 
information on sexuality and reproduction. Because of this, they lack a sense of ‘having 
the right to know’, which would greatly aid them in the prevention of an unwanted 
pregnancy. One young woman, who became a mother in Chile, explains why she thinks 
she would not have become pregnant if she had remained in Peru:

R: If I were in Peru I wouldn’t have had a baby. 
L: Why? What would have happened there? 
R: Because there is another upbringing; another form of upbringing. My mother, my 
father, they have been here (in Chile) many years – 7 or 8 years. And I was with 
my granny and my aunt. And they, their upbringing is the old fashioned one. They 
don’t let you go out of the house easily. From the school to the house and from the 
house to the school. But here (it’s) not (like that). My mother and father were 
working so I took advantage of that. (She laughs).

For young women who have begun their sexual lives in Chile and want to prevent 
conception, consulting family planning services is not a possibility. They lack 
experience and pertinent information on where to consult. More importantly they do not 
feel entitled to know about or use contraceptives, and often experience great 
embarrassment to openly express their needs. Therefore, access to modern 
contraceptives simply is not a feasible alternative for them in Chile.

I felt ashamed to go to a pharmacy and say… I need something to cuidarme (prevent 
pregnancy). I felt terrorised. Once we went (to a pharmacy with her partner) but we 
turned around, because I felt so embarrassed. (Hilda, 25 years old; completed secondary 
school.)

Indira, who is 23 years old, did not consult a doctor when she began to have sexual 
relations. She believed that only married women could have access to family planning 
programs. As a single woman, she did not perceive herself as being entitled to know 
about and use contraceptive methods. In such situations, young women often rely on 
their partners to provide ‘protection’ or use traditional contraceptive methods. This is 
discussed next.

He talked to me like an experienced man (the role of men in women’s reproductive decision- making)
Men play a pivotal role in the use of traditional contraceptive methods. This is 
particularly true when women are initiating their sexual lives or when they are 
experiencing difficulties in the use of modern methods, such as undesired side effects. 
Aspects of this will be examined in detail in a following section.

Several of the women interviewed reported that the use of traditional contraceptive 
methods such as the calendar had either been taught to them by their partners or 
monitored by them. Men are often the ones who keep account of women’s fertile days.
When asked to explain the way the calendar method works, as they remember it was taught to them, all its users described it incorrectly; information was supported by the survey results. This was evident in Aurora's case. Aurora went to family planning services in Peru, accompanied by her husband. After having tried numerous contraceptive methods and having experienced problems with all of them, they both were taught to use the rhythm or calendar method by the midwife. It was her husband's job to keep the record. She describes how they went about it:

A: We counted the days. Let’s say he, himself, was counting. I did not count. I almost didn’t. …He was the one that was more. …He counted.
L: So you didn’t know which days you could... (have safe sexual relations)?
A: Ah, well no. He used to tell me such days. Sometimes he would put a mark in his wallet (for) the days that we could and the days we couldn’t. … So I don’t know.

Erika (29 years old) was using the calendar method with her partner in Chile, and still, she got pregnant.

E: Me cuidé (used the method) for about a year but we lost track. ...What happened was, my period wasn’t regular, and that is why I got confused. I ended up pregnant.
L: And who taught you that method?
E: (laughs) You know that is always the husband (who teaches) us. The husband always knows because one…

Women often use another traditional method, coitus interruptus, when they are initiating their sexual lives. This is also true for women who have problems with modern contraceptives. In virtually all cases, it appears to be proposed and taught to women by men. María Paredes is 17 years old. Initially she said she was not using any contraceptive method, no me cuido con nada (I don’t look after myself with anything). But, later she explained she was using coitus interruptus with her partner. She honestly did not consider it to be a contraceptive method.

L: And this method of ejaculating outside… That is actually also a method, who knew about it? Who decided on that?
M: He knew it. He told me let’s do this.
L: And you did not say that you might want to use another method?
M: Yes. But not because I did not want to go to any medical care centre.¹⁴³
L: And how do you feel about this method?
M: Well I don’t feel safe. I fear I might get pregnant.

Norma Leandro (23 years old) did not know anything about contraceptives because she never had a sexual partner before. Although she had been practicing coitus interruptus with her partner, she now believes this method is unreliable. She fears her partner will not be able to keep himself in control. As it is, she has already had one pregnancy scare. However, her partner was convinced this method is a safe means of birth control.

He talked to me like an experienced man. As I thought he already knew a lot about such things, I felt assured he would not make me pregnant. He assured me of that.

