PERCEPTIONS AND REALITY OF REPRODUCTIVE RIGHTS, HEALTH AND
CHOICE IN NORTHERN CHILE

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Abstract

Women in Chile continue to face various forms of gender discrimination and oppression, especially in regards to their reproductive rights and autonomy over their own bodies. This thesis investigates ideas of reproductive rights, health and choice in Northern Chile with a focus on working class women’s access to reproductive health services within public health facilities. A mixed methods approach was used within a feminist framework using qualitative methodologies including Progressive Verification Method (PVM) and Critical Methodology (CM). Single semi-structured interviews were conducted with a total of eleven participants (five health professionals and six working class women) residing in Iquique, a city in Northern Chile. Working class women’s perceptions and realities in regards to topics surrounding reproduction are analyzed within the context of neoliberalism, medicalization, marianismo and other mechanisms of institutional domination and control such as bureaucratic processes. It was found that for women with less financial means there still exists more of an “illusion” of access to reproductive technologies and services, including contraceptives and therapeutic abortion, rather than literal access. This is largely due to bureaucratic roadblocks which are reinforced by neoliberal and classist ideologies. When examining the lived reality of working class women in contemporary Iquique, it was found that women are shifting away from traditionalist patterns when making decisions about marriage and motherhood, although ideas of reproduction and reproductive responsibility remain highly feminized.
Lay Summary

The focus of this research is to better understand the reality of reproductive rights, health and choice in Iquique, a city in Northern Chile. This thesis explores how legal, political, and social factors affect working class women’s perceptions and access to reproductive health services within public health centres, such as birth control, the morning after pill, and abortion. As well, it investigates working class women’s perceptions on reproduction and citizenship rights, looking at cultural changes in regards to marriage, maternity and childcare responsibility.
Preface

This thesis is the result of the original, unpublished, and independent research investigation conducted by the author, Laura Anne Belliveau. All fieldwork, research design, and subsequent qualitative data were approved by the University of British Columbia Okanagan Behavioural Research Ethics Board, certificate number: H14-03222.
# Table of Contents

Abstract .................................................................................................................................................. iii

Lay Summary ......................................................................................................................................... iv

Preface .................................................................................................................................................... v

Table of Contents .................................................................................................................................. vi

List of Tables .......................................................................................................................................... ix

List of Abbreviations .......................................................................................................................... x

Glossary ................................................................................................................................................... xii

Acknowledgements ................................................................................................................................ xiv

Chapter 1: Introduction ...................................................................................................................... 1

1.1 The Coup d’état of 1973 & its Indelible Mark on Health, Economics & Women’s Rights .............................................................................................................................................. 3

1.2 The Instability of Women’s Reproductive Rights in Chile ............................................................................... 7

1.3 Iquique ................................................................................................................................................ 10

1.4 Research Questions ............................................................................................................................ 13

1.5 Background Literature .................................................................................................................... 13

1.6 Thesis Overview .................................................................................................................................. 15

Chapter 2: Literature Review & Theoretical Orientations ................................................................... 17

2.1 Medicine Gains Legitimacy ............................................................................................................. 17

2.2 Medicalization of Bodies & Reproduction ....................................................................................... 20

2.3 Medicalization and Reproductive Technologies ............................................................................. 25

2.4 Religious Control over Women’s Bodies & Reproduction ................................................................ 27
2.5 Neoliberalism & Health ........................................................................................................30
2.6 Politics of Gender Oppression & Reproduction .................................................................35

Chapter 3: Methodology ........................................................................................................42
3.1 Research Location ..............................................................................................................42
3.2 Methodological Approach ................................................................................................43
3.3 Interviews ..........................................................................................................................47
3.4 Participants .......................................................................................................................48
3.5 Interviews & Other Data Collection Processes .................................................................50
3.6 Post Fieldwork Experience: Life Through the Looking Glass ...........................................54

Chapter 4: Bureaucracy and the Illusion of Accessibility: Contraceptives in Iquique ......58
4.1 Reproductive Health in Chile: An Overview .....................................................................59
4.2 Bureaucracy and the Illusion of Contraceptive Accessibility in the Public System. 67
   4.2.1 Distance .....................................................................................................................69
   4.2.2 Time ..........................................................................................................................70
   4.2.3 Satisfaction ...............................................................................................................71
4.3 Emergency Contraceptives ..............................................................................................77

Chapter 5: Neoliberalism, Responsibility & Reproduction .......................................................84
5.1 Neoliberalism in Chile .......................................................................................................85
5.2 Una Tiene que Cuidarse ....................................................................................................89
5.3 Tu Soy Irresponsable .......................................................................................................96

Chapter 6: Abortion in Chile: Two Steps Forwards, One Step Back ....................................102
6.1 Abortion in Chile: A Brief History ...................................................................................103
6.2 Abortion as a Moral Issue & the 3 Causales Debate .....................................................107
6.3 Legality vs. Accessibility: The Reality of the 3 Causales Law .................. 115
6.4 Illegal Abortion in Chile: A Continuing Practice ................................... 120

Chapter 7: Healthy Relationships & Sex Education: The Faulty Equation ............... 126

7.1 Relationship Priorities: Love ≠ Marriage .............................................. 127
7.2 Ideal Maternity: Career > Motherhood .................................................. 136
7.3 Safe Sex and Sex Education: The Missing Part of the Equation ..................... 139

Chapter 8: Conclusion ............................................................................... 146

8.1 Limitations, Further Studies & Contributions ........................................... 149

Bibliography ............................................................................................... 151
List of Tables

Table 3.1 Medical Professional Participants.................................................................50

Table 3.2 Women Participants..........................................................................................51

Table 4.1 FONASA Levels in Comparison to Income, Co-pay and User Base ...............64
List of Abbreviations

AFPs: Pension Fund Administrators (Administradoras de Fondos de Pensiones)

APROFA: Chilean Association of Family Protection (Asociación Chilena de Protección de la Familia)

CAPREDENA: National Defense Security Fund (Caja de Previsión de la Defensa Nacional)

CDN: Canadian Dollars

CEMERA: Centre of Reproductive Medicine and Adolescent Development (Centro de Medicina Reproductiva y Desarrollo Integral del Adolescente)

CLP: Chilean Pesos

CORFO: National Development Agency (Corporación De Fomento de la Producción)

CORMUDESI: Iquique Municipal Department of Social Development (Corporación Municipal de Desarrollo Social de Iquique)

CM: Critical Methodology

DAR: Responsible Adolescent Decisions Sex Education Program (Programa Decisiones de Adolescentes Responsables)

ER: Emergency Room

FONASA: National Health Fund (Fondo Nacional de Salud)

FWCW: 1995 Fourth World Conference on Women in Beijing

GDP: Gross Domestic Product

ISAPREs: Health Insurance Institutions (Instituciones de Salud Previsional)

ICPD: 1994 International Conference on Population and Development

IPPF: International Planned Parenthood Federation
IUDs: intrauterine devices

JO CAS: Conversations on Relationships and Sexuality (Jornadas de Conversación sobre Afectividad y Sexualidad)

MINEDUC: Ministry of Education (Ministerio de Educación)

ODEPLAN: Office of National Planning (Oficina de Planificación Nacional)

OVO: Obstetric Violence Observatory (Observatorio de Violencia Obstetrica)

PAD: Program Associated to Specific Diagnostics (Programa Asociado a Diagnóstico)

PAE: Program Associated to Emergencies (Programa Asociado a Emergencias)

PDC: Christian Democrat Political Party (Partido Demócrata Cristiano)

PPD: Party for Democracy (Partido Por la Democracia)

PVM: Progressive Verification Method

SERMENA: National Employee Medical Service (Servicio Médico Nacional de Empleados)

SERNAM: National Women’s Service (Servicio Nacional de la Mujer)

SAPU: Emergency Primary Care Centres (Servicios de Atención Primaria de Urgencia)

SNS: National Health Service (Servicio Nacional de la Salud)

STIs: Sexually Transmitted Infection

ZOFRI: Duty Free Zone of Iquique (Zona Franca de Iquique)
Glossary

**barrio:** a neighbourhood.

**barrio alto:** A *barrio alto* is a wealthy sector/neighborhood of a region/city.

**cobertura reducida en parto:** reduced birth coverage plans; private health insurance plans

where the insurer is only obligated to cover twenty-five percent of pregnancy and birth related costs.

**consultorio:** small medical centres which make up part of the “primary care” for FONASA patients. They handle minor non-emergency medical and dental consultations, family planning appointments, take laboratory samples, etc.

**control:** a follow up medical appointment.

**convenio:** a financial agreement between two or more entities (pricing contract).

**cuidarse:** *cuidarse* literally means to “take care of yourself” and is the verb used to refer to using contraceptives.

**cuotas:** installment payments available when paying by credit card in stores, restaurants, etc. where the cost is divided over the chosen amount of installments, but are many times charged at a premium interest rate, generally well above thirty percent.

**gringa:** Although the term *gringa* is generally used to refer to women from the United States, in Chile, it is often used for any English speaking white woman.

**hotelería:** hospitality

**marianismo:** the concept of how images of the “Virgin Mary” have become incorporated into Chilean women’s identities, especially in regards to ideas of suffering and sacrifice; women as martyrs.
*matrona:* midwife. They handle most appointments and procedures in relation to reproduction and reproductive health that do not require a doctor, and assist in birth procedures (both natural and cesarean).

*parto:* birth

*población:* a poverty stricken neighborhood.

*siete modernizaciones:* seven modernizations. A set of radical changes to public policy during the military dictatorship which included the privatization of pensions, education and health.

*taxis colectivos:* shared taxis with flat rate tariffs and fix routes.

*Teletón:* an annual fundraising initiative for children with disabilities since 1978
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To every woman who has had to choose
Chapter 1: Introduction

My first visit to Iquique was in June of 2005, right after high school graduation. It was my first visit to a non-English speaking country, and I didn't speak any Spanish. The desert port city with a population of about 200,000 enchanted me from the moment I arrived.

The swarms of people hurrying along narrow streets, street vendors selling everything from socks, to street food, to toilet paper, everywhere you turn. With the beautiful beaches like Playa Cavancha or Playa Brava to the west and the Andes to the east, sandy and stark of any vegetation, it was like nothing I had ever seen before.

It was during that first visit to Iquique that I met Isabela, when she was 11 years old. Isabela lived with her maternal grandparents after her mother had died when she was very young. When I returned to Iquique two years later, I attended Isabela’s primary school graduation. By that time, there was talk that her paternal aunt wanted to bring her to Canada to live. The plan was for her to finish high school, and go to university, in Canada. A few years later, and after a substantial amount of planning and paperwork, the plan was finally in motion with the appropriate permissions and visa applications filed. However, a couple of months before seventeen-year-old Isabela was set to leave, she found out that she was pregnant. Today she continues to live in Iquique with her maternal grandparents and her three young children, looking for work while her husband is in rehabilitation for substance abuse.

I have heard countless stories similar to Isabela’s in Chile. Young girls with dreams and ambitions, some to travel abroad, some to study to become university graduates, have their possibilities altered forever with the responsibility of motherhood in the blink of an eye,
and long before they wanted or even thought possible. So, why does this happen? Why do girls and women in Chile continue to face unwanted pregnancies?

Stories such as Isabela’s stem from a multitude of factors that can increase or decrease the risk of experiencing an unwanted pregnancy; at the center of these factors lies access; access to contraceptives, access to health facilities, access to abortion services, access to reliable sex education. When examining the situation of women’s access to reproductive services in Chile, points of access are determined in important ways by one’s positioning within the Chilean social class system. Women who belong to the upper and middle classes have better access to almost all of the factors that determine one’s likelihood of sustaining an unwanted pregnancy. This corroborates Casas & Ahumada’s (2009) study that found that girls from vulnerable backgrounds were five times more likely to sustain an unwanted teen pregnancy than girls from wealthy backgrounds.\(^1\) Although in recent years there has been a downward trend in teen pregnancy in Chile,\(^2\) there still exists a disparaging gap in occurrence based on socioeconomic status.\(^3\) I argue that this gap is largely due to class divides, where women living in poverty\(^4\) have limited accessibility to reproductive devices, services, and sex education, and neoliberal ideologies developed during the military dictatorship exacerbated this problem. My study looks to shed light on the lived reality of working class women in relation to accessing reproductive services within public health. I pay special attention to how

\(^1\) Casas & Ahumada, “Teenage Sexuality and Rights in Chile: From Denial to Punishment,” *Reproductive Health Matters* 17 (34, 2009), 88.


\(^3\) Casas & Ahumada, “Teenage Sexuality and Rights in Chile,” 88.

class stratification, longstanding neoliberal ideologies, and *marianismo* have impacted working class women’s progress in gaining autonomy over their own bodies and sexuality.

1.1 The Coup d’etat of 1973 & its Indelible Mark on Health, Economics & Women’s Rights

Before being able to understand the platform on which contemporary women’s reproductive rights in Chile are set, it is crucial to understand how certain aspects of Chile’s recent history have influenced contemporary culture. The coup d’état of September 11th, 1973 shook Chile in tremendous ways. It changed the political atmosphere from a longstanding democracy to a military controlled dictatorship overnight. Many of the policies and ideologies that were introduced during this period persist today, and many of the marks that the seventeen-year-long dictatorship left behind (almost thirty years ago) are still tangible within Chilean contemporary culture.

The military dictatorship was the response to the democratically elected socialist government of Salvador Allende (1970-1973). Salvador Allende had a vision for Chile which included limiting the power of the land-owning class with land reforms. He nationalized Chile’s resources, such as copper, and thought maternal medicine should be the responsibility of the state. However, Chilean elites, with support from the United States, did not share in Allende’s vision. Those with money and power began to sabotage the democratically elected socialist government through manipulating the availability of food goods and other basic necessities. The famous “March of the Empty Pots and Pans”, which took place in December 1971 to protest food shortages, was organized and executed primarily by wealthy women as a demonstration of the failures of the Allende government to feed their families. However, as Salvador Allende pointed out in his farewell speech to Fidel Castro a day after the march, the
majority of the women who participated in the march had never cooked a meal nor washed a pot in their life.\textsuperscript{5} Those opposed to Allende had paved the way to justify a coup, although what happened following the initial attack was much more than many had expected.

Many supporters of the coup d’état were under the impression that the military would take over power temporarily and then reinstate democracy quickly.\textsuperscript{6} This did not happen, and many were not prepared for the death, terror, violence and discipline that would follow the initial attack on La Moneda Palace on September 11th, 1973. Over three thousand people were murdered or “disappeared”, and over forty thousand tortured.\textsuperscript{7} Over two hundred thousand people fled Chile to seek asylum abroad for their political ideas, education, beliefs, occupations, or family names.\textsuperscript{8} Political, class, and racial divides were permanently etched into Chilean culture. To this day, September 11th is a day of protest in Chile. Many businesses do not open, and many people leave work early to get home before dark. Every year on September 11\textsuperscript{th}, gunfire can still be heard, cars are set on fire, and the repression continues.

With the dictatorship also came a series of changes to public discourse, policy and commerce. Shortly after the coup d’état, Pinochet began to implement a new, ultra-rightist financial system, with the help of the “Chicago Boys” (as discussed in Chapter 5) called neoliberalism. Neoliberalism depends on the free market to function, and changes in Chile to

\textsuperscript{6} Sofía Correa Sutil et al., \textit{Historia del Siglo XX Chileno: Balance Paradojal} (Santiago: Editorial Sudamericana Chilena, 2001), 287.
\textsuperscript{7} Corporación Nacional de Reparación y Reconciliación, \textit{Informe de la Comisión Nacional de Verdad y Reconciliación}, (Santiago: Andros Impresores, 1996), 945.
Manuel Délano, “Chile reconoce a más de 40.000 víctimas de la dictadura de Pinochet,” \textit{El País}, August 20, 2011.
foster a neoliberal economic system included endorsed trade deregulation to promote foreign
investment accompanied by reduced social spending on healthcare and education. With the
neoliberal system in Chile, many aspects of Chilean life previously paid by the state became a
commodity, and as with all commodities, value comes with a price. Chile kept an
underfunded public health insurance system, FONASA, but also opened the markets for a
privately insured system, ISAPREs (as discussed in Chapter 4).

Through the commoditization of Chile, class divides deepened and poverty grew. An
oppressive approach was taken by the military regime, especially against those living in
poverty (which were traditionally ideologically leftist).9 Pinochet and his military regime
sought to “extirpar el cáncer marxista” (remove the Marxist cancer) from the country, and
often used health metaphors to justify the disciplining of poor bodies.10 Patriarchal
domination was also part of Pinochet’s agenda, and women were subordinated and returned to
the realm of motherhood and reproduction.11 Disciplining of bodies was incorporated into the
everyday, including curfews, bans on social gatherings, as well as constant military and police
surveillance which included phone taps and opening mail. The majority of the kidnappings
took place in the first few years of military control. They continued and rose in occurrence
again briefly in 1986 after a failed assassination attempt on Pinochet. There was always an
element of fear and punishment.