¹⁴³ Further on in the interview she says she does not want to go to a health centre because she does not know where it is or how to consult. Also, further on, she says she fears she will not be treated well.
She once tried to buy (contraceptive) pills in the pharmacy. But she did not dare do it as she feared she could get the wrong pills and they would make her sick. Only in a few cases – the minority – it was found that men were using condoms. Men seem to associate the use of condoms with promiscuous behaviour:

The midwife gave me condoms and all that, but my husband doesn’t like it! What do you think that I am a street guy, that I will use that sort of thing?! (María Roxana, 4 children, 28 years old, family planning program)

It is interesting to observe, the metaphor of being ‘a street person’ to signify promiscuity is also used by men. However, men – unlike women – are able to challenge such notions for not using condoms. In this way, they manage to reassert their power over women. As seen, men don’t value the use of condoms as a less harmful contraceptive method. Instead, they discard its use as they associate it with women wanting protection against their ‘supposed promiscuity.’

She knew...practically she took the decision (the role of older women in women’s reproductive decision-making)

Interviews showed that even after becoming a mother, women do not necessarily gain clear autonomy on decisions about their own reproduction. Mothers and mothers-in-law have a say regarding woman’s use of contraceptives. They have input on whether it is suitable – and when it is suitable – for the woman to have more children. Jessica recalls it was her mother-in-law who decided on what contraceptive she should use.

I was very shy. I was 21 years old. I did not know about those issues. My mother-in-law who was more advanced… She knew...practically she took the decision (that she should use the copper T). (Jessica Acosta, 31 years old, pregnant)

Older women maintain decision-making power even if they remain in Peru. Hilda, 25 years old, called her aunt in Peru to consult with her about what contraceptive methods she should use after having had her first baby.

She told me: ‘...My dear, it is better with the ‘T.’ Yes, because I also me cuide (prevented pregnancy) with the ‘T.’ …Ah my little one, I can’t believe we are taking about this,’ she said. (And Hilda said to her:) It is because I am not a little girl any more. I am really sorry that I had to come here and get pregnant to be talking about this.

Maria has two children in Peru from her first relationship. She migrated to Chile leaving her children behind with the intention to provide for them. She started a relationship with a migrant man whom she married and soon she became a mother of another two children. The first pregnancy was planned but the second wasn’t. Her mother used to call her from Peru to remind her that she should not forget to take her pills that she should cuidarse – to use contraceptives. Maria’s husband, on the other hand, wanted to have more children as he did not have his own family before he met Maria. The issue was discussed over the telephone by him and Maria’s mother who was in Peru.

He (her husband) talked to my mother and said to her: …Ah, no, señora, I want to have more (children)... And, my mother got very upset. No, she said, My daughter has already four! - Two children here (in Peru) and two there (in Chile)!
Maria, 28 years old, has pressing economic reasons for not wanting more children: One gets too impoverished with so many children. A baby is a God’s blessing, but also, one has to put out so much more effort. Sometimes one does not have enough to get them out (of poverty).

Similarly, Ana is in her second relationship and has a child from her previous one. This child remains in Peru and she provides economic support - a valid reason why she desires no more children. Before Ana left Peru, her mother-in-law was spreading rumours that she was cheating on her son. To this Ana’s mother suggested she have a medical check up to see why she wasn’t having more children and recommended that she became pregnant as soon as she reunited with her husband in order to stop the rumours of her mother-in-law. She was treated for a fibroid tumour and some time later, she got pregnant. When asked whether or not she wanted to have her second child, Ana answered:

I would have preferred to work. No? To work, because I have been a mother and father for the older one. And now, he (her son) is asking me for more, school fees, uniform, and (the rent of) the room here.

The role other women play in women’s actual decision-making process regarding contraception is manifested in the existent prototypes which guide women’s decisions. Indeed, in spite of the fact that women may have access to reproductive healthcare and to consultations with healthcare providers, migrant women regularly make decisions regarding their use of contraceptive methods guided by other women’s reproductive experiences, even while these women may be in Peru.

What happens is that I got scared with the copper T. Because my older sister, there in Peru ehhh…. She was put on the copper T method and she got out pregnant. So my sister told me: *for you to be sure (use) the pill* (Erika).

Healthcare providers’ opinions often are not the ones that prevail. This may also be due to the nature of the relationships these women have with healthcare institutions in Chile. These issues will be explored in the next chapter.