In 1988, a plebiscite was held to determine if Pinochet should remain in power another
eight years or if Chile should return to being a democracy. Fifty six percent of the population

11 Ricardo Trumper & Patricia Tomic, “From a Cancerous Body to a Reconciled Family: Legitimizing
Neoliberalism in Chile,” Transgressing Borders: Critical Perspectives on Gender, Household and Culture, ed,
Suzan Ilcan & Lynne Phillips (Westport, CT: Bergin & Garvey, 1998), 5.
voted for redemocratization.\textsuperscript{12} With the return to democracy, which was accompanied by a deeply rooted fear of another coup, there were not any immediate radical changes to policy. Neoliberal policies continued to dominate commerce, although certain aspects of social funding were increased, such as in health, and education, as well as minimum wage was increased.\textsuperscript{13} Poverty, which had reached forty-five percent of the population in 1987, was cut almost in half over the first ten years of redemocratization, although high rates of social inequality still persist today.\textsuperscript{15} However, in the domain of women’s rights, legislation was slow.

The new coalition government of Patricio Aylwin was careful when drafting policy to not infringe on traditionalist Catholic ideologies.\textsuperscript{16} The Catholic Church was an important part of the re-democratization process, and acted as a “moral authority” by speaking out on behalf of Chileans for the oppression and human rights infractions that they endured.\textsuperscript{17} During the democratization process, the Catholic Church supported these new fragile political parties while they became established, which allowed the Church to influence the political agenda, especially when discussing policy that may have gone against Catholic values.\textsuperscript{18} The Catholic Church was also able to integrate itself further into Chilean society by constructing educational institutions, and civil society organizations.

\textsuperscript{14} Minimum wage in Chile is still low today in 2018, at CLP 270.000 (CDN $540.00) when compared to the price of living, which is in many aspects comparable to the price of living in Canada.
\textsuperscript{17} Ibid.
\textsuperscript{18} Ibid.
The impact of the military regime that took place in Chile from 1973 to 1990 can still be felt within contemporary culture. Although the dictatorship ended almost thirty years ago, many systems and policies still persist today, including the commoditization of Chile within a neoliberal context. When analyzing systems of power, such as neoliberalism in Chile, it has to be understood within the context of a military dictatorship and its discipline and punish approach.

1.2 The Instability of Women’s Reproductive Rights in Chile

Over the past century, women’s reproductive rights in Chile have not developed steadily over time, but rather have been volatile, with advancements and cessations occurring sporadically. These sporadic changes in regards to women’s reproductive rights have been tied to the political party in power’s agenda of the time, as can be seen with legislation pertaining to abortion, contraceptives and emergency contraceptives, with other influences sometimes taking center stage, such as the Catholic Church.

In Chile, emergency contraceptives are a classic example of the instability of women’s reproductive rights in contemporary times. In 2001, emergency contraceptives were first utilized in Chile for rape victims. In 2004, the use of emergency contraceptives was expanded to be part of the treatment protocol for sexual abuse victims. However, the inclusion of emergency contraceptives into these treatment protocols sparked opposition from the Catholic Church. Oppositional forces towards emergency contraceptives, backed by the Catholic Church, continued to grow and came to head in 2006. During this time, the government of newly elected Michelle Bachelet of the Socialist Party had tried to further expand the use of emergency contraceptives to include gratuitous access to any girl or woman that needed it.

19 Lidia Casas, “Invoking Conscientious Objection in Reproductive Health Care,” Reproductive Health Matters, no. 17 (34, 2009), 82.
The opposition took the issue to the Constitutional Court, where they claimed that emergency contraceptives were unconstitutional due to being “abortive” in nature. The Constitutional Court, which is a highly conservative institution, was implemented as one of the mechanisms of the 1980 Constitution (which was heavily devised by Jaime Guzman, who is introduced in Chapter 6). In 2008, the Constitutional Court deemed emergency contraceptives to be unconstitutional, and they were subsequently banned from Chile. In 2010, emergency contraceptives were again legalized, after a long and controversial debate. However, the 2010 re-legalization of emergency contraceptives did not go so far as to allow unrestricted distribution. In 2013, the centre-rightest government of President Sebastian Piñera of the Renovación Nacional party (elected under the Coalición por el Cambio), passed decreto N° 49, which mandated that emergency contraceptives be freely available in consultorios and public hospitals, including to girls under the age of 14. Most recently, in September 2015, emergency contraceptives were finally made available in pharmacies without a prescription, although at the same time as this policy change, emergency contraceptives almost doubled in price.

Abortion in Chile, like in most of the western world, has been and continues to be a controversial topic. Abortion policy has traditionally been very restrictive, but still has fluctuated greatly over the past century. Therapeutic abortion was legalized in Chile in 1931 to help curb high rates of maternal mortality. From 1931-1967 a woman needed the signature of three doctors approving the procedure (after 1978 only two doctors were required), which was only supposed to be given when the pregnancy posed a serious risk to the women’s life.

Casas “Invoking conscientious objection”, 82.

With the Decreto N° 49, emergency contraceptives are mandated to be given to girls under the age of 14, however, after the fact medical professionals are obligated to inform a parent, guardian or adult over 18 years.
However, induced abortions were common, and relatively accessible to women with financial means. For women with less financial means, there existed trusted women in the community that would perform illegal abortions in their homes. In 1989, one of the last acts in office of dictator Augusto Pinochet was that he criminalized abortion in all circumstances.

After the return to democracy in 1990, there were a few attempts to overturn the newly established abortion law with no success due to heavy opposition from the political right and the Catholic Church. In 2017, abortion was finally decriminalized again, but only in three very strict circumstances, when the pregnancy poses a risk to the women’s life; when the fetus is non-viable; or when the pregnancy is the product of rape (as discussed in Chapter 6). To this day, a woman cannot legally abort an unwanted pregnancy that does not fit within the three criteria outlined above, and could face prosecution in the event of inducing an illegal abortion.

Lastly, contraceptive accessibility has also fluxed over time, although to a lesser degree than emergency contraceptives or abortion. Contraceptive use in Chile began to gain popularity in the 1960s under right-wing president Jorge Alessandri. A key concern for Chile at the time was to reduce maternal mortality, and the rate of induced illegal abortions. In 1961, the IPPF (International Planned Parenthood Federation) took an interest in Chile and visited the country in order to build alliances with groups such as APROFA (Asociación Chilena de Protección de la Familia) and the SNS (Servicio Nacional de la Salud); together they formulated planned parenthood programs. These planned parenthood initiatives where then further implemented by PDC president Eduardo Frei in 1964. Even when the Catholic

Church took a harder stance on contraceptive devices in 1968, it did not have any real effect on family planning services in Chile.\textsuperscript{24} In 1970, democratically elected socialist president Salvador Allende continued with family planning services, and made these services the responsibility of the state.\textsuperscript{25} With the coup d’etat of 1973, family planning services received budget cuts.\textsuperscript{26} In the late 1970’s the military regime took a pro-natalist stance, and contraceptive availability decreased. In fact, many women reported getting pregnant after their IUDs were removed without their consent or knowledge during annual exams.\textsuperscript{27} Since the return to democracy, family planning services have continued to exist, and since 2000, under PPD & Socialist Party President Ricardo Lagos, contraceptives are offered free of charge to persons residing in Chile with public health insurance.

In conclusion, in recent years women’s reproductive rights have progressed substantially, although their progression has not been linear. It is important to understand that within the Chilean context, women’s rights have largely been influenced by the political atmosphere of the current time period. Furthermore, outside of the political agenda, women’s rights also continue to receive opposition from powerful religious institutions, such as the Catholic Church.

1.3 Iquique

Iquique is a desert port city in the first region of Chile, 1,760 kilometers from the capital Santiago. The city of Iquique holds a long history of working class struggles, which have been characterized by both its geographical location as a port city, as well as its main

\begin{itemize}
\item [\textsuperscript{24}] Ibid.
\item [\textsuperscript{25}] Ibid.
\item [\textsuperscript{26}] Ibid.,111.
\end{itemize}
industries of mining and international imports. An example of these struggles, which is still remembered today, is the Santa Maria School Massacre of 1907, where thousands of striking mine workers, along with their wives and children, were assassinated by gunfire by the Chilean military when they refused to return to their work posts. Working class struggles have continued throughout history in the region, in part by the fact that Iquique is a port city, as well as its key industries in importations and mining.

The extraction of natural resources in the region, and the economic importance associated with Iquique being a port city, has brought with it a dynamic distribution of wealth within the community. The mining industry is of great economic importance in this region, and the extraction of natural resources, such as copper and nitrite, make up almost ten percent of Chile’s GDP annually. Furthermore, mining companies employ a number of local unskilled workers who are, therefore, able to achieve middle class status due to higher paid wages within the mining industry. This is significant because these individuals transgress entrenched class divisions, where their class background and income level do not necessarily coincide. Furthermore, although the mining industry continues to be dominated by men, women’s presence in the mining workforce is growing and is being heavily promoted; their employment now makes up about eight percent of the industry in 2018.

The Zona Franca of Iquique (ZOFRI) which is a dutyfree zone in the port is another large revenue producer in the region since being established in 1970. In ZOFRI, international imports are sold, including vehicles, alcohol, perfume, electronics and clothing (both new and

29 Corporate Citizenship, Collahuasi’s socioeconomic impact in the Tarapacá region of Chile, July 2016.
used). ZOFRI is owned in part by CORFO\(^{31}\) (*Corporación De Fomento de la Producción*) and by private investors. As well, ZOFRI makes up twenty-three percent of the employment opportunities of the region.\(^{32}\) However, many of these positions, such as sales associates, are low paid positions. Therefore, in the case of Iquique, class based issues take on a unique position through its distribution of wealth within the region, where certain traditional working class individuals are able to achieve a higher class status through certain employment opportunities.

When examining class and communities in Iquique, the differentiation is not as clear as in other cities within Chile, such as Santiago, which could be in part due its distinct distribution of wealth as discussed above. In Santiago, class status and “barrio” (neighbourhood) are intrinsically linked, with little variance and are heavily segregated; one either lives in a wealthy neighbourhood “barrio alto” (which is generally geographically situated above the landmark of Plaza Italia), or they don’t. Communities outside of “barrio alto” are then segregated into middle, lower-middle, and working class neighbourhoods or *poblaciones*.\(^{33}\) The class stratification of each area is common knowledge, and neighbourhood boundaries are generally maintained and enforced.

In turn, in Iquique the relationship between class divides and *barrios* is more fluid. Generally, regions extending south of the city centre, and closer to the ocean, are considered more wealthy areas. These generally consist of gated communities or areas only accessible by private vehicle. Areas around the city centre, and further away from the ocean (extending up

\(^{31}\) CORFO is a government agency which supports economic development in the country, including offering financial assistance to projects of innovation and entrepreneurship. (*Corporación De Fomento de la Producción [CL]* “Sobre CORFO,” https://www.corfo.cl/sites/cpp/movil/sobrecorfo.)


\(^{33}\) A *población* is a poverty stricken neighbourhood.
to Alto Hospicio) are considered less well-to-do, while areas around ZOFRI also include poblaciones, and shantytowns. The women participants for this study lived in various neighbourhoods, all of which would be considered more “working class” areas, while many of the medical professional participants lived in the southern sections of Iquique.

1.4 Research Questions

1. Are contraceptive devices and abortion accessible in Chile, and do bureaucratic processes disproportionately disadvantage working class and women living in poverty from accessing these technologies?

2. Does a woman’s class status affect her experience within healthcare facilities in Chile?

3. Have neoliberal ideologies in Chile impacted reproduction and notions of responsibility?

4. How do working class women in Iquique view and prioritize romantic relationships and motherhood in contemporary society?

1.5 Background Literature

My study looks to bridge the gap in literature between reproductive rights in Chile and institutional hurdles, such as bureaucracy, within a contemporary neoliberal context. On reproductive rights in Chile, Casas (1998; 2007; 2009) has been at the forefront of scholarship, especially on the subject of abortion, including prosecution due to having an illegal abortion, and unsafe abortions. Rodriguez Herrera (2004) has also focused on abortion in Chile, in her ethnographic work she focuses on the lived reality of women who have undergone an illegal abortion and their experiences. Haas (2009) has focused mainly on legislation in regards to reproductive and women's rights, including domestic violence laws.

34 In Iquique it very rarely rains, and therefore semi-permanent shelters can be made with various materials that wouldn’t be effective in other climates, such as cardboard.
and the previous attempts to the reinstatement of therapeutic abortion in the early days of redemocratization. Jiles Moreno (1992) and Jadwiga Pieper-Mooney (2009) have written on reproductive policy in Chile during the twentieth century with a focus on policies affecting motherhood. This thesis looks to complement these works by providing a contemporary discussion on how new legislation regarding abortion will most likely affect women who experience and unwanted pregnancy.

Studies on sex education in Chile have generally been conducted only within the capital, Santiago, and have focused on Chile’s first attempt to formulate a standardized sex education program in the mid-1990s, “JOCAS”(Conversations on Relationships and Sexuality), such as those by Casas & Ahumada (2009), Guzman et al (2010), and Montero (2011). Toledo et al.’s study in Santiago in the 1990s on the impacts of sex education program “Adolescence: Time for Decisions” in regards to rates of STIs, pregnancy and sexual initiation rates (2000). Apart from taking place in Santiago, many studies have also focused on an abstinence-centred approach, such as Silva & Ross’ (2003) study on implementing the DAR (Responsible Adolescent Decisions) program in an all-boys vocational school in Santiago, and Cabezon et al.’s (2005) study on an abstinence-centred program TeenSTAR in a Santiago public high school in the late 1990s. The most northern study on sex education is that of Barrientos (2010) which focuses on sex education program efficacy in the region of Antofagasta, which is located in the second region of Chile. In turn, this thesis seeks to demonstrate the importance of a proper sex education curriculum and its implementation, as well as highlight how an absence of knowledge of sex education, and safe sex practices, disproportionately impacts women living in poverty while reinforcing the feminization of reproduction.
Scant attention has been paid attention to the relationship between bureaucracy and its impact on access to public health services in Chile, as this thesis attempts to do. Auyero (2011; 2012) has written on the subject, but within the Argentine context. However, much of the critical evaluation of the Chilean health system is written instead within the neoliberal context, including Trumper & Tomic (1998) and Trumper & Phillips (1996) who explore the relation between health and body metaphors to justify the dominance of poor and racialized bodies. Han (2009) provides an exemplary ethnographic account of neoliberalism and its impact on vulnerable social groups, specifically through how debt traps have contributed to increasing income inequality. Therefore, my study looks to examines accessibility through bureaucratic process within a neoliberal context.

My study contributes to decentralize research on sexual health, portraying the lived experiences of working class women in Iquique through their perceptions and choices on reproductive rights and sexual health. It is my hope that my research will aid community centres in developing programs better suited towards educating women who are at a higher risk of having an unwanted pregnancy, as well as sway policy to improve accessibility to reproductive health services and methods.

1.6 Thesis Overview

The following chapter, Chapter 2, contains a literature review and a discussion of the theoretical framework that guides my analysis. Chapter 3 discusses the methodology of the thesis project, as well as post-fieldwork reflections. Chapter 4 begins the analysis of the empirical data portion of the thesis, which discusses ideas of accessibility in relation to “free” contraceptives in the public health system. Chapter 5 discusses notions of reproductive responsibility within a neoliberal and medicalization context. Chapter 6 discusses the new 3
Causales abortion bill and what this legislation realistically means for Chilean women with public health insurance. Chapter 7 discusses women's current trend in ideas of relationships including marriage and motherhood. Finally, Chapter 8 presents the concluding remarks of the thesis, its limitations and contributions and a section describing further studies related to this piece.
Chapter 2: Literature Review & Theoretical Orientations

The purpose of this chapter is to examine literature pertaining to the disciplining of women’s bodies in an attempt to illuminate my own study of working-class Chilean women’s lived realities in relation to their reproductive rights and experiences, including, in particular, accessing contraceptives, unwanted pregnancy, and abortion. In this review, I examine factors affecting women’s reality in relation to autonomic control of their bodies that range from the process of the medicalization of women’s bodies, neoliberal ideologies, religious teachings and symbolic violence.