L: What have you heard about the pill?
R: Ehh… the nerves.
L: That it affects them?
R: Yes, that it affects the nerves quite a lot. Because in the case of my mother, she used the pill for years. Uff!! We would tell her something and she would yell at us and send us to Hell, because she was using the pill. *(Rocio also recalls the experience of her own mother who used the pill.)*

Stories about contraceptives and how their side effects manifest themselves circulate among the women in the migrant community. A woman interviewed said:

I was scared because (of what happened to) my sister back in Peru. They put her on the IUD method and (still) she got pregnant with the “copper T”. Then I asked the midwife and she said to me that to be sure, then better use the pills. And I was silly. I did not ask her that (how the pill functions).

As migration alters the direct control exerted by the family on women’s sexuality, women see themselves with greater spaces of freedom in the host country. Theoretically
and cognitively women obtain in the host society, more access and knowledge about contraceptives than in their home environment. While these factors provide migrant women with a certain degree of empowerment at the same time, traditional forms of control over women’s sexuality and reproduction are reassembled in the new society. On the one hand men continue to have the legitimacy and continue to be in control of women’s contraception, and women concede to that. On the other hand, distant control exerted from their families continues to exist. Women guide themselves and take decisions in terms of their own reproduction based on the experience of older women in their families. This happens in spite of the distance and the many differences that may exist in their reproductive condition and experiences. This double set of power relations which run across national frontiers is acting upon migrant women by limiting them in making use of their freedom.

10.5.1 Women’s embodied perceptions of their anatomy influencing their (non) use of modern contraception

The perception that migrant women have about their reproductive systems and the way modern contraceptives work in the body is presented next. Exploring these embodied perceptions helps to understand why some women, while using these contraceptive methods, still face difficulties in accepting them. It also helps to explain why some of these women desert these methods later on.

The ‘copper T’ and its effect on the body

Women interviewed were asked to draw a picture of their reproductive system; to explain the way in which contraceptive methods act in their bodies, preventing pregnancy. This graphical representation of the reproductive system, and where the IUD is placed in their bodies, shows a mechanical perception of the body functioning with the ‘T’ thus, blocking the transit of the sperm. Given that the IUD “T” acts in blocking sperm, then it should be placed either at the entrance of the vagina or at the entrance of the uterus.

L: Could you draw for me please, the way you see it, where do you think the T is inserted in your body?
X: Where do I think it is?
L: Yes.
The above drawing was made by Hilda, 25 years old. She has a secondary education and was attending a family planning program. Hilda holds a mechanical conception of the action of the IUD in her body. Under this conception, ‘protection’ against conception offered by this method, is often linked to an uncomfortable physical experience. She does not visualise the systemic action of the IUD in her body.

In Vilma’s perception, the copper T must be located at the entrance of the vagina.

Women think that the copper T is not a secure method because it gets displaced, moved inside the body during sexual intercourse or as result of physical effort. Such an event, to their way of thinking, may facilitate pregnancy.

The disadvantage (of using the copper T) was that sometimes the T wasn’t… Let’s say… I had to manage it carefully. Had to have sexual relations, let’s say, carefully. Little by little, and do not lift heavy weights, because the ‘T’ could be move to a side. (Jessica, 31 years old)

There also is a strong association between the use of the copper T and infections as well as cancer. There was a suspicion that the use of the copper T could cause cancer. Women often referred to rumours about babies that were born with the T protruding from their foreheads. However, nobody ever confirmed having actually seen such a
case. But always, according to them, these stories came from a trustful and reliable source.

Side effects of using the copper T, as recounted by these women, included headaches, abdominal pain, pain during intercourse, weight gain, weight loss and excessive menstrual bleeding. These women also said that men often complain they could feel the copper T while having intercourse. Perceptions held by women are also shared by their partners. Both experienced discomfort, particularly with the use of an IUD.

**Oral contraceptives and its effects on the body**

Women perceive oral contraceptives with even less clarity than the IUD. They virtually have no idea how oral contraceptives work in the body to prevent pregnancy. Only a very small minority refers to oral contraceptives as hormones. Still, this notion remains associated with a mechanical perception of its action in the body. In short, some women believe birth control pills stop or kill sperm in the same way as the IUD blocks their passage. Juanita Quevedo, explains it like this:

L: How does the pill work in your body to prevent pregnancy?
J: It kills the sperm. Let's say, it does not let the sperm get to the ovaries [sic] of the woman. Do you understand me? Let’s say, it does something with the sperm. When one is having relations, I say that it stops them. For me personally, I say that (it is) like it stops them and kills them.