2.1 Medicine Gains Legitimacy

When exploring topics such as medicalization and institutional domination of women in the realm of medicine and healthcare services, one must first question and understand how biomedicine gained the power and authority it holds in contemporary western society. Biomedicine in the western world has become the authority on ‘health’ related issues, and has gained legitimacy in our daily lives. For example, the ‘sick’ go to the doctor where they can be ‘prescribed’ pharmaceuticals and medical treatments. However, this was not always the case. Before mid-nineteenth century, western physicians did not have the status within society that they hold today. In fact, at this time there was no regulated curriculum for medical training, with many medical practitioners having no vocational training at all.\(^{35}\) There are different theories as to how biomedicine gained the dominance and authority it holds today.\(^{36}\) Briefly, Latour (1988) provides an interesting argument on the legitimacy of biomedicine


\(^{36}\) Ibid., 52.
being directly related to Pasteur’s discovery of microbes in nineteenth century France. Pasteur was credited with the success of identifying microbes, and through this discovery, making formerly invisible spontaneous diseases visible for everyone to see and comprehend.\textsuperscript{37}

Furthermore, Latour argues that Pasteur was able to gain authority and power over the medical field through the use of the laboratory, and the incorporation of the laboratory into the field of medicine, which has influenced contemporary medical thought and procedures in many regions of the world.\textsuperscript{38} This supports Latour’s notion that Pasteur was able to add legitimacy to his work precisely through his ability to visually demonstrate his findings to a mass audience through his “Theatre of Proof.”\textsuperscript{39} Pasteur’s “Theatre of Proof” was a theatrical type performance designed to legitimize his vaccine (in a time where his germ theories on disease were still not recognized as valid) to a mass audience through a live demonstration. When the curtains were pulled back, the vaccinated sheep were still standing and alive, while the unvaccinated sheep lay dead on the ground, therefore, “proving” the success of his vaccine.\textsuperscript{40}

Scheper Hughes & Lock (1987) add that the legitimacy of biomedicine is directly related to Western thought regarding mind/body dualism, which gained popularity with Descartes and his dichotomous understanding of the world.\textsuperscript{41} Scheper Hughes & Lock (1987) argue that through Cartesian duality, the mind (self/spirit/soul) was preserved for theology, while the body became the domain of science, without challenging the religious aspects of the

\textsuperscript{38} Ibid., 73.
\textsuperscript{39} Ibid., 85.
\textsuperscript{40} Ibid.,87.
\textsuperscript{41} Nancy Scheper Hughes & Margaret Lock, “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology,” \textit{Medical Anthropology Quarterly, New Series} no. 1 (1, 1987), 9.
This mode of thought allowed science, and clinical medicine, to expand as a logical and rational entity without hindrance from the Church. They point out that the mind/body dualism is not universal, but a concept deeply ingrained in the cultural and historical constructions of Western thought.\textsuperscript{43}

In the Chilean context, Cruz-Coke (1995) argues that biomedicine was introduced to Chile through their close ties with Europe in the nineteenth century, with the first medical professionals being European, while the incorporation of Chilean professionals quickly followed.\textsuperscript{44} He argues that Western biomedicine was then further indoctrinated into Chilean society through Chilean medical students finishing their studies in Europe or the United States.\textsuperscript{45} These students were typically young white men belonging to European immigrant families and members of the Chilean aristocracy. Cruz-Coke points out that biomedicine became a formal discipline in Chile in the 1880s, precisely when the first scholars returned from finishing their studies abroad.\textsuperscript{46} Therefore, Chilean epistemology of biomedicine is deeply rooted in European thought and has been traditionally dominated by men belonging to the Chilean aristocracy.

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\textsuperscript{42} Ibid. \\
\textsuperscript{43} Ibid., 11. \\
\textsuperscript{44} Ricardo Cruz-Coke, \textit{La historia de la medicina chilena}, (Santiago:Editorial Andrés Bello, 1995), 500-512; Dunlop Echavarría, Grace, “Historia de la medicina chilena: Una secuencia de grandes personajes y políticas sociales,” \textit{Patrimonio Cultural} (48, invierno 2008), 4. \\
\textsuperscript{45} Cruz-Coke, \textit{La historia de la medicina chilena}, 500. \\
\textsuperscript{46} Miguel Laborde Duronea, \textit{Medicina Chilena en el siglo XX: Reseña Histórica}, (Santiago: Corporación Farmacéutica Recalcine, 2002), 15. \\
\textsuperscript{46} Cruz-Coke, 500. \\
\textsuperscript{46} Maria Angelica Illanes, \textit{Historia social de la salud pública, Chile 1880-1973}, (Santiago: Ministerio de Salud de Chile, 2010).
\end{flushright}
2.2 Medicalization of Bodies & Reproduction

The process of objectifying the body and transforming the patient into a “docile” entity to be examined by physicians developed over time by means of societal and individual control. In Chile, this process has been essential, in particular, in the control of working class women’s bodies. Armstrong (1983) claims that a transformation occurred over time in the early twentieth century from the focus of medicine on the diseased individual, to patterns of pathologies and diseases throughout society. This transformation swayed the focus from a single patient to the relationships and patterns of ailments within a community. In turn, this allowed medical professionals to not only study the sick, but the opposite, the “normal,” therefore broadening the scope of the medical domain. Within this framework, medical professionals were able to legitimize their interference in the daily lives of all individuals, incorporating a variety of aspects of patients’ (and non-patients’) lives into the medical realm for observation.

Within the medicalization framework of the western medical model, medical professionals are the only ones able to interpret symptoms and fit them into meaningful scientific analysis of the body. However, as Reissman (2010) argues, medicalization is a social process that cannot be reduced to being simply scientific. Medicalization is a form of social control where physicians have the authority to mark deviant or socially unacceptable behaviour as illness. Yet, the relationship between medicalization and social control is not a new one. Authors such as Foucault (1976), Conrad (1992), Conrad & Schneider (1992) and

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49 Armstrong, Political Anatomy of the Body, 43.
49 Bordo, 67.
50 Reissman, 51.
Turner (1992) have all written extensively on the subject, with the general consensus that certain aspects of daily life have been medicalized in an attempt to control social behaviour. In fact, behaviour that is constructed as deviant is soon medicalized into a disease in need of medical intervention, or at the least in need of constant surveillance under the clinical gaze. The term “clinical gaze” which refers to the constant surveillance of patients, was first developed by Foucault (1976) in his work *The Birth of the Clinic*. He argues that through the clinic and constant medical surveillance of patients, which surpasses individual ailments into a lifelong relationship, the clinical gaze has the ability to bind together truth and time.\(^{51}\) This refers to the fact the clinical gaze has the power to frame behaviours as disease, which is taken as medical fact (i.e. scientific and objective as opposed to social and subjective), and therefore does not require scrutiny (i.e. an absolute truth).

Medicalization has been especially prevalent within realms that mainly affect women and women’s bodies. Medicalization of bodies is one form of disciplining women. Medicalization has impacted many aspects of natural functions of women’s bodies, especially those related to the domain of sexuality and reproduction, such as childbirth, menstruation, contraceptive use, and induced abortion. Women’s unique reproductive capabilities have all lent to the legitimization of the medicalization and control of their bodies. In fact, women receive less rights and control over their bodies, as compared to men, precisely because of their reproductive capabilities.\(^{52}\)

As Riessman (2010) argues, the medicalization of women’s bodies and reproduction was a form of elevating the status of medical professionals during the early twentieth

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century.\footnote{Riessman, 53-54.} Before contemporary medicine became widely legitimized, childbirth was thought entirely as a natural phenomenon not requiring medical intervention. Midwives were widely used by pregnant and birthing women, and although many of these midwives were from impoverished backgrounds with no formal education, their practical knowledge was highly valued.\footnote{Ibid., 55.} However, it was upper and middle class women who aided in reframing childbirth as a medical procedure in their search for less painful births.\footnote{Ibid., 56.} Interestingly, women of the dominant class were not seen as being physically disposed to childbirth, although this could have been a consequence of the high fashion of the time, namely, the corset.\footnote{Ibid.} Abortion shares a similar history with physicians’ struggle to gain legitimacy over the medicalization and control of the domain of child birthing procedures. According to Brown (2013), before the 1850s (i.e. before the medicalization of women’s bodies and reproduction) abortion was practiced not only by physicians, but also by midwives and other non-medical practitioners, such as trusted women in the community.\footnote{Lori Brown, \textit{Contested Spaces: Abortion Clinics, Women’s Shelters and Hospitals} (Burlington: Ashgate Publishing Company, 2013), 43-44.} Further, Ehrenreich & English (2010) find a correlation between the medicalization of childbirth and of other reproductive functions, and the framing of women’s bodies as passive and inferior.\footnote{Barbara Ehrenreich & Deirdre English, \textit{Witches, Midwives, and Nurses: A History of Women Healers}. Second ed. (New York: Feminist Press, 2010), 101.}

Holland et al. (2003) address patriarchal control and women’s disembodiment, arguing that due to systematic male domination and oppression throughout history, women have lacked autonomous control over their bodies. This disembodiment is especially apparent when examining women’s sexual relations. Women often lack power to communicate their own
Their bodies have been framed as docile bodies, through notions of “heterosexual femininity” or the “hegemonic feminine ideal,” which are equated to natural passivity and lack of control, such as during sex. According to Holland et al., ideas of male domination are especially valid when discussing topics such as the female orgasm; female orgasm does not necessarily fit into hegemonic notions of sexual intercourse given that male arousal and orgasm generally depict the beginning and end of intercourse. Supported by Holland et al.’s perspective, I suggest that framing women’s bodies as disembodied bodies has resulted in the disciplining of women in other areas of their lives, such as in the sphere of reproduction. Framing women as docile, passive entities during acts such as sex reinforces the “hegemonic feminine ideal”, and adds legitimacy to ideas of women’s bodies as passive in other aspects of their lives such as medicalization, or other forms of dominating control.

Riska (2003) points out that, historically, ideas of medicine followed a male-centric approach where men’s bodies were treated as the norm, and afflictions pertaining to men were seen as being “gender neutral.” She argues that the medicalization of women’s bodies and women’s bodily functions stems precisely from the divergence of their bodies from the male-centric model. Furthermore, Riska demonstrates that the medicalization of women’s bodies has been shown to reinforce traditional gender roles and patriarchal control, even when

60 Ibid., 89.
61 Ibid.
research demonstrates otherwise. Analyzing medical textbooks and literature on sexuality, she found that traditional sex roles persisted over actual research findings.\textsuperscript{64}

In the Chilean context, Pieper Mooney (2009) frames the lived reality of working class Chilean women throughout the twentieth century as being valued only for their reproductive capabilities. This was represented in politics and society through the use of the term “Mother-Child Unit.” Pieper Mooney (2009) argues that this discourse was used to subordinate women, especially working-class women.\textsuperscript{65} Indeed, the Mother-Child Unit was first recognized as a matter of public health discourse and medicalized during the first decades of the twentieth century, in part, with the creation of the profession of social work. Middle-class social workers, visitadoras sociales, gained legitimacy to enter working class women’s homes in order to teach them about modern motherhood techniques.\textsuperscript{66} During this time, high maternal mortality was explained as a result of the nation lacking in modernity (underdevelopment). In fact, Peña et al. (2012) argue that the nation’s underdevelopment was associated with high maternal mortality rates.\textsuperscript{67} The authors provide a Foucauldian analysis of how the state used the discourse of modernity and underdevelopment to control working class women’s reproductive capabilities. They state that, the discourse depicting women as passive sexual entities was necessary for the medicalization of fertility and population control. In the process, individual freedoms of reproductive choice were erased from legislative policies.\textsuperscript{68} They show how state institutions were male dominated domains, which structured women’s

\textsuperscript{64} Ibid.
\textsuperscript{67} Alejandra Peña et al. “Ruling the Womb,” 147.
\textsuperscript{68} Ibid., 148.
identities primarily as mothers, subordinating and keeping them within their “domestic imprisonment.”

2.3 Medicalization and Reproductive Technologies

With the medicalization of reproduction also came new reproductive technologies, such as contraceptives. One of the benefits of contraceptive availability is to drastically reduce maternal deaths associated with unsafe pregnancy termination procedures. Also, it increases women’s reproductive freedom, separating sex from the purview of reproduction.

Before contraceptives became widely available in the western world, women had few and unreliable ways to control reproduction. Western upper class women confronted this issue by fighting for the ability to refuse sex to their husbands, an abstinence-centred approach, over other reproductive choice options. An abstinence-centred approach was favoured due to the fact that women lacked reliable mechanisms to prevent pregnancy, as well as lacked agency in sexual relations with their husbands, in that their satisfaction or pleasure during sex, including their preferences regarding pregnancy-risk taking, were largely overlooked or ignored.

Eventually with the development of knowledge on contraceptive technology, these women were able to take more control over their own sexuality, moving towards contraceptives instead of abstinence-based methods of child spacing. However, contraceptive use also

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Ibid.


Reissman, 58-59; Roth, “Backlash and Continuity: The Political Trajectory of Fetal Rights,” 347.

Reissman., 59.

Ibid., 60.
reinforces the medicalized model of reproduction. As well, most contraceptives are feminine-based, which reinforces the notion of reproductive responsibility as woman-centred.

In Chile, the medicalization of reproduction started early. As Sibrian (2016) points out, Chilean elites, who dominated the medical field during the nineteenth century, were eager to incorporate reproduction into the purview of the clinical gaze. In fact, natural occurring phenomena, such as childbirth, were key for the process of “professionalization” of medicine in Chile. Political and medical elites worked together in order to medicalize childbirth by focusing on its potential health risks, and through this justification (and political backing), childbirth was moved early to the medical field and handled by “experts”.

Later on, the medicalization of reproduction expanded in Chile to include pregnancy prevention. Indeed, in Chile, contraceptive availability has largely been the result of political agendas, without much regard for women’s autonomic reproductive freedom. In the 1960s, under the Christian Democrat government of Eduardo Frei Montalva, with the development of the Comité de Vida Familiar y Educación Sexual, public policy was concerned with lowering fertility rates as a means to modernize the country. The Catholic Church’s stance against contraceptives in the late 1960s, which will be discussed below, had little impact on the government’s agenda of controlling overpopulation. To help control pregnancy rates within the country, copper intrauterine devices were made accessible to women, and were heavily

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75 Ibid.
76 French Dr. Lorenzo Sazie opened the first College of Matronas in Chile in 1834 and started offering courses in Obstetrics as early as 1835. (Nairbis Sibrian, “El proceso de medicalización del embarazo en Chile: Siglos de posicionamiento y legitimación discursiva,” Revista Latinoamericana de Estudios sobre Cuerpos, Emociones y Sociedad, 21 (8, 2016), 30.)
77 Sibrian, “El proceso de medicalización del embarazo en Chile”, 29.
78 Ibid.
79 Ibid.
80 Peña et al., 149.
promoted, particularly among working class women.\textsuperscript{81} Maira et al. (2010) argue that contraceptive accessibility during this time was primarily for the benefit of the government, and not a step towards reproductive choice and women’s control over their own bodies.\textsuperscript{82} President Salvador Allende of the Socialist Party was elected in 1970, and during his short presidency put an emphasis on women’s reproductive freedom.\textsuperscript{83} This not only included access to contraceptives or voluntary sterilization, but also included sex education programs in schools and health care centres.\textsuperscript{84} Conversely, under the dictatorship of Pinochet (1973-1989), women became severely restricted and policies were implemented to returned them to the home.\textsuperscript{85} Valdes et al. (2009) argue that Pinochet restricted access to contraceptives as part of a pro-natalist regime.\textsuperscript{86} Family planning services received budget cuts under the military regime and contraceptive availability decreased.\textsuperscript{87} In fact, many women had their copper intrauterine devices (IUDs) removed during annual medical exams, without their consent or even without been aware of the procedure.\textsuperscript{88}

2.4 Religious Control over Women’s Bodies & Reproduction

As in other parts of the western world, in Chile the Catholic Church has had a significant influence, in particular, in controlling women’s bodies. Weitz (2010) argues that Christian theologians had legitimized the control over women’s bodies through interpretations

\begin{itemize}
  \item \textsuperscript{81} Peña et al. 150. The copper IUD was designed by Chilean doctor, Jaime Zipper, in 1969.
  \item \textsuperscript{82} Gloria Maira et al. “Feminist Positions on Abortion in Chile” \textit{Women’s Health Journal} (2, 2010), 26.
  \item \textsuperscript{83} Lidia Casas & Tania Herrera. “Maternity Protection vs. Maternity rights for Working Women in Chile” \textit{Reproductive Health Matters} 40 (20, 2012), 142-143.
  \item \textsuperscript{84} Lidia Casas & Tania Herrera. “Maternity Protection vs. Maternity rights for Working Women in Chile”, 142-143.
  \item \textsuperscript{85} Maira et al., 23; Pieper Mooney. 138.
  \item \textsuperscript{86} Teresa Valdes et al. “Towards an Egalitarian and Non-Discriminatory Order: Teaching Gender and Sexuality at Universities in Chile,” \textit{International Journal of Sexual Health} (21, 2009), 253.
  \item \textsuperscript{88} Pieper Mooney, 142.
\end{itemize}
of biblical stories, in particular to those involving Eve and Mary.\textsuperscript{89} Focusing on the “original sin,” Weitz suggests that theologians have been able to frame women as being less intelligent and more susceptible to the passions of the flesh, therefore placing them at higher risk “of the Devil’s blandishments.”\textsuperscript{90} Weitz’s discussion, although limited, demonstrates how patriarchal institutions, such as the Catholic Church, have been able to justify the subordination of women through religious teachings.

The Catholic Church deems sex and sex related issues to be a private matter but encourages religious teachings to be the preferred code of conduct for the public when dealing with sex related matters.\textsuperscript{91} This can be seen with the Humaneae Vitae encyclical of 1968, which, as Jiles Moreno (1992) argues, the Church formulated in response to contraceptive devices gaining popularity.\textsuperscript{92} In the document, Pope Paul VI (1963–78) outlines that marital sexual acts should not involve artificial prevention of pregnancy, and if the purpose of sex is not to procreate, it should only take place using natural measures such as the rhythm method, or during the times of the woman’s menstrual cycle, when pregnancy is less probable.\textsuperscript{93} In Jiles Moreno’s view, the Humane Vitae was especially problematic for single women, as it denied them any sort of sexual agency.\textsuperscript{94} However, she maintains that despite the power and strong influence of the Catholic Church, Chilean women still sought contraceptives after the Humanae Vitae encyclical, and believed that advice on the use of contraceptive methods should be the responsibility of medical personnel, and not of religious

\begin{footnotes}
\item[89] Weitz, 4.
\item[90] Ibid., 4-5.
\item[91] Virginia Guzman et al. “Democracy in the Country but not in the Home? Religion, Politics and Women’s rights in Chile,” \textit{Third World Quarterly} no.6 (31, 2010), 973.
\item[92] Ximena Jiles Moreno, \textit{De la miel a los implantes: Historia de las políticas de régulation de la fecundidad en Chile}, (Santiago: CORSAPS, 1992), 135.
\item[93] Ximena Jiles Moreno, \textit{De la miel a los implantes}, 135.
\item[94] Ibid., 136.
\end{footnotes}
advisors, to married and single women alike. Therefore, during this period women in Chile were more likely to support the medicalized model for reproductive matters rather than religious models. Yet, both models highly centered reproduction around reproduction being women’s responsibility.

In fact, the Catholic Church has had a significant influence in all Latin America from colonial times to the present. Women’s everyday lives, in particular, must be understood in that context. Stevens (1973) first coined the term “marianismo” to describe the discursive influence of the image of the Virgin Mary into cultural norms and into Latin American women’s identities, although she argues that marianismo is not only circumscribed to Catholicism, but rather it is a secular edifice of women’s subordination in society. Herrera Rodriguez (2004) studies how religious teaching has become intertwined with women’s identities in the region. She argues that the image of the Virgin Mary has become embedded into the lives of women through a discourse that naturalizes women’s sacrificing their own desires and agency in order to serve their families and nation. In her study on illegal abortion in Chile, she argues that the image of the Virgin Mary is important when discussing women perceptions of their role within Chilean culture as a women-mother unit. This can be seen in women’s identification with sacrifice (women as martyrs) and suffering as being an integral part of Chilean culture. Throughout Herrera Rodriguez’s work many women spoke of their fear of being punished by God for the sin of having an abortion. For example, interviewees interpreted infertility resulting from a botched abortion not as a consequence of

95 Ibid.
98 Herrera, El aborto inducido, 85-86.
the procedure, but as punishment for their sin. However, some women were able to rid themselves of the guilt from having had an abortion by turning to the Church and asking for forgiveness. Although the population who identifies as religious has decreased in recent years, ideas of marianismo and long standing conservatism within society and culture continues and needs to be further examined, especially in how women as martyrs influences and reinforces ideas of the feminization of reproduction in contemporary society, and how these notions influence and affect women’s perceptions of sexual freedom and reproductive choice in contemporary times.

### 2.5 Neoliberalism & Health

Though neoliberalism has become widespread throughout the globe, one of the first countries to adopt a neoliberal model was Chile. As with medicalization, neoliberal ideologies focus on individualization. Under neoliberalism the state discards its responsibility to assist civil society in accessing their most basic necessities and protecting their rights. In relation to health, neoliberal policies brought in by the Pinochet regime (1973-1989) privatized healthcare, restricted women’s access to contraceptives, and criminalized abortion; at the same time, it used metaphors related to the human body, health and illness to legitimize the brutality of the regime.

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99 Ibid., 90-91.
100 Ibid., 88.
101 Rates of Chileans who identify as Catholic fell from 74% in 1995 to 57% in 2013 (Latinobarometro, *Las religiones en tiempos del Papa Francisco* (Santiago de Chile: 2014), 17.)
Focusing on “the body politic” of the country, Trumper & Tomic (1998) argue that neoliberal ideologies and practices became hegemonic in Chile soon after the dictatorship took power. The concept of “body politic” refers to the interconnections made in politics between a metaphorical human body and the state, where individual bodies become subordinated and controlled by state institutions and laws. In order to promote and/or protect the state, violence through horrific means could be justified. According to Trumper & Tomic, Pinochet utilized these metaphors in order to justify the return of patriarchal control to the country, often focusing on the subordination of women and their return to the realm of motherhood and reproduction. Patriarchal control was in part exercised through the disciplining of individual bodies (along with the body of the nation) and enforced by the military. It was through the paths of disciplining individual bodies to restore the body politic that metaphors for the dictatorship and its practices gained legitimacy.

Trumper and Phillips (1996) expand on the idea of a neoliberal model of disciplining bodies to achieve modernity by focusing on health within a Foucauldian framework. They look closely at how the Pinochet regime introduced neoliberal policies on health matters, as well as how death became incorporated into health during this period. Indeed, with the military regime came the death of solidarity, tradition and non-whiteness (i.e. visual

107 Scheper-Hughes & Lock, 26-27.
108 Trumper & Tomic, 5.
109 Ibid., 5-6.
minorities) in the path of development. In other words, the military regime used violence and terror to maintain social control and dehumanize poor bodies (nobodies), all in the name of modernity, or development. During the period of re-democratization that followed, the metaphor commonly used for this process was “reconciliation”. Reconciliation framed Chile as one “big Chilean family”, a concept that blatantly ignored oppression and excluded racism, a constant element of Chilean culture since conquest; reconciliation, hence, participated in the falsely portrayal of a single homogeneous “Chilean Race.”

Trumper & Phillips argue that metaphors of sick bodies in need of medical intervention were key for the dictatorship to explain its practice. The neoliberal approach was explained as a “medicine” to “treat” (cure) the country from leftist ideologies, in particular, by disciplining Chileans living poverty, and in the process, reestablishing aristocratic power relations. As they explain, “[m]edicine as torture and neoliberalism [were] … interlinked in this metaphor of pain and health.” Other medical metaphors were the “shock treatment” of the Chicago Boys for the economy and the use of the cattle prod (picana electrica) to remove the Marxist cancer (extirpar el cáncer marxista) from the nation. Claiming the existence of apartheid conditions of Chilean society, medicine became a vessel for disciplining poor and racialized bodies, through treatment protocols that sharply differed according to social class. Public hospitals were to be used by lower socioeconomic groups, where they were treated poorly and by a “strong hand”, whereas the middle and dominant classes were cared

112 Ibid., 22.
113 Ibid., 25.
114 Ibid., 28.
115 Ibid., 28.
116 Ibid., 25.
for and cured with a “soft touch” in private clinics.\(^{117}\) Through examining reproductive rights and health in contemporary Chile, one can see that metaphors of sickness and bodies in need of disciplining by health institutions and professionals, especially gendered bodies who live in poverty, still persist today.

In a more contemporary context, Han (2012) offers an interesting ethnography which explores the effects of neoliberalism on the daily lives of residents in a *población\(^{118}\)* in Santiago from 1999-2010. Han argues that neoliberalism has further marginalized and impoverished working class and poor people in Chile. She studies the various social effects of such impoverishment, in particular, mental health issues, such as depression. The debt trap that credit cards *cuotas\(^{119}\)* represent for poor families, Han argues, affects *pobladores* in a variety of ways. First and foremost, the ability to buy on credit way beyond their economic means due to payments and credit limits not being based on income, sets up many families for financial failure.\(^{120}\) The interest rates through department store’s credit cards are preposterous, and it takes years to pay a debt.\(^{121}\) Secondly, the ability to buy consumer goods on credit also works against families trying to sustain themselves on government subsidies.\(^{122}\) In order to receive government subsidies a social worker is required to pay a home visit in order to assess eligibility. Han’s study shows that when social workers assess the financial situation of families in their homes they do not base financial need on employment or income,

\(^{117}\) Ibid., 27.
\(^{118}\) A *población* is a poverty stricken neighbourhood.
\(^{119}\) *Cuotas*, are installment payments available when paying by credit cards in stores, restaurants, etc. where the cost is divided over the chosen amount of installments, but are many times charged at a premium interest rate, generally well above 30%.
\(^{121}\) Clara Han, *Life in Debt*, 31.
\(^{122}\) Ibid., 57-58.
but rather on the possession of material goods, independent if said material goods are owned outright or on credit. Both of these issues stem from the neoliberal capitalist model implemented in Chile since the late 1970s, where the private interests of large national and international companies take precedence, and are subject to little regulation, while individuals are blamed for purchasing outside of their financial means, even though wages do no match living costs within the country.

In her research, Han also found that the neoliberal policies disproportionately affected women. For example, many women from lower socioeconomic backgrounds are employed in settings at or below minimum wage. Many of these jobs are also on a contractual basis, where employers do not need to provide benefits, and renewal of contracts is under the discretion of employers. This puts women living in poverty in an especially precarious position when becoming pregnant. Without benefits, women have to pay their own medical bills when pregnant and do not receive maternity leave. Employers have also been known to harass pregnant employees into leaving, as it is against the law to fire women on the basis of pregnancy, and when employees are live-in domestics, this means that they also lose their accommodations. Han points out that there have been instances when employers have aided women in obtaining an abortion, but the debt incurred by the illegal abortion is repaid through free labour for an extended period of time, which puts these women in situations of further exploitation and vulnerability. Han’s work demonstrates how neoliberal ideologies have been incorporated into contemporary culture, and how personal responsibility is at the

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123 Ibid., 58.
124 Ibid., 61.
125 Ibid., 61, 101.
126 Ibid., 156.
127 Ibid., 158.
forefront of societal and institutional issues, especially those affecting the poor. These ideas reinforce that the poor, and poor women especially, are subject to a disciplining within the system, whether be through financial institutions, government subsidy programs, or as I demonstrate in my research, public health institutions.

2.6 Politics of Gender Oppression & Reproduction

Gender based violence can take many forms and appear under many names, such as domestic, structural, and symbolic violence. This is particularly relevant when studying women living in poverty in Chile. Feminism has sought to make these forms of violence visible in the public sphere, bringing to light how matrices of oppression have negatively affected women. Rodning (1988) argues that violence towards women needs to be considered as a social/structural phenomena, with a direct link to patriarchal control. She claims that withholding the label of “victim” from victims of violence can individualize the wrong-doing and remove associations to larger institutional levels of oppression. In other words, institutional violence and oppression becomes individualized, much like as is the case with neoliberal ideologies and responsibilities as previously discussed.

As Narayan (2006) argues, discourses explaining domestic abuse may vary depending if societies are considered to be modern or not. She argues that while violence against women in a place like India may be explained as part of the ‘backward’ non-modern Indian culture -- death by culture -- in North America, a culture where the use of guns has been normalized, conversely, violence against women in often explained as the result of an individual

129 Rodning, “Victim”, 94.
pathology rather than the result of a culture of violence and male domination. She points out that feminists, and scholars in general, need to critically analyze the complex ways in which information/discourse is filtered when crossing international borders. In the case of my study, Narayan’s argument is particularly relevant due to the location of my study taking place in the Global South, and therefore, discourses pertaining to Global North superiority need to be reconsidered.

In the case of Chile, laws against domestic violence were not passed until 1994, with the Intra Family Violence (IFV) Law, under the government of Eduardo Frei Ruiz-Tagle. This law has been seen as both a revolutionary step for women’s rights in Chile, and an example of how laws that challenge women’s position in society have had to be “watered down” before successfully passing through Congress.

Scheper-Hughes’ (1992) coined the term “everyday violence” during her work on high infant mortality rates in the North of Brazil. Scheper-Hughes argues that through “everyday violence” the horrific can become normalized under conditions of continual oppression, poverty and vulnerability. In her fieldwork, she found that infant death was normalized and accepted as a matter of fact under the conditions of poverty, as death generally occurred from malnutrition linked to severe poverty, inequality, lack of employment opportunities, and lack of social spending in the region. I argue that “everyday violence” in

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131 Narayan, “Cross-Cultural Connections, Border Crossings, and Death by Culture,” 70. Narayan provides a compelling example in her article, where she reframes US gun control and violence to fit the “culturally” based violence model she is arguing against.

132 Liesl Haas, Policymaking in Chile, (University Park, Pa.: Pennsylvania State University Press, 2010), 97.

133 Haas, Policymaking in Chile, 103-104.

the form of long standing disciplining through bureaucratic mechanisms, exacerbated by neoliberal ideologies, have had the ability to normalize oppression, making it unrecognizable to its victims.

Parson (2013), in turn, argues that violence against women is a product of gender inequality, which stems from women’s deeply embedded second-class citizenship status in Chile.\textsuperscript{135} Even after the law against domestic violence (Ley 19.325) passed in 1994, women still lacked the ability to exercise agency, in what Parson argues is a foundation for male dominance to persist in Chilean society.\textsuperscript{136} She points out that women’s inability to exercise agency is, to a large extent, the result of their oppression on multiple levels including personal, institutional and legislatively.

Herrera Rodriguez (2004) links gender inequality to machismo arguing that is a result of androcentric ideologies, which have been embodied into Chilean culture and way of life since colonial times.\textsuperscript{137} In addition, Haas (2010) argues that the domestic violence law (Ley 19.325) is problematic in that women were given very little power within the law to stop the abuse perpetrated against them. For example, the law, conceived within a patriarchal frame of reference, excludes marital rape from the definition of abuse, and did not include provisions to remove the aggressor from the home in situations of domestic violence.\textsuperscript{138} However, Haas also states that, in fact, the 1994 IFV law was a significant step forward for women’s rights in Chile, as it was the first domestic violence law to pass in Chile as previous bills pertaining to

\textsuperscript{135} Nia Parson, \textit{Traumatic States: Gendered Violence, Suffering and Care in Chile} (Nashville: Vanderbilt University Press, 2013), 16.
\textsuperscript{136} Parson, \textit{Traumatic States}, 17-18.
\textsuperscript{138} Haas, \textit{Policymaking in Chile}, 106.
women’s rights had been largely rejected on the grounds of being unconstitutional. In any case, the law was revised in 2005, under the government of Ricardo Lagos, member of the Partido por la Democracia (Party for Democracy). Many of the changes implemented in the 2005 enabled women to protect themselves better from domestic violence, and for longer periods, such as being able to remove the aggressor from the home and criminalizing marital rape. In my view, as a whole, this law still creates a band-aid effect to larger social problems and reinforces the ideology that places women in the home, as I will discuss later on.

Legislation in Chile concerning reproductive rights also needs to be examined. Casas’ (1998) work, regarding women who have undergone illegal abortions, argues that not only did a complete criminalization on abortion legislation violate human rights on a gender equality platform, but also discriminated against women according to socioeconomic status, as well as violated their right to due process. Although since September 2017 abortion has been decriminalized in three circumstances (as discussed at length in Chapter 6), women procuring an abortion outside the purview of the law still are at risk of being prosecuted for an illegal abortion. Women prosecuted for having an illegal abortion are often not appointed a lawyer when they cannot afford one for themselves, and over half of women facing prosecution for abortion related crimes are held in prison on “preventive imprisonment” while awaiting trial. In Casas’ piece, all women who were reported to the police for having had an abortion had sought help for post-abortion complications in public hospitals. This means that they had

139 Ibid, 104.
140 Nia Parson, Traumatic States, 55-56.
141 Ibid., 62.
been reported by the hospital personnel; none were reported from private clinics. This shows how a class system is deeply embedded in the organization of Chilean society. Within such system, it is normalized, as if by nature, that woman of lower socioeconomic status must experience disproportionate disadvantages when trying to navigate through gendered, classed and racialized institutions. It is well documented that when seeking treatment in a public hospital, many women are coerced into confessing to having had an illegal abortion before they can be treated.