Indira thinks the pills’ effect the sperm in the moment the couple is having intercourse.

L: Ehhh it kills the virus of the man’s semen.
I: The pill does that?
L: It kills that, I have heard that, I don’t know.

According to this conception, Irina thought she could only have protected intercourse at the time she took the pill, which was every day at 9 in the evening. In spite of her husband’s demands she always refused to have intercourse before 9 o’clock. The one time she had sex in daylight, she feared she would get pregnant and washed herself immediately after having sex, as she thought it would prevent an eventual pregnancy. Unlike other women, she would not believe her husband when he tried to convince her of the contrary.

Many women refer to the negative effects of oral pills experienced by them, or that they have heard about. These include drastic changes in weight (gaining or losing weight, but more often gaining), nervousness, mood changes, nausea and vomiting. Women also believe the pill causes sterility, as they heard from healthcare providers that a pregnancy may take time to occur after having taken the pill. These may be first-hand experiences or other people’s experiences which become prototypes guiding women’s decisions. However, first-hand experiences and negative side effects that women have experienced with oral contraceptives abounded among the interviewees.

Rosita explains her emotional distress as connected with the fact that she began to use oral contraceptives in Chile. She quit her job as live-in nanny, which she thought
was the main cause of her stress. However, since leaving the job, she still does not feel right. She examines the factors which may be causing her discomfort to persist. Given the fact that in Chile, she does not have access to the tri-monthly injection, a method she used in Peru, she decided to try the pill. When asked about how it was to use an oral contraceptive, she answered:

R: I feel as… I blame the pills. But I don’t know what they do. – It is as if they turn me inside. I don’t know. Suddenly, I feel bad… I don’t know.
L: Is it?
R: [I don’t know] whether these are the same pills or it is the tension, I don’t know… And even though I try to avoid it (getting angry)…But I also understand Luis [her partner, who at the time was unemployed], he is sitting here waiting. He always comes to meet me [when she comes back from work].
L: So you relate the way you feel to the fact that you are taking the pills?
R: Yes I relate it to the pills I am taking, because… Let’s say I am taking them from January (the interview was carried out in April). Yes, in January, I was taking the pills already and I felt the same way. (Annoyed). It was like I would get angry over anything…. Yes, I think it is the pills.

Her use of oral contraceptives allows Rosita to have a reason to be angry when she sees her unemployed partner sitting in their room, waiting for her to return home from work. Rosita understands his situation, but she can’t avoid getting irritated. Independent of actual physical effects the pill may have upon her body, her anger can be blamed on “side-effects”. This becomes a more neutral and external explanation for her hostility rather than her partner’s extended unemployment. Almost all the women who had used the pill and stopped using it, reported having experienced drastic mood changes. Moods ranged from being irritated most of the time to having abrupt explosions of anger. In many cases as they expressed, their partners suffered the consequences of frequent fights and requested them to stop using the pill.

**Tri-monthly injection and its effect on the body**

While the Tri-Monthly Injection method is the most preferred among this group of migrant women participating in family planning programs, half stated that they preferred it. Some women had experienced undesirable secondary effects. Some experienced the suspension of their menstruation. While for some women, the cessation of their periods was viewed with a sense of relief and liberation, for others, the suspension of their cycles caused them great concern about its affect on the body. They worried that the interruption of natural discharge produced by the monthly period would do them harm.

Juanita Quevedo tried the three-month injection but stopped menstruating while using it.

In the beginning how should I say, it was magnificent not to see it (her periods). That is the truth. But then I was thinking, I should be crazy to be using these things. One has to have a way to vent. With the ampoule, I put on weight. I was like a cow.

Aurora Paredes used the tri-monthly injections in Peru:

L: Why did you stop using the pill?
A: Because the pills were like too many hormones. I gained weight. It was like eating and eating and I put on more weight. My husband told me that we better stop with the pills and thus I began to use the injection every three months but I did not have my period.

L: And was it uncomfortable for you?
A: Yes because it could cause nerve attacks. They said it is bad, so I also stopped the injections.

L: And is that bad?
A: Let’s say it is as if one would have… As we say over there (in Peru), if we don’t have our period it upsets the nervous system. …For any little thing, in a minute, I would explode.

As seen, women’s perceptions of their reproductive bodies and their experience with modern contraceptives appear to be simultaneous but contradictory processes. The difficulties women have in using contraceptives prove to be an embodied experience. Thus while women obtain higher cognitive access to knowledge and information about contraceptives, this knowledge does not erase the realm of their own personal experiences and the difficulties they have using them. Cultural conceptions which influence women’s practices and decisions regarding contraception have been reviewed in detail here. This discussion also contributes to understanding the difficulties these women face in adapting to the existent offer of contraceptives in the Chilean public healthcare system.

10.6 Strategies to avoid pregnancy in a context of multiple barriers to contraception

In this section I discuss the strategies used by women when dealing with existing barriers to reproductive healthcare. I also deal with the disparity between women’s preferences in terms of contraceptive methods and their actual access to these methods.

10.6.1 Resorting to traditional contraceptive methods

When secondary effects are experienced with modern contraceptive methods, women often interrupt their use and switch to traditional methods such as the calendar or coitus interruptus. This last alternative is always proposed and managed by men. Although with some exceptions, the same applies for the calendar method.

L: If you could choose, what birth control method would you choose?
E: I wouldn’t use any.
L: Not one?
E: The period (the calendar).
L: Your period? Why?
E: The pill, I don’t like, because I put on weight and affects my nerves. I fear the ‘T’ because it gets introduced (into her body). (Elsa, 31 years old)

Interviews showed that the chances of women resorting to traditional and ineffective contraceptive methods after suspending the use of a modern method increased when they did not have access to healthcare. This is because, in Chile, some methods can be
obtained outside the healthcare system as is the case with birth control pills. Oral contraceptives can be purchased without a medical prescription.

Rosa Maria was 22 years old and working as a live-in nanny. She had no free time during the workweek. In addition, she thought she couldn’t access healthcare as she did not have her visa in order nor did she have medical insurance. After she tried the pill and it had negative effects on her, she decided to use the calendar method as recommended by her cousin:

That, my cousin told me about. Because at first, I did not want to ‘cuidaarme’ (to avoid pregnancy) with anything because once I took the pills (which she bought in a pharmacy). And, I had vomited. I felt very bad, but I did not know whether it was for that (reason, the pills). Also, as I never went to any clinic, I did not know this clinic either (where she is now attending). And the injections, I fear the needle. I said what can I use to cuidarme? So I was cuidándome one year (with the method of the calendar). I was like that.

Mirna suffered secondary effects from contraceptive pills that she bought at the pharmacy. She did this because she was not allowed to take time off her job to visit a healthcare clinic. Her concern for her health increased when she heard that the pill could produce breast cancer and sterility. She decided to suspend its use and tried coitus interruptus with which, she got pregnant.

She is doubtful about what method she will use next as she already knows she will not receive the tri-monthly injections – the method she prefers – at the primary healthcare clinic. Women use traditional methods as a last resort when other methods of birth control are not suitable for them. The higher degree of failure using these methods – and the fact that women use them wrongly – results in many unwanted pregnancies.

10.6.2 Changing to another modern contraceptive method

When women have access to healthcare and experience undesired side effects with their birth control methods, they look for a better modern method within the same healthcare system. Unfortunately, the alternative method offered may not suit a woman any better.

Karin began using the copper T in Chile after one year of feeling constant headaches and pain in her body; pain that was especially acute during intercourse. She talked to her husband and he agreed that she should have the IUD taken out.

In consultation with the midwife, Karin said that she would like to change to another method. Contraceptive pills where the only alternative offered to her by the midwife, who reluctantly agreed on changing the method but warned her that she should not be made responsible if the pills had a negative effect on her. The midwife warned Karin that she could be prone to suffer from something. Karin decided to give it a try and see how she felt.

Indira (25), like Karin, changed from the copper T to the pill. Indira initially decided to use the copper T, as friends told her that was the most secure method of contraception. After two years with the T, she continued feeling physically bad. She switched to pills, but is not satisfied with this method either. Indeed, she never really wanted to use the pill since she knew what happened to her sister while she was using it.
I have doubts about the pill because I sometimes argue a lot with my husband. Sometimes, I get disturbed and I have headaches. I remember my sister and what happened to her. (Indira's sister, who was on the pill, died of a cerebral stroke while arguing with her husband.) So I begin to calm myself down, to drink water. But I fear. Sometimes I think I would like to have an operation.

Indira would like to be sterilised but being as young as she is, and with only one child, she knows she can’t go ahead with the procedure. This procedure, although it might assist women in their present circumstances, raises questions regarding its irreversibility.

Indeed, women negotiate with themselves the acceptance of alternative contraceptive methods when an earlier one has not worked well for them. Even when they have had bad experiences with these same methods before they eventually might use them again.