There are many methods to interrupt a pregnancy, with women from more impoverished backgrounds usually having no other option but to rely on more unsafe methods that can result in life threatening complications. Casas & Ahumada (2009) argue that women from poorer backgrounds are at more risk of complications when undergoing an unsafe abortion procedure, but add that young women living in poverty are also more likely to sustain an unwanted pregnancy than woman from higher economic backgrounds. Indeed, Bernstein (1998) claims that, in general, for women who lack economic means, inserting sharp objects into their uterus or ingesting harmful substances are common methods for terminating an unwanted pregnancy. She discusses how these methods can lead to puncturing organs, internal bleeding, hemorrhaging, poisoning, and infection, while not always being successful in terminating the pregnancy, and have a high probability in causing

143 Casas, *Women Behind Bars*, 9;
infertility in surviving women. Back to Chile, Peña et al. (2012) point out that women with higher socioeconomic status largely have access to private clinics, which can perform clandestine but safe abortions, prescribe antibiotics and other drugs to lessen the chance of complications, and if complications do arise, they provide discreet professional care. The high cost associated with illegal abortions performed in clinics means that these services are almost exclusively used by women of higher socioeconomic status.

In turn, in her piece on abortion, Herrera Rodriguez (2004) claims that its criminalization can be viewed as a gender inequality issue, as it is a procedure that is only practiced on women. Through institutional violence, women have been denied full citizenship rights, for example, in legislation regarding reproduction rights, which blatantly denies women equal rights in contemporary society. Herrera Rodriguez addresses the double standards with which women and men are treated in a patriarchal society organized and managed by machista institutions. For example, she examines the role of men in relation to women's experiences with ending a pregnancy. She argues that men are not stigmatized the same way women are for being involved in abortions, most likely due to the fact that in Chile, this reproductive responsibility is traditionally feminized. However, through her fieldwork it became apparent that men played a significant role in whether or not a woman terminated a pregnancy. This significance took many forms, including the man being emotionally, spatially or economically unavailable to aid in the care of the child, to the man outright demanding that

148 Peña et al. 159.
149 For the purpose of this study, I focus only on cisgendered women, but an exception to this statement would be in the case of transgendered men.
150 Herrera Rodriguez. El aborto inducido, 47.
151 Herrera Rodriguez, 43.
the woman has an abortion against her will.\textsuperscript{152} Women who were married to a man who did not want to have children, felt obligated, or were forced into having an abortion, although the man was not a source of support. This is further evidence of patriarchal dominance and symbolic violence within relationships. Herrera Rodriguez’s work is important as to draw connections between the power of institutional actors of reproductive health in relation to the individual women. Furthermore, her analysis of men’s influences on abortion related decisions, while reinforcing reproduction as women centred, is also important when considering how long standing \textit{machista} ideologies have manifested in contemporary culture.

When examining the disciplining of women’s bodies, in this case, in the context of working class Chilean women's access to reproductive services and autonomous control, one has to identify and consider the effects of institutional forces. Medicalization of women’s bodies has largely influenced how a woman’s reproductive capabilities are viewed and have moved her natural functions into the medical realm purview to the “clinical gaze”. Neoliberal ideologies introduced during the late 1970s and beyond have had a disciplining effect for Chileans living in poverty, which disproportionately affects women. Although rates of religious followers have decreased in recent years in Chile, concepts such as \textit{marianismo} have persisted in contemporary culture and still shape Chilean women’s identities.

\textsuperscript{152} Ibid., 98-99.
Chapter 3: Methodology

In order to fully conceptualize the lived realities of women living in Iquique in regards to their reproductive rights, health and choices, a mixed methods approach was used within a feminist framework. My approach included the analysis of secondary sources, national newspaper articles, official statistics, coupled with the use of semi structured interviews with medical professionals working in the private and public health systems in Iquique, and working-class women living in Iquique. Finally, my approach includes the analysis of my experience as a “stranger” (as will be defined and discussed below), within the same institutional systems which I had studied as a researcher.

3.1 Research Location

The location of my research was Iquique, Chile. I chose Iquique as my fieldwork cite for two key reasons. First, it was due to familiarity. I had stayed with family friends twice in Iquique previously, in 2005 and 2007, and I was comfortable navigating the city, as well as I had contacts, and friends there. Second, most studies pertaining to sexual health in Chile have taken place in the capital, Santiago, with only Barriento’s study (2010) taking place in Antofagasta. Therefore, my fieldwork aims to contribute to the decentralization of studies on sexual health in Chile, to include other regions.

I was fortunate with the timing of my fieldwork (April-June 2015), as the political agenda of President Bachelet to legalize abortion in three circumstances was still under debate, and had attracted considerable media attention and public opinion on abortion and

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154 As discussed in Chapter 6: Abortion in Chile: Two Steps Forwards, One Step Back
other sex related topics. The public relevance of my research topics helped create a platform for participants to feel more comfortable discussing the matters I was studying. I was also fortunate in that in previous trips to Iquique I had established relationships with members of the community, with many stretching over a decade. I stayed with family friends during my fieldwork in Iquique, which was essential to completing my investigation. Their support and insider knowledge were a key part to my success during my fieldwork. As well, through my friends I was invited out to a variety of social events where I was asked about my research. In these informal settings, I was able to gather valuable anecdotal information, where informality facilitated conversions on the delicate issues, such as those related to my research. Through these conversations, many of these acquaintances were able to send interested participants in my direction, recommend where I should look for information, and provide direction on how to navigate Chilean bureaucracy more effectively.

3.2 Methodological Approach

For my research I used a mix methods approach which was based in a cross culture and cross language feminist framework. In order to conduct my research project, I based my research design on Progressive Verification Method,\textsuperscript{155} and Critical Methodology,\textsuperscript{156} as described below.

Billson (1991) argues that the “Progressive Verification Method” is a choice methodology for studying women cross culturally, as it advocates feminist methodology for doing research with women as collaborators instead of objectifying them. Billson presents five myths associated with traditional methodologies in the social sciences, including the


myths of: a single society; objectivity; historical and cultural abstraction; non-interference; and the myth of authority. Billson argues that the Progressive Verification Method (PVM) overcomes these myths by “defining research ‘subjects’ as equal participants.” Also, PVM frames interview questions with an emphasis on asking “public” rather than “personal” questions, in order for participants to answer more openly or generally than other interview methods, such as life histories. For my research, certain aspects of PVM were used, such as incorporating as many “public” interview questions as possible, in order for participants to feel more comfortable and open in talking about issues related to abortion.

Yanchar et al. (2005) argue that Critical Methodology (CM) poses that researchers need to take into account scientific assumptions and be critical of their own positioning when conducting research. Furthermore, critical methodology calls for less rigidity when selecting methods for a research project, with methods being chosen to suit individual projects, and follow an empirical design. Critical methodology also argues for reflection, and for researchers to be reflexive of their own position within the research while formulating research methods on a more individual basis, and in a way that benefits the project the most. Likewise, Fleming & Fullagar (2007) argue that reflexive methodologies are an important part of qualitative research to account for the ways in which “social forces or power relations shape what one does, how one thinks about one's identity and responds to the expectation of others within the context...” This means critically evaluating one's positionality and privilege and identifying how these factors can influence or shape how we see the world, and our identity, which could be otherwise taken simply as “personal traits”. I am a white woman,

158 Ibid., 209.
who, at the time of my fieldwork, lived and was educated in North America, who studied working class women’s perception and realities on sexually based topics in Northern Chile. Conscious of my privileged positionality, I am inspired by Sherene Razack’s (2000) work where she warns us about the power imbalances that may be developed in the construction of knowledge, and encourages white researchers to avoid making Eurocentric assumptions or “othering” women from cultural backgrounds different from ours. Thus, when I examined Chilean women’s experiences around reproductive rights and autonomy over their own bodies, it was important for me to consider all factors participating into the discourses and practices that organize women’s lives and serve to control their bodies and choices. Therefore, I had to analyze how being a white, young, non-religious, upper middle class, Canadian feminist female graduate student educated in the North, with Spanish as a second language, positioned me within my research. I had to be aware of the influence that living and being educated in the North has had on my positionality as a researcher, specifically in relation to discourses that locate the North, and its cultures, in a position of advantage and superiority over those of the South.

My position as a Canadian woman encouraged more frankness in discussions related to sex because, as many of participants pointed out, North American women are assumed to be more open regarding sex and sexually related topics. However, this openness did not extend to discussions on abortion. Generally, during interviews, discussions on abortion lacked detail, with some participants wishing to disclose additional information only after the interview session was over, i.e. after I had turned off the recorder, and had packed up my belongings to leave. In fact, it even came to my attention many months after my fieldwork

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that one participant did not mention that someone close to her had terminated an unwanted pregnancy. The silence on abortion related subjects spoke to my position as being a foreigner and an outsider, and to the degree of controversy associated with abortion in Chile (and in most of the western world).

When analyzing the language component of my research, I had to be aware of how being a bilingual researcher would affect my study. Borgusia (2006) argues that when conducting cross-language research, meaning cannot only be tied to language but that there are other markers as well, including gender, class, and personal history. Therefore, in the case of bilingual researchers, it cannot be assumed that they have the ability to speak for entire communities based solely on their language competence. This can lead to stereotyping, and ignores the subjectivity of the bilingual researcher. This point is especially important in the Chilean context, where language use is deeply connected with markers of social class. My knowledge of “Chilean” Spanish (and being familiar with class-based language use in Chile) was a positive aspect in my research both for my ability to better understand my participants within their own cultural and linguistic context, as well as positioning myself as knowledgeable of/interested in Chilean culture and customs. Furthermore, it allowed me to not have to rely on a translator for any process of my study.

163 I first began to independently learn Spanish online when I was seventeen. At eighteen I took my first trip to Chile for three months, where I was immersed into everyday life and learned through my everyday interactions. I returned to Chile at age twenty for another three months, and had a similar experience. My major for my Bachelor Degree was in Spanish, where I had many professors who were either from Chile, or familiar with Chilean Spanish, and often did not point out my chilenismos.
3.3 Interviews

Recognition of power dynamics with research participants is encouraged in reflexive methodologies.\textsuperscript{164} My interviews involved two different and distinct groups, each with very different positioning within the power structure. Hoffman (2007) recognized that positioning herself as student would often “signal” to her participants that they were in a greater position of power.\textsuperscript{165} Although her purpose of using her status as student was to help equalize power differentials when “studying across,” or “studying down”, for myself it became problematic in situations where I wanted to “study up”. Interviews with medical professionals, such as doctors, would be in itself “studying up” due to medical professionals’ status of authority within Chilean society. In fact, I was not able to interview any actual medical doctors for my research, partly due to the fact that they “didn’t have time” for me, and administrative personnel deemed that matronas\textsuperscript{166} were better suited participants for my research. This was probably true, as matronas generally deal first hand with the issues that I was examining, and doctors were seldom directly involved. However, I was not able to make the decision for myself to forgo my interviews with doctors, and to focus my professional interviews on other medical professionals. The decision was made for me due to the fact that I did not hold the “authority” necessary to make such decisions.

Even when conducting interviews with medical professionals holding less status than doctors, I became aware of the systems of subordination in place within these medical institutions. Although the interviews with matronas were not “studying up”, like a doctor

\textsuperscript{165} Ibid., 329.
\textsuperscript{166} Matronas are midwives. They handle most appointments and procedures in relation to reproduction and reproductive health that do not require a doctor, and assist in birth procedures (both natural and cesarean).
would be, they were often resentful to the fact that their superiors had encouraged them to participate in my study. Therefore, many times I was made to feel uncomfortable and rushed during interviews. I was often made to wait, or my interviews were cut short for some reason or another. In order to interview any staff member of a consultorio one has to officially request permission from the director of the health administration department (CORMUDESI). I had to comply with this requirement before I could conduct my interviews with matronas and nurses in any consultorio. Since the director of CORMUDESI was interested in my study, she had the board of directors grant me permission to conduct interviews within two weeks of my request. However, the permission I obtained from the board provided me with a specific day and hours every week when I was allowed to interview staff on-duty in any consultorio in Iquique. Unfortunately, the specific day and the times I was allowed to interview were often used for events, meetings, workshops, and during my stay, also fell on a statutory holiday, and therefore, many times finding participants, or ideal participants, was trying.\footnote{One week I interviewed a nurse instead of a matrona, and although she was eager to speak to me, and gave me some valuable information for some parts of my study, I later found discrepancies in some of her responses.}

During my interviews with local women there was less of an apparent power differential, and I considered it to be “studying across”. Many of these women were around the same age as myself, as well as many were students. This somewhat similar positioning, notwithstanding the interviewee-interviewer dynamic, resulted in more successful interviews.

3.4 Participants

Participants for this study fall into two distinct categories. The first group was constituted by young local working class women. They were of reproductive age and were members of the public health insurance system, the Fondo Nacional de Salud (FONASA). I was interested in their perspectives on the subjects of relationships, sexual health and
reproduction. The second group consisted on medical professionals, in particular, those working with women in areas of reproduction, which included pharmacists, *matronas*, and a nurse.

The recruitment process and interview success differed greatly between these two groups, with each having its own unique set of challenges. I found that medical doctors would not speak to me directly, but many were eager to provide me with access to the head *matrona*, or other staff members under his or her supervision who worked closely with young women. Pharmacists would often respond to my letter of initial contact directly, and set up meeting times with me, but later canceled or did not show up to scheduled interview times. In total, I interviewed five medical professionals, as outlined in the table below (Table 3.1)

### Table 3.1 Medical Professional Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Religious</th>
<th>Occupation</th>
<th>Marital Status</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veronica</td>
<td>41</td>
<td>Yes: Catholic</td>
<td>Matrona: Private Clinic</td>
<td>Married</td>
<td>2 children: 8 &amp; 14 years old</td>
</tr>
<tr>
<td>Maria</td>
<td>31</td>
<td>No</td>
<td>Matrona: Public Hospital</td>
<td>Single</td>
<td>2 children: 4 &amp; 10 years old</td>
</tr>
<tr>
<td>Susana</td>
<td>37</td>
<td>No</td>
<td>Matrona: Consultorio</td>
<td>Single</td>
<td>2 children: 6 &amp; 10 years old</td>
</tr>
<tr>
<td>Josefina</td>
<td>48</td>
<td>Yes: Catholic</td>
<td>Nurse: Consultorio</td>
<td>Lives with Partner</td>
<td>2 children: 22 &amp; 24 years old</td>
</tr>
<tr>
<td>Tomás</td>
<td>29</td>
<td>No</td>
<td>Pharmacist</td>
<td>Lives with Partner</td>
<td>No</td>
</tr>
</tbody>
</table>

The criteria I used to select the women interviewees was as follow: They were 18 years of age or older; of reproductive age; of Chilean nationality; residents of Iquique; and from working class families. In my experience the snowball sampling was the most successful method for recruiting this type of participants Once again, my former contacts in the
community were essential in my ability to find suitable participants. As with pharmacists, at times, women I contacted as potential interviewees would agree to an interview, but later canceled or did not show up for the scheduled interview. This only happened with women who were not referred to me by another participant or known contact, which further demonstrates the importance of snowball sampling in my research. In total, I interviewed six women, as outlined in the table below (Table 3.2)

### Table 3.2 Women Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Religious</th>
<th>Occupation</th>
<th>Marital Status</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catalina</td>
<td>22</td>
<td>No</td>
<td>Student</td>
<td>Single</td>
<td>No</td>
</tr>
<tr>
<td>Cynthia</td>
<td>24</td>
<td>No</td>
<td>Student</td>
<td>Lives with partner of 6 years</td>
<td>1 son: 4 years old</td>
</tr>
<tr>
<td>Fernanda</td>
<td>18</td>
<td>No</td>
<td>Student</td>
<td>Single</td>
<td>No</td>
</tr>
<tr>
<td>Mercedes</td>
<td>21</td>
<td>Yes: Catholic</td>
<td>Unemployed</td>
<td>Married, 2 years ago</td>
<td>2 daughters: 3 years old &amp; 1 year 10 months</td>
</tr>
<tr>
<td>Paola</td>
<td>18</td>
<td>No</td>
<td>Student</td>
<td>Single</td>
<td>No</td>
</tr>
<tr>
<td>Ramona</td>
<td>22</td>
<td>Yes: Catholic</td>
<td>Student</td>
<td>Single</td>
<td>No</td>
</tr>
</tbody>
</table>

### 3.5 Interviews & Other Data Collection Processes

Before travelling to Chile, my research was approved by the Behavioural Research Ethics Board at the University of British Columbia Okanagan. All recruitment and interview materials were presented to participants in Spanish; as well, as all interviews were conducted by myself in Spanish, without the use of a translator. I began my interviews on April 22, 2015, two weeks after arriving to Chile. I made the decision to hold off on interviewing right away, as I had not been to Chile for eight years, and needed to readjust to Chilean life and become reacquainted with the city. I decided to begin with a couple of interviews with
medical professionals before conducting interviews with local women. This decision was based on the idea that I wanted to have a better understanding of how the system functioned before asking women their perspectives on said systems. First, I visited various local pharmacies and private clinics in Iquique, and left recruitment letters. In one of the private clinics I visited, I was offered an interview with a *matrona* right away. This proved to be the ideal starting point, as prior to my first interview, even with my extensive review of secondary sources, I was completely unaware of the functioning of *consultorios*.\(^\text{168}\) I also went to the public hospital in Iquique to leave recruitment letters and was offered an interview with a *matrona* an hour later. As previously stated, I needed to acquire special permission in order to conduct interviews in *consultorios* through the health administration department (CORMUDESI). From there, when I arrived to the *consultorio* on my designated day of the week, a staff member would help me find out if any medical professionals were interested in participating in my study that day. Women participants were generally recruited via snowballing techniques. One participant I met while out with friends, and I gave her a recruitment letter to see if she would be interested in participating. She later contacted me, and we carried out the interview a few days later. I completed my interviews on June 4, 2015.