10.6.3 Obtaining contraception in Peru

Teresa got the tri-monthly injection during a trip to Peru just before returning to Chile. Once she had returned, she learned such injections were not available in Chile. Her menstruation had not stopped since the day she was supposed to get the next injections. This was the reason which led her to consult with a doctor. She is now considering using the pill as the midwife said she can change to pills only once her menstruation normalises. While she waits that to happen she is having unprotected sex and chances that she fall pregnant are high. Teresa now believes, as the midwife told her, that the Tri-Monthly injection is not used in Chile as it produces “disorders”.

Elena chose to use the “T” in Peru as they heard that in Chile, the tri-monthly injection is not available. She decided to use the “T” in spite of the fact that she believes it is not 100% secure and it may produce cancer. In Peru, she was told by a healthcare practitioner that cancer could be prevented by regular checking of the IUD. But she is not going for medical check-ups in Chile as she is not allowed to take time off from her job. Gladys Torres gets medical check-ups in Peru when she travels there, using her husband's health insurance.

By obtaining the tri-monthly injection in Peru women are relying on temporal and insecure alternatives in their attempts to prevent pregnancies. In other cases the limited options of contraceptives in Chile, force women to adopt alternative methods that may not be preferred. As discussed before, while women may initially accept the use of IUDs or oral contraceptives, their experiences with these methods are often negative. Therefore chances of them discontinuing the use of these methods are also high.

10.7 Conclusions

The lack of access to preventative care in Chile together with the discontinuity of medical check-ups is notably evident. Although there is not enough evidence to assert it, these facts may be indicative of some degree of deterioration in migrant women’s reproductive health in Chile.
Several detected barriers are contributing factors that affect migrant women’s reproductive health. Economic and practical barriers as well as disinformation and mistrust of Chilean healthcare practitioners are important factors discouraging women from consulting family planning services. As a consequence, self-prescription of oral contraceptives is observed. Furthermore, incorrect use of traditional methods, such as coitus interruptus and the calendar method is also practiced. Silences around sexuality and women’s culturally legitimised disinformation around reproduction also contribute to women incorrectly using contraceptives methods.

In addition, there are cultural factors that create distance between migrant women and healthcare providers. There are existing culturally sanctioned practices which are at play and interfere in this relationship. Additional factors relate to the (trans)migrant condition of these women. Indeed, a double set of power relations acts upon women’s reproductive decisions; those derived from the relations they maintain with from their families in Peru and those they have set up in the host society. As is often the case woman’s decisions regarding contraceptives are guided by men or older women. In the first case, men themselves often have wrong information. In the second case, prototypes of other women’s personal experiences are applied. Analogies between the compared cases may not be well supported since women probably live under very different reproductive circumstances. Furthermore they are often distant from each other.

When women have access to healthcare, they are confronted with the limited choices of contraceptive methods available to them. Cultural factors again interfere in women’s utilisation of the existent contraceptives on offer. Embodied perceptions of the female anatomy showed to be influential in women’s acceptance or rejection of modern contraceptive methods. This is especially true with the IUD and oral contraceptives. The fact that these conceptions are covered by cultural silence which surrounds the topic of sexuality has contributed to perpetuate these (mis)conceptions.

As we have seen, women look for alternative strategies to meet their reproductive health needs. However, these are not always effective as traditional contraceptive methods are usually employed incorrectly.

As a consequence of the many barriers to effective contraception, migrant women often see themselves confronted with unwanted pregnancies. Unwanted pregnancies among migrant women are a too common outcome of all the factors previously discussed. Unplanned pregnancies often place these women at a difficult crossroads. These are determined by the effect of their pregnancies on their families as well as the consequences the event has in their lives as migrants. A pregnancy limits migrant women in their ability to earn an income. Often women’s pregnancies lead to conflicts with their families in Peru. Hilma recounts her experience of being criticised and rejected by her own family in Peru when they found out about her pregnancy:

I needed affection that was all I needed. That nobody would complain to me. That nobody would tell me… I used to call Peru and all there was – only screaming at me. That was all. They were upset because I was pregnant. All disappointed. My aunt used to tell me how were you able to do this? It is a sin what you have committed. They treated me bad, bad my family. So, I did not call… Nothing. And my boss told me about a shelter for pregnant women, here in Maipu.
Despite the multiple factors at play, pregnancies are interpreted by healthcare providers as a deliberate strategy of migrant women to obtain visas and remain in the country. This last aspect will be discussed in the next chapter.