This part of my fieldwork consisted of single, semi structured interviews with participants in two groups: medical professionals (five interviews) and working class women of reproductive age (six interviews). Although I conducted a relatively small number of interviews, I must emphasize the value of having lived in the community, as, through my daily routines and outings, I often found myself having informal conversations with young women concerning the topics covered in this thesis. Additionally, during the process of

\(^{168}\) Discussed in length in Chapter 4. *Consultorios* are part of the “primary care” for FONASA patients, which includes sexual health, pregnancy prevention, and emergency contraceptives.
conducting interviews with medical professionals, I was often subjected to bureaucratic processes and I was made to wait, which gave me the opportunity to observe the functionalities within the waiting room.

When conducting an actual interview, I began by explaining the purpose of my research to the participant, and went over the letter of Informed Consent with the participant. I explained that they were able to leave the study at any time and that they could think over whether they want to participate and get back to me within three days. I also requested permission to audio record the interviews with a second signature. The professional interviews always took place in the office of the participant. The interviews with local women took place in their homes, or in public places such as the beach or cafes. Interview times varied, lasting between fifteen minutes to an hour. I had the chance to conduct more in-depth interviews when the questions pertaining to the participant’s personal information were asked at the end instead of at the beginning of the interview. Beginning with the questions about the participant’s personal information seemed to increase the interviewee-interviewer dynamic, where participants were giving short, concise answers, which hindered the process of building a more in-depth dialogue further along in the interview. After the interview, all participants were thanked for their participation, and given my contact information and shown how they would be able to access my thesis online. I also promised and will provide each participant with an executive summary in Spanish.

All of the participants were ensured that their anonymity will be protected, and that their identity would remain confidential. For those reasons names were changed on all transcriptions and coding data, as well as in my thesis. One local woman asked for a copy of the interview schedule before the interview took place. She had the opportunity to reflect on
the questions and made notes on some of her answers prior to the interview; she gave her notes to me at the time of the interview.

For the analysis of my interviews, I first transcribed the interviews into Spanish and then coded them using Nvivo, also in Spanish. Then, I began to analyze my interview data. As argued by Squires (2009) when conducting cross-language research it is important to outline when and why translations take place.\footnote{Allison Squires, “Methodological Challenges in Cross-Language Qualitative Research: A Research Review,” \textit{International Journal of Nursing Studies} (46, 2009), 277-287.} I chose not to translate all my interview data except for the direct quotes used in the body of this thesis. The translations which appear within this thesis were done by myself, with any translation doubts being cleared by bilingual friends and colleagues.

Regarding the collection of official statistics, I was able to request them from government organizations, including Iquique’s public hospital, as well as its consultorios through the Transparency Law (Ley 20.285) in Chile. Many resources were also available on government web pages, such as their suggested sex education curriculum,\footnote{Grupo Internacional de Currículo en Sexualidad y VIH. \textit{Un Solo Curriculum: Pautas y actividades para un enfoque integrado hacia la educar en sexualidad, genero, VIH y derechos humanos} ed. Nicole Haberland & Deborah Rogow, trans. Xavier Gonzales. New York: Population Council, 2011.} as well as the consultorio’s manual on the regulation of fertility.\footnote{Ministerio de Salud de Chile. \textit{Normas Nacionales Sobre Regulación de la Fertilidad}. 2014.} To collect newspaper articles related to my study, I began by reading newspapers online, daily, in search for relevant articles. After a while, I became aware of certain word markers that were likely to appear in relevant articles. I then set up a “Google Alert” for Chilean newspapers containing these words; at the end of every day, links to relevant articles were sent to me via email.

\footnote{Ministerio del Interior. \textit{Informe de la Comisión Nacional sobre Prisión Política y Tortura}. Santiago: \textit{La Nación}, 2005.}
3.6 Post Fieldwork Experience: Life Through the Looking Glass

In January 2016, six months after completing my fieldwork, I returned to Chile to reside indefinitely in the country. In the time that has lapsed since first moving to Chile, my time spent as a “stranger” has become a crucial part of this thesis. Simmel (1950) defines the “stranger” as:

The stranger is thus being discussed here, not in the sense often touched upon in the past, as the wanderer who comes today and goes tomorrow, but rather as the person who comes today and stays tomorrow. He is, so to speak, the potential wanderer: although he has not moved on, he has not quite overcome the freedom of coming and going. He is fixed within a particular spatial group, or within a group whose boundaries are similar to spatial boundaries. But his position in this group is determined, essentially, by the fact that he has not belonged to it from the beginning, that he imports qualities into it, which do not and cannot stem from the group itself.  

Simmel refers to the lived reality of the foreigner, which can share common ground with nationals, however, there is a degree of difference due to not originating from the same group. Therefore, in my own case, when I moved to Chile, I passed the threshold of “wanderer” (tourist), into the status of “stranger” (permanent resident). Although I am different, I walk, talk, and look different, I am still subjected to some of the very issues I studied as a student researcher. For example, I am a user of the public health system, FONASA (as discussed in Chapter 4). I experience the same bureaucratic red tape and

neoliberal disciplining I have studied when trying to access services. However, as a “stranger” I am able to more easily recognize these forms of institutional control for what they are. This has awarded me with the opportunity to better understand societal idiosyncrasies that both infuriate and reinforce the love for this country to nationals and foreigners alike.

Living in Chile as a foreigner who belongs to a privileged social class, race and nationality, I experience privilege, especially within an institutional context. When applying for permanent residency, I was not overly worried about being rejected; being a white, university educated woman from North America awarded me a quick and relatively painless immigration process, precisely due to being *gringa*. When having to go to government offices in relation to my immigration process I was always treated nicely and with respect, which I observed countless times to not always being the case with other foreigners. ¹⁷³ However, being a white young woman in the day to day context also complicates some aspects of my existence in Chile. Due to my foreignness (easily detected from a distance by my white skin, the way I walk, and confirmed by my accent) I am sometimes an “object” of interest. Furthermore, due to my physical appearance I have been targeted for theft in public spaces, and therefore, I have to be overly aware of my surroundings at all times.

When I arrived in 2016, for the first six months, I lived in a neighbourhood in Santiago that was a mixture of working class and *poblaciones*¹⁷⁴. I was familiar with this neighbourhood; I had visited it multiple of times for varying periods without any problem, and had family friends who lived there. However, I soon realized that extended visits and residing indefinitely are quite different situations. During my time in this particular

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¹⁷³ Currently there is a large influx of immigrants from Venezuela and Haiti, many of these immigrants are of afro-descent.
¹⁷⁴ *A población* is a poverty stricken neighbourhood.
neighbourhood, and largely due to being a white woman, I became restricted in my movements; I was no longer able to go out alone after dark, or walk my dogs\footnote{I have two French bulldogs, Desirée and Amelie, that I brought with me from Canada. In Chile this breed can be targeted for theft due to their market value.} alone. I became constrained in the “everyday”. When doing everyday activities, such as buying bread at the corner store, I was often leered at and/or verbally harassed, and fearing for my personal safety became internalized and normalized.\footnote{I say normalized in the fact that I always prepare for the worst case scenario before leaving the house. I never go out alone with expensive jewelry or accessories; I go inside a store to talk on my cell phone; I wear a purse with a chain strap that crosses my chest (under my coat if the weather allows); I carry a bit of money other than in my purse incase my purse gets stolen I can still get home, and I never, ever leave the house without my pepper-spray.} I realized that large aspects of my identity had been constructed on pillars of privilege, such as being “independent”.\footnote{By independent, I mean being able to do anything or go anywhere, at any time, without being accompanied by another person, preferably a man.} Having these aspects of my personal identity stripped from me was an extremely painful experience. Of course when conducting my fieldwork in Iquique, I was also more aware of my personal safety than when I was in Kelowna, but I feel that this is typical “tourist”-like behaviour, especially in regions outside of the global North, as one is outside of their own setting, and it is temporary; “exotic”.

Through my situation as “stranger”, I was able to experience certain sectors of Chilean life discussed in this thesis, such as bureaucracy and neoliberalism. I was also able to participate in conversations through my everyday interactions with other women, both with Chileans and other foreigners, to better understand what the reality of being a woman in Chile is like. I make no claim to be an “insider” due to my geographic location; I will always remain somewhat as an “outsider” (a “stranger”) due to my positionality.
In this chapter I discussed the various methods used in creating this thesis, with a special focus on my positionality within my research and beyond. In my next chapter I begin my empirical discussion on Chilean bureaucracy within the context of the healthcare system; I will pay particular attention to how it affects working class young women’s efficacy in their reproductive choices.
Chapter 4: Bureaucracy and the Illusion of Accessibility: Contraceptives in Iquique

As I stepped in the consultorio for the first time, I was startled by the hustle and bustle that was contained within those walls. There were many people sitting and waiting, so I went and took a seat by the entrance, and waited for someone to acknowledge me. I then remembered what a Chilean friend had said to me, “You have to go and make yourself noticed. This isn’t Canada, no one is going to ask you why you are there. You need to go and just walk into an office or something, and demand to be noticed.” Not only this, as Scheper-Hughes (1989) writes in her influential Death without Weeping for Brazil’s North East, show that “you are a somebody” and not an “nobody”. In other words, show that, unlike most in the waiting room, I am white middle class, and better still, a gringa. So, after a while, I worked up the courage, with my interview material and permission slip in hand, and walked straight into an office off of the main waiting area. There I found someone who appeared to be a supervisor, and explained the purpose of visit. I explained to him that I had been authorized by the director of the health administration department (CORMUDESI) to do interviews every Thursday afternoon. He then passed me off to reception for them to eventually find an available matrona with whom to meet, and so this became my weekly routine.

Since the end of the military dictatorship, a large step forward in women’s reproductive health and pregnancy prevention occurred. In 2000, the Chilean government, under President Ricardo Lagos, representing the Coalition of Parties for Democracy (‘Concertación de Partidos por la Democracia’), made contraceptive accessibility a priority
for its citizens.\textsuperscript{178} Through this initiative, provisions were made by the government to ensure that publicly insured healthcare receivers were able to access contraceptives for family planning purposes. Since this time, in all publicly funded \textit{Atención Primaria} centres, also known as \textit{consultorios} (which I will describe soon), contraceptives are given free of charge. Many options are available, from condoms, to birth control pills, intrauterine devices (IUDs), implants and emergency contraception. \textit{Consultorios} also offer limited STI testing including HIV. Although \textit{consultorios} may offer treatment for STI, in Iquique most of them do not.

Pregnancy testing is offered in \textit{consultorios} where blood tests are preferred over urine tests.\textsuperscript{179}

At a glance, it looks as though from 2000 the Chilean government has taken seriously the need for women to be able to protect themselves from unwanted pregnancies, to take control of their bodies and also to protect themselves from STIs. However, delving more in depth, I argue in this chapter that there is a gap between the letter of the policy and its application in Chile. I demonstrate that in reality there is more of an illusion of accessibility rather than actual accessibility through bureaucratic roadblocks.

4.1 Reproductive Health in Chile: An Overview

Health is perhaps one of the key markers of Chile’s class segregation. Chile has parallel health care systems. Around seventy percent of Chileans are users of the public healthcare system, which broadly treats the unemployed, blue-collar workers, middle class families, retirees, professionals and technicians. There is also a private healthcare system,


\textsuperscript{179} It is unclear as to why blood tests are preferred over urine in \textit{consultorios}. I believe that it is related to ideas of the medicalization of reproduction and the reassertion of the \textit{matrona}’s power and dominance. Instead of women offering a urine sample (non-invasive, painless, and voluntary), they are subjected to having blood drawn, which includes the \textit{matrona} acting on the patient (penetration, pain and by force). Urine pregnancy tests are sold in Chilean pharmacies, and cost between $2.500-3.500 CLP ($5.00-7.00 CDN). In Canada, equivalent tests can be bought for $1.25 CDN. Therefore, purchasing urine pregnancy tests (to avoid going to the \textit{consultorio}) is outside the scope of many women.
which covers approximately seventeen percent of the population. This population has higher incomes and the ability to pay a higher price for health care services through accessing private health insurance. Next, there is a small sector of the population (less than one percent), constituted by members of the dominant classes, who pay for exclusive medical services directly from their own pockets. And finally, military personnel and their families, comprising around ten percent of the population, are serviced by a separate health care system, *Caja de Previsión de la Defensa Nacional* (CAPREDENA), with its own hospitals and other medical facilities. In this investigation I focus primarily on the public healthcare system, as the persons who concern my study are women of working class backgrounds, who are mostly users of this system of care.

The public healthcare system includes three divisions of care, primary, secondary and tertiary (*Atención Primaria, Secundaria, and Terciaria*).\(^{180}\) *Atención Primaria* includes *consultorios*, which are small medical centres. They handle minor non-emergency medical and dental consultations, family planning appointments, take lab samples, etc. Also within the *Atención Primaria* system exist SAPU centres (*Servicios de Atención Primaria de Urgencia*) for minor emergencies and uncomplicated ambulatory care. *Atención Secundaria* consists mostly of diagnostic centres, or centres for treatment of moderate complexity (such as cancer treatment). *Atención Secundaria* facilities require that the patient has a referral, and therefore, the patient must go through an *Atención Primaria* facility first. Finally, *Atención Terciaria* includes hospitals, where complicated procedures, emergencies, surgeries, childbirth, etc. take place.

\(^{180}\) Fondo Nacional De Salud [CL] “Red Publica Preferente (MAI)”

https://www.fonasa.cl/sites/fonasa/beneficiarios/informacion-general/red-preferente
The private health care system is a for profit system. Mostly large corporations own and operate expensive for profit private clinics and emergency care centres. In Iquique, these institutions include Clínica Tarapacá and Clínica Iquique. There are also large centers of ambulatory care, in the hands of corporate capital, that offer the service of medical doctors, tests, and some invasive procedures. Finally, there are private doctor’s offices.

There are two health insurance systems, available to Chileans, a publicly owned insurance system (Fondo Nacional de Salud-FONASA), and a for profit private insurance system (Instituciones de Salud Previsional-ISAPRE) in the hands of large capital. As of 2013, seventy-five percent of the population was covered by FONASA, with just under seventeen percent being covered by ISAPREs. Most of FONASA affiliates and those covered by ISAPREs pay into healthcare insurance through compulsory deductions to their wages (seven percent). As I mentioned earlier, for the purpose of this study I only focus on those covered by FONASA, who are, in their majority, users of the public system of health. In 2015, ninety-six percent of the population earning a monthly salary of $500,000 CLP (about $1000.00 CDN) or less was covered by FONASA. Indeed, the large majority of low-income people are covered by FONASA, including the majority of women. In 2014, eighty percent of all women were covered by FONASA (as compared to seventy percent of all men).

FONASA was created in 1979, during the military dictatorship. FONASA replaced the two existing public systems, the Servicio Nacional de Salud (SNS), created in 1952, and the

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Servicio Médico Nacional de Empleados (SERMENA) created in 1949. FONASA is a public system, funded through contributions from its users, totalling a seven percent deduction from users’ wages, as well as from portions of general taxes.\textsuperscript{185} FONASA is broken down into categories A, B, C, and D corresponding to income level, as shown in Table 4.1, with FONASA “A” users being from most vulnerable backgrounds. The category under which one falls determines how much is co-paid by the user for any given treatment (Table 4.1). People insured by FONASA generally use public hospitals and consultorios, and in some cases receive a discount at some private clinics, centers for ambulatory care, or laboratories that have a “convenio” (financial agreement), with FONASA.\textsuperscript{186} However, many gratuitous services, such as contraceptives, can only be accessed by FONASA users (regardless of level) in public facilities. The co-payment for FONASA members to use private facilities depends on the type of agreement (convenio) between FONASA and the establishment, and not on the category of FONASA coverage.\textsuperscript{187} There are three levels of convenios between FONASA and private facilities, with level 1 convenios providing the lowest prices and co-pay amounts.\textsuperscript{188} There are also a number of services that FONASA subsidizes within the private sector in order to offer its users access to private facilities. These are predetermined and offered at a flat rate to FONASA patients through the Programa Asociado a Diagnóstico (PAD) (Program Associated to Specific Diagnostics) and Programa Asociado a Emergencias (PAE) (Program

\textsuperscript{185} Castillo-Laborde et al. “Caracterización del gasto de bolsillo en salud en Chile”, 1456.
\textsuperscript{186} Fondo Nacional De Salud [CL], “Red Privada (Modalidad MLE)”
https://www.fonasa.cl/sites/fonasa/beneficiarios/informacion-general/red-privada
\textsuperscript{187} Fondo Nacional De Salud [CL], “Tramos y Co Pagos”
https://www.fonasa.cl/sites/fonasa/beneficiarios/informacion-general/tramos
\textsuperscript{188} Pricing varies considerably between procedures, but for example in the case of an “elective medical consultation” the co-pay amount would be as follows. Level 1- $3.730 CLP ($7.50 CDN); Level 2- $4.390 CLP ($9.00 CDN); Level 3- $6.090 CLP ($12.00 CDN). The particular price of these consultations, depending on facility, can run between $25.000 CLP ($50.00 CDN) to $47.000 CLP ($94.00 CDN). Lorena Leiva “¿Porque bajan los médicos de Fonasa en libre elección?, La Tercera, 17/04/2017
Associated to Emergencies).\(^{189}\) Therefore, due to these subsidies, services supported through PAD and PAE may be provided by private facilities to FONASA users. PAD includes, among others, treatments or procedures for abdominal hernias, cataracts, and childbirth. For example, through the program associated to birthing (PAD *Parto*) women can elect to give birth (natural or cesarean) in a voluntarily affiliated private facility for the flat rate of $263.290 CLP ($527.00 CDN), paid by the thirty-seventh week of pregnancy.\(^{190}\) However, FONASA “A” users are not eligible to use supplementary systems such as PAD and PAE.\(^{191}\)

Table 4.1\(^{192}\) FONASA Levels in Comparison to Income, Co-pay and User Base

<table>
<thead>
<tr>
<th>FONASA Level</th>
<th>Monthly Taxable Income</th>
<th>Co-Pay Amount</th>
<th>% of Users Based on Total Population (2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Non-contributor (Unemployed, retired, informal worker, etc)</td>
<td>0%</td>
<td>18.4%</td>
</tr>
<tr>
<td>B</td>
<td>&lt;$276.000 CLP (&lt;$552.00 CDN) -Public health employees</td>
<td>0%</td>
<td>26.5%</td>
</tr>
<tr>
<td>C</td>
<td>$276.001-402.960 CLP ($552.01-806.00 CDN)</td>
<td>10%</td>
<td>12.9%</td>
</tr>
<tr>
<td>D</td>
<td>&gt;402.961 CLP (&gt;806.01 CDN)</td>
<td>20%</td>
<td>17.4%</td>
</tr>
</tbody>
</table>

The fact that FONASA “A” users cannot use their healthcare insurance in the private system demonstrates the classist approach to health in Chile due to class-based segregation of services. Non-contributors are confined to a certain system of care, whereas those with the

\(^{189}\) Fondo Nacional De Salud [CL], “PAD” https://www.fonasa.cl/sites/fonasa/beneficiarios/coberturas/pad.
\(^{190}\) Fondo Nacional De Salud [CL], “PAD Parto” https://www.fonasa.cl/sites/fonasa/beneficiarios/coberturas/pad/prestaciones/09
\(^{191}\) Fondo Nacional De Salud [CL], “Programa PAD” https://www.fonasa.cl/sites/fonasa/beneficiarios/coberturas/pad
\(^{192}\) Fondo Nacional De Salud [CL], “Tramos y Co Pagos” https://www.fonasa.cl/sites/fonasa/beneficiarios/informacion-general/tramos

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63
financial resources to spend on healthcare have choice in which sort of “care” they would like to receive. Even throughout private facilities there is a gradient of both cost and perceived care through notions of hoteleria (hospitality). As argued by Castillo-Laborde et al. (2013), overall, FONASA users pay less in out of pocket expenses than ISAPRE users, regardless of the service.¹⁹³ Therefore, the fact that ISAPREs still hold a large amount of the market share (almost exclusively of clients from wealthier demographics), even when FONASA users can access many of the same facilities, is evidence of the stigma associated with public health insurance. Ideas of stigma associated with being a FONASA user are rooted in ideas of perceived poor quality of care based on stereotypes of public facilities being inadequate. Public system inadequacies are often expressed in terms of time; that one will die waiting to be attended. These ideas have become entrenched into contemporary society, oftentimes appearing in pop culture, and are also used as recruitment tools for ISAPRE representatives recruiting new clients.

Not only social class plays an important role in determining Chileans’ right to health insurance coverage. Gender is also a significant factor in accessing health insurance. At the beginning of the 21st century, women of reproductive age were paying up to three times more than men for the same health care in the private sector.¹⁹⁴ As said earlier, for ISAPREs the minimum monthly contribution is seven percent (like with FONASA), but private users can pay more than seven percent of their pay, especially for those who fall under the “risk factors” category.¹⁹⁵ These “risk factors” have a direct impact on women of reproductive age due to

¹⁹⁴ Mooney, 189.
¹⁹⁵ Castillo-Laborde et al. 1457.
the fact that the Pinochet dictatorship granted permission to private health care institutions to charge more for pregnancy related services.\textsuperscript{196}

Until 2010, women who had undergone hysterectomies were able to obtain health care coverage for a reduced rate, called “planes sin útero” (Plans for those with no uterus), which was an effect from the changes made in healthcare coverage under the military regime. However, women who were either infertile or did not wish to have children were refused a health plan at a reduced rate.\textsuperscript{197} In 2010, Constitutional Court Ruling 1710 included a ban on discrimination based on gender or age. It found that using charts to determine “risk factors” was unconstitutional given that applying the “risk factors” category obviously discriminated against women and the elderly. Since then plans such as the “planes sin útero” have been deemed unconstitutional.\textsuperscript{198}

Yet, ISAPREs still continue to sell discriminatory plans to women of reproductive age. For example, today, in lieu of “planes sin utero,” ISAPREs offer plans with “cobertura reducida en parto” (reduced birth coverage plans). Under these plans, women of reproductive age can choose to pay lower monthly premiums (lower in comparison to plans that include birth coverage, but not lower than plans for men). There are a variety of factors that can affect the price of ISAPRE premiums, including which ISAPRE one chooses, clinic of affiliation, as well as the age and gender of the user, and therefore, it is difficult to provide concrete values on cost. However, to provide context to my argument I will share the following two examples. I was quoted by two sales agent for two well known ISAPREs (Colmena & Banmédica) and given the following monthly premium values: Without reduced birth

\textsuperscript{196}Mooney, 189.
\textsuperscript{197}Ibid., 189.
\textsuperscript{198}Ibid.
coverage: $129,000/ $169,000 CLP ($258.00/$338.00 CDN); with reduced birth coverage: $86,000/$151,000 CLP ($172.00/$302.00 CDN); and for the equivalent plan for a man: $52,000/$56,000 CLP ($104.00/$112.00 CDN).

If a woman covered by a plan with “cobertura reducida en parto” becomes pregnant, only twenty-five percent of the birth costs (the stipulated lowest legal amount of coverage), is covered by her insurance.\textsuperscript{199} Therefore, if a woman elects an ISAPRE plan with reduced birth coverage, her monthly premium could potentially be less, but if she becomes pregnant, she will have to pay seventy-five percent of birth associated costs out of pocket. This is an important consideration to take into account given that a birth (natural or cesarean) in a private clinic in Chile can cost between $1 million and 7 million pesos ($2,000-14,000 CDN).\textsuperscript{200} As of 2014, plans with reduced birth coverage held 35 percent of the market share of all women of reproductive age buying private health insurances.\textsuperscript{201}

In the case of pregnancy prevention, ISAPRE patients may access contraceptives by scheduling an appointment with a doctor in a private facility where they are provided with a prescription for the agreed upon method of contraception, such as hormonal contraceptives (emergency contraceptives were included in this procedure until September 2015). With their prescription, they then go to the pharmacy of their choice to purchase their contraceptives. In 2017, the cost of contraceptive pills ranged from $3,000 to 10,000 CLP/month ($6.00-20.00 CDN). Since 2013, according to Decree 49 (Decreto 49), women with ISAPRE coverage may

\textsuperscript{199} Gabriela Sandoval, “El 20% de cotizantes de ISAPREs tiene un plan de coberatura reducido en parto” La Tercera, September 16, 2013
\textsuperscript{201} Oriana Fernandez & Gabriela Sandoval, “Afiliados con cobertura de parto reducida se duplican en isapres en ocho años,” La Tercera, June 24, 2014.
receive emergency contraceptives (but not regular contraceptives) for free in public hospitals and consultorios.

In conclusion, the majority of women are at a disadvantage when navigating healthcare services in Chile in a variety of ways. Women who choose to use private health insurance are discriminated against and pay more, in the form of higher premiums and out of pocket expenses. Being part of the private health insurance is also an indicator of class, a status symbol in a society where class differences are marketed in any possible way, and having access to a private health insurance is one of the indicators of belonging to a higher social class, which is reinforced by ideas of perceived “better” care. Therefore, ISAPREs will continue to generate huge profits while women pay three times more than men. However, women with FONASA (B,C,D) can also access some of the same facilities as ISAPRE users, generally at an overall lower price. They are, however, restricted in that not all private facilities have a convenio with FONASA, and furthermore, they carry some of the stigma of being part of FONASA. FONASA “A” users are the most disadvantaged, as they are limited to be cared for only within the public system, and carry the full stigma of being a FONASA user. As well, many gratuitous services, such as contraceptives, can only be accessed by FONASA users (regardless of level) in public facilities.

4.2 Bureaucracy and the Illusion of Contraceptive Accessibility in the Public System

When discussing notions of accessibility, it is important to have a holistic understanding of the term. As Hawthorne & Kwan (2013) argue, when discussing the accessibility of healthcare, both spatial and non-spatial factors need to be assessed. Spatial

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factors include factors such as distance to healthcare facilities and travelling times. Non-spatial factors include availability, meaning whether or not the population can adequately access a service due to cost, times (waiting times, as well as hours of attention), supply of medical professionals, as well as an individual's satisfaction with the services rendered. When examining public health in Iquique in regards to contraceptive accessibility, I pay attention to both spatial and non-spatial factors when assessing the actual availability of services within the lived reality of women from lower socioeconomic groups, especially in regards to distance, time and satisfaction

As previously mentioned, the public health system in Chile offers free contraceptives to FONASA users. However, gratuitous contraceptives are only available in Atención Primaria centres, i.e. consultorios. There are nine consultorios distributed throughout Iquique, which has a population of about 200,000. Out of these nine consultorios, only five are designated as family health centres (the others include two mental health facilities, a dental service facility, and a rehabilitation services facility) within the city, and they are generally open from 8:00-17:00 daily. It is also important to note that in order to use consultorio services, one must be registered at the consultorio that one plans to attend, and one can only be registered and attend the consultorio that corresponds with one’s address. When registering one must provide proof of address, generally via a utility bill in the users name. In the case that the user does not have any basic services registered in his or her name that coincides with their direction, it is the patient’s responsibility to provide documentation from the Neighbourhood Council (Junta de Vecinos) to prove residency, which can require the declaration of two witnesses in front of the council. (ChileAtiende, “Certificado de Residencia” https://www.chileatiende.gob.cl/fichas/37958-certificado-de-residencia)
4.2.1 Distance

The physical location of consultorios which offer family planning services present a problem as they are situated various kilometers from one another. In Iquique, there are a few different options of public transportation to reach any of these locations, as they are not within walking distance for many of the FONASA users. First, there are micros (public buses), which cost about $450 CLP ($1.00 CDN) per adult. Second, there are colectivos\(^\text{206}\) (shared taxis), which cost about $600 CLP ($1.20 CDN) per adult. Third, there are regular taxis, which are more expensive than colectivos; they generally start at about $2,000 CLP ($5.00 CDN) per trip.\(^\text{207,208}\)

To put transit prices into perspective in Iquique in 2018, a person working full time for minimum wage, (which in Chile is a forty-five hour work spread over five or six days a week) would spend an average of about $22,000 CLP ($44.00 CDN) a month for work related travel, which constitutes almost eight percent of their gross pay (ten percent of net pay).\(^\text{209,210}\) In Kelowna, British Columbia, unlimited monthly passes are available for $70.00 CDN,\(^\text{211}\) which

\(^{206}\) For those familiar with colectivos in other regions of Chile, Iquique colectivos differ in that they do not have “set routes” (similar to a bus route) like in other regions. Before getting into the colectivo in Iquique, one just asks the driver if they are able to take you to your destination. This system has both advantages and disadvantages, such as the flexibility of being dropped off right at your final destination like in a regular taxi. However, if you are going to an area that is out of the way, or a hassle to get to, many drivers will opt out of taking you as a passenger. As well, it can take longer to get to your destination because it is a shared taxi, and there are often detours for the other passengers getting dropped up and picked up along the way.\(^\text{207}\)

\(^{207}\) In Iquique, taxis do not use meters. Their tariff is agreed upon between the driver and the passenger before getting into the taxi.\(^\text{208}\)

\(^{208}\) In 2017, Santiago, public transportation costs on average the following: micro $660 CLP ($1.25 CDN), metro $760 CLP ($1.55 CDN), colectivos $700 CLP ($1.40 CDN) and taxis are metered, starting at $330 CLP ($0.80 CDN) and goes up in increments of about $200 CLP ($0.40 CDN).\(^\text{209}\)

\(^{209}\) Based off of the current Chilean minimum wage, gross $270,000 CLP ($540.00 CDN), net $216,000 CLP ($435.00 CDN).\(^\text{210}\)

\(^{210}\) In Santiago the cost of public transportation for work travel increases to about $40,000 ($80.00 CDN) a month, which is 15 percent of their gross pay (18 percent of net pay).\(^\text{211}\)

\(^{211}\) BC Transit, “Fares” https://bctransit.com/kelowna/fares
would constitute to about four percent of gross minimum wage (based on a five day, regular forty hour work week).

4.2.2 Time

When arriving to public health care centres, one generally has to endure long waiting periods. As argued by Auyero (2011) in his work on welfare centres in Argentina, the act of waiting required to receive services by the state represents the way in which the state reaffirms its dominance over its recipients. Auyero refers to this system of subordination of welfare recipients, and their relation to the state, as the “patient model”. As Auyero describes, “[t]his subordination is created and re-created through innumerable acts of waiting (the obverse is equally true, domination is generated anew by making others wait).”

Although the work of Auyero is centred on the welfare office, his participants drew parallels between the act of waiting in the welfare system and public health. Within the Chilean context, the “patient model” can be seen within the public health context among many others. It is common knowledge that accessing healthcare in the public system in Chile is slow. There are generally long waiting periods and queues, and many services require more than one visit or appointment due to extensive bureaucratic processes. As discussed in the previous section, the majority of women routinely accessing services in public health facilities are generally the most vulnerable, in particular those with FONASA “A” coverage. As mentioned above, FONASA “A” patients do not have the means to pay market prices and are not covered for subsidies to use private healthcare facilities, and therefore, must always be attended in these

213 Ibid.
215 Ibid., 18, 21, 23.
slow moving public health care centres. *Consultorios*, such as the one in which I conducted my research, are generally composed of a large waiting room with rows of plastic chairs, and many times there is not enough seating for everyone. They tend to have harsh fluorescent lighting, and many buildings are quite old, and not well maintained. When a patient is called into the examining room, the *box*, it is not a separate room, but one of many partitioned cubicle type structures. Each *box* contains a small examination table; personal privacy is not a priority. In turn, private clinics generally have more comfortable waiting rooms with adequate furniture and soft lighting. They have nice examination rooms, and are, generally, well maintained.

### 4.2.3 Satisfaction

Not only are the most vulnerable forced to wait longer, but there is also a perceived substandard quality of care. For example, free hormonal birth control pills distributed in *consultorios* are perceived to be of less quality than those bought with a prescription in the pharmacy. As pharmacist Tomás puts it,

> There is a system in the *consultorios* to give gratuitous contraceptives, but the majority of women complain and do not use them for the fact that, well, except for those that *really* can’t spend money on contraceptives, they complain that they make them gain a lot of weight. And really, through personal experience with friends… I saw a noticeable weight change… even though it is not listed in the literature as a common side effect, it really is. Unfortunately the most expensive ones are the
best… they have the contraceptive effects without the weight change effects… and that’s why it is necessary to do a good hormonal profile of the patient.  

Although the correlations between the contraceptive pills offered by consultorios and gaining weight are admitted to being anecdotal at best, this type of perceived substandardness perpetuates feelings of an inadequate and discriminatory system which is to be only used by the poor. Furthermore, Tomás’ comment reinforces not only a classist approach to women’s contraception options (“most expensive are best”), but also the need of surveillance and medical control over women’s bodies (need for “hormonal profiles”).

Satisfaction, perceived quality of care, and stigma associated with using public health facilities are closely linked to time constraints. Those insured by FONASA using public consultorios are generally made to complete long bureaucratic processes and wait-times in order to receive care. These processes reinforce the “patient model”, where those who are in need of free services, must first be subjected to domination techniques (by medical professionals, justified by the authority of biomedicine) to reinforce their subordination (therefore reaffirming their status as “nobodies”). For example, to receive gratuitous contraceptives in consultorios the process generally includes:

a) scheduling an appointment to meet with a matrona (often done in person early in the morning).

b) an initial forty five minutes appointment with a matrona to decide on a birth control method. This appointment includes: i) Basic personal information including: name, schooling

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216 Tomás Interview, 2015, translation mine.
level, marital status, birthdate, age, RUT, address, employment. ii) Medical history of family members, self and sexual partners, as well as of any substance addictions or use (tobacco, alcohol, drugs). iii) Sexual history, including gynecological history, number of sexual partners and types of relationships, history of contraceptive use or hormonal treatments, etc. iv) Identifying pre-existing medical factors or dysfunctions v) Physical examinations, including: weight, height, breast exam (only if protocol dictates), vi) Gynecological exam including PAP exam, vii) Laboratory samples (blood) for HIV and STI testing.

c) an appointment for the initiation of the method (which is generally on the first day of the patient's next menstrual cycle).

d) thirty minute appointments for refills and control (recheck) appointments (with frequency depending on the duration of use, and contraceptive method chosen). This appointment can include: i) Evaluations of sexual conduct, as well as evaluations of “psychosocial risks”, ii) general physical exam iii) gynecological exam iv) education on current contraceptive method, HIV and STI prevention.

The fact that multiple appointments may be needed in order to receive contraceptives is especially problematic for women with young children, and working women. As Han (2012) argues, many women living in marginalized situations often work domestic type jobs

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218 One’s “RUT” (Rol Único Tributario) is the number found on their identity card (Cedula de Identidad), and is one’s main piece of identification. A “RUT” number is assigned just after birth during registration at the Civil Registry, or in the case of foreigners, when one gains legal status in the country. This number is critical for almost any type of transaction in Chile from personal taxes, to opening a bank account, to using health services, to buying or renting almost anything of value (it is linked to one’s credit score through DICOM), to collecting reward points at their local supermarket.
that require longer hours than other jobs, and offer less than minimum wage.\textsuperscript{219} Many domestic type jobs are also without contract, which leaves these workers with very few rights, or job security.\textsuperscript{220} Therefore, women with this type of employment are even more disadvantaged when trying to use health services, especially if needing to take time away from work. Even for women with non-domestic employment, the average workweek in Chile is 45 hours a week, with a six-day workweek.\textsuperscript{221} This would mean missing at least one day’s work, most likely without pay, if permission is granted, or the risk of losing one’s job in order to receive “free” contraceptives.

The bureaucratic barriers described above affecting access to public health due to time constraints, were not quick to surface during my interviews with health care professionals or users of the health care system. Even though some participants admitted to not be using contraceptives, or not going to their “control” appointments, the correlation between barriers to accessibility and women’s inaction rarely surfaced. Only during one interview, the interview with Catalina, did she recognize a correlation between time constraints in consultorios and unwanted pregnancies, while other interviewees only addressed the topic covertly. The lack of recognition behind time constraints ties into Auyero’s (2011) ideas of the “patient model”, where disciplining and dominance reinforced through prolonged waiting

\textsuperscript{219} Clara Han, Life in Debt: Times of Care and Violence in Neoliberal Chile, (Los Angeles: University of California Press, 2012, 61.
\textsuperscript{220} In this case being “without contract” refers to being employed outside of Chilean Labour Code. Even though, legally, these domestic workers could go to the Chilean Labour Board (Inspección de Trabajo) and file a complaint, which would most likely result in their employer being fined as legally you must contract a worker within 15 days of the hiring date, this information is largely overlooked and/or unknown, notwithstanding the fact that the job of the individual would be put in jeopardy.
\textsuperscript{221} Gobierno de Chile: Dirección del Trabajo “Cuales son los límites que la ley establece para la jornada de trabajo” http://www.dt.gob.cl/consultas/1613/w3-article-60058.html
becomes normalized and no longer recognized as a bureaucratic controlling mechanism.\textsuperscript{222} When I asked Catalina about contraceptive accessibility, she replied,

Yes, in fact they are free in the consultorios… and well, not all women are responsible and make time to go… so they end up pregnant… I think that it’s due to neglectfulness; neglecting oneself… sometimes people do not want to deal with it because maybe they are worried about something else.

In the above statement, Catalina makes a point about women not making time to go to the consultorio to get contraceptives or a checkup; even more importantly, the reason she gave for women to not seek out contraceptives was their irresponsibility; but she also hints at the fact that other factors may prevent women from being responsible towards their fertility, “because maybe they are worried about something else”. I will address the perception of women’s lack of responsibility, or better said, the blaming of an individual for a societal and institutional problem later on, in Chapter 5.

Up until now I have mainly focused on bureaucratic barriers to female contraceptives, however, accessibility to contraceptives for men, such as condoms, also need to be addressed. Condom use in Chile is not very high. According to the Encuesta Nacional de Salud 2016-2017, only ten percent of sexually active persons answered to using condoms “always”, while fifty-two percent answered to using condoms “never”.\textsuperscript{223} Condoms are available in consultorios. They are free of charge, but restricted to a limited number of condoms per person, and are subject to an appointment with a matrona, which corresponds with the patient model discussed earlier, that control through subordination must be reinforced. As of 2012,

\textsuperscript{222} Javier Auyero, “Patients of the State: An Ethnographic Account of Poor People’s Waiting,” Latin American Research Review 1 (46, 2011).

men accessing these family planning services in *consultorios* were only fifteen percent of the total male population.\footnote{224} In other words, men received less than one percent of all contraceptive methods administered in the public system.\footnote{225} Vasectomies are another form of male contraception offered in the public health system, but they are not often used. In fact, in 2012, in Chile, only twenty-six vasectomies were performed (in comparison to 16,752 tubal ligations in the same year).\footnote{226} In 2017, the number of vasectomies performed in Chile had increased to 269, while tubal ligations still accounted for almost ninety-seven percent of all permanent contraceptive procedures.\footnote{227} These statistics not only reaffirm that reproduction as highly feminized in Chile, but also demonstrate that men are able to avoid bureaucratic procedures by simply refusing to participate.

More so, condoms are not generally available to women receiving other forms of contraceptives, such as birth control pills, which do not protect from STIs. Furthermore as Josefina, a nurse in a *consultorio*, pointed out, quite often there is not enough supply of condoms in the *consultorios* to respond to the demand. These techniques of not supplying women with multiple forms of birth control while reducing the availability of condoms is an implicit form of sexual control. Working class women (many of whom do not have the purchasing power to buy condoms in pharmacies) are denied autonomy over their own sexuality which translates into institutional medicalized pressures reinforcing feminine monogamy or abstinence.

\footnote{224} Ministerio de Salud de Chile, *Normas Nacionales Sobre Regulacion de la Fertilidad*, 2014, 177. \footnote{225} Ibid. \footnote{226} Ibid., 178. \footnote{227} El Desconcierto. “Infografía: Más de 6,700 mujeres se han ligado las trompas este año mientras que solo 264 hombres se han vasectomizado.” September 12, 2018.
Their accessibility is furthermore restricted due to the scheduling times in consultorios, as previously discussed. Through these mechanisms, including bureaucratic hurdles and insufficient supply of condoms in public health facilities, men’s lack of responsibility in reproduction is legitimized and reinforced. Outside of the public health system, condoms are also readily available; they are available to purchase in various venues, such as supermarkets, gas stations, pharmacies, and even vending machines located in some neighbourhoods. However, the price of condoms varies from $500 CLP ($1.00 CDN) per condom in vending machines, to a price that ranges from $1.500 to $4.000 CLP (from $3.00 to $8.00 CLP) for a box of three in supermarkets. When comparing these prices with minimum wage of $270.000 CLP gross, or $216.000 CLP net, it is reasonable to say that they are out of the reach of many as a routine form of birth control.

In conclusion, through bureaucratic barriers, reflected, among other conditions, in long waiting times, routine contraceptives are not always within the reach of many, and especially of those forced to attend public facilities. Furthermore, due to low participation of men in seeking out birth controls methods, reproduction remains highly feminized.

4.3 Emergency Contraceptives

When a reliable birth control method is not implemented, or said method fails, there also exists the possibility to seek out emergency contraceptives gratuitously in public health facilities. In Chile, emergency contraceptives share a long controversial history. Emergency contraceptives first came available in Chile in 2001, to rape victims. A few years later, in 2004, emergency contraceptives were included, free of charge, as part of the treatment protocol for sexual abuse victims, which triggered an oppositional response from the Catholic
Church. By 2006, the government of the newly elected president Michelle Bachelet, member of the Socialist Party and representing the Concertación de Partidos por la Democracia, tried to implement free access to emergency contraceptives for any woman who needed it, but this led to court action from the opposition. The conservative opposition, backed by the Catholic Church, then took the issue to the Constitutional Court (an ultra-conservative institution implemented during the dictatorship via the 1980 Constitution). The opposition argued not only that emergency contraceptives were unconstitutional due to their “abortive effects”; the use of IUDs and adolescent contraceptives were also part of the opposition’s court challenge. In 2008 the Constitutional Court banned emergency contraceptives on the premise that they were unconstitutional, but threw out the complaint about IUDs and other contraceptives. In 2010, after a fierce debate, the drug was again legalized by law 20.418, but not so far as allowing unrestricted distribution. As of 2013, Decreto N° 49, implemented by the rightist government of President Sebastian Piñera of the Alianza Por Chile coalition, mandated that emergency contraceptives were to be provided, free of charge, in consultorios and public hospitals, including to girls under the age of fourteen.

Until September 2015 a prescription was needed for emergency contraception pills. However, in that year, the recently re-elected Bachelet government did away with this requirement. Prior to September 2015, emergency contraceptives cost on average of $8.000

228 Lidia Casas “Invoking conscientious objection in reproductive health care” Reproductive Health Matters no. 17 (34, 2009), 82.
229 Karen Longenecker “Sex and the Church”. (MA diss, University of California, San Diego, 2010), 62.
230 Casas “Invoking conscientious objection”, 82.
231 Longenecker. “Sex and the Church”, 62.
232 With the Decreto N° 49, emergency contraceptives are mandated to be given to girls under the age of 14, however, after the fact medical professionals are obligated to inform a parent, guardian or adult over 18 years.
CLP ($16.00 CDN) in pharmacies. After the prescription requirement was eliminated, pharmacy prices increased to $15,000-16,000 CLP ($30.00-32.00 CDN) with no real justification for this price change.

Although the stigma related to the emergency contraceptive pill and, more importantly, whether or not it could be considered as “abortive”, have subsided, there is still a tendency to label women who use this free service as “irresponsible”. This stems from the fact that many users of emergency contraception are not regularly using contraceptives, and are thought of only searching out the service after having a “one night stand” after a “night out”. The medical professionals and the women I interviewed shared the belief that the use of emergency contraceptives was linked to women’s “irresponsibility”. Women who seek out emergency contraceptives repeatedly are further seen as “abusing the system”.

Free emergency contraceptives are provided in an “emergency” setting. As Maria, a matrona in a public hospital explains,

> Well, when the matrona gives the pill, they tell them how it is, and how it is taken, but not more than that. We only offer it in the Emergency Room, and therefore there isn't time to educate them. That’s why there is atención primaria in the consultorios, to do all of the education about contraceptives. We just give them the pill in the case of an emergency and we do not have a lot of time…

This means that the bureaucratic barriers surrounding access to regular contraceptives are not present when getting emergency contraceptives. Women do not have the opportunity to start a routine contraceptive plan at the same time. Therefore, there is a relative simplicity in receiving emergency contraceptives in comparison to regular contraceptives, which has left a

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233 Interview with Maria (matrona), 2015, translation mine.
gap where some women choose to avoid unwanted pregnancies and bypass bureaucratic hurdles by only using emergency contraceptives when necessary. However, bypassing the steps necessary to be on a regular contraceptive method is then interpreted as “abusing” the system. As Catalina states,

> I think that [emergency contraceptives] are still… are still controversial. You know what happens? Sometimes the person, I believe, takes advantage of the pills because they aren’t on birth control and every time that they have [sexual] relations, they go to Emergency to get the pill instead of having a regular birth control…Again, it happens because they do not make time to go to the consultorios, they just [go] to the ER to get the pill.\(^{234}\)

Another issue with emergency contraceptives is that many women are not clear on how or where to get the drugs. With several legislation changes spanning over almost two decades, misinformation is common, which has also led to a black market for emergency contraceptives. For example, as previously stated, according to Decreto 49 emergency contraceptives have to be distributed to anyone who solicits it, including girls under the age of 14. However, when asking about age restrictions with emergency contraceptives matrona Maria of the public hospital told me that,

> I guess that after they are 14 you have to give them [emergency contraceptives] and younger than that, the parents have to request it.\(^{235}\)

Staff members in a public health facility should be absolutely clear on protocol for emergency contraceptives; as this interview with matrona Maria shows, there is still confusion, or even

\(^{234}\) Interview with Catalina, 2015, translation mine.

\(^{235}\) Interview with Maria (matrona), 2015, translation mine.
resistance, to accept the mandate of the decree. As well, women such as Mercedes were also unclear on emergency contraceptive protocol,

The only thing that they do not want to give you right, right away, and they do a bit of an investigation, is with the morning after pill… they do not give you it so easy… it’s because they say that its abortive and others say that it’s not, so there is a conflict in debate. That’s why it takes more to get them to give it to you.\textsuperscript{236}

Mercedes touches on an important issue within public health. When women are already in a precarious situation (needing emergency contraceptives), matronas have the power to exacerbate the situation by conducting an “investigation” to determine if they will subject the patient to the risk of an unwanted pregnancy or not. The power and dominance held over women using this system is linked back to bureaucratic procedures, and the fact that systemically, medical professionals have been conditioned to discipline instead of heal.\textsuperscript{237}

Through ideas of discipline, medical professionals in the public system are alienated from their patients, lacking empathy for the “nobodies” they treat, and even less so for deviant, or sexually promiscuous “nobodies”. These notions of discipline and domination may also explain why reliable information regarding emergency contraceptives is not well distributed. Women do not demand better information due to their subordinate position, as well as because of the stigma surrounding the need for emergency contraception. Furthermore, staff members who deal with distributing these drugs often do not bother to be well versed in

\textsuperscript{236} Interview with Mercedes 2015, translation mine.
\textsuperscript{237} Ricardo Trumper & Lynne Phillips, “Give Me Discipline and Give Me Death” Race & Class no.3 (37, 1996), 27.
current legislation (or choose to selectively ignore changes in legislation), as the responsibility is shifted to the user of the system, as will be further discussed in Chapter 5.

In conclusion, emergency contraceptives are available gratuitously within the public health system. Women who take advantage of these services are often thought as being “irresponsible” and repeat users are considered to be “abusing the system”. Although the emergency contraceptive system allows women access to these drugs without having to go through the same bureaucratic processes required for regular contraceptives, it prevents women from accessing a regular contraceptive program at the same time. In other words, the system is not designed to facilitate access to a regular contraceptive program at the time of receiving emergency contraceptives, which ties into ideas of individual responsibility, as discussed in the following chapter.

A public health system characterized by extensive, all-encompassing bureaucratic procedures, including normalizing “waiting”, results in that accessibility to contraceptives differs widely among social classes in Chile, with the most vulnerable becoming “patients of the State”. Accessing contraceptives in pharmacies, which cuts through the waiting time factor extensively, are expensive and out of the reach of many. Therefore it is imperative to reevaluate the shortcomings of the current system in place, and make real accessibility an essential factor. This would include deconstructing processes based on the systematic disciplining, control and regulation of women’s bodies by having simpler and less time consuming procedures in consultorios, or make the government-subsidized contraceptives available in pharmacies to aid in reducing bureaucratic process. For the reasons discussed in

this chapter, it is understandable why women, and especially working women and women living in marginalized situations, would choose the route of emergency contraceptives instead of being on a regular contraceptive schedule. This is not a simple or easy choice, especially when, even in the case of seeking regular contraceptives, the *matrona* holds to power as to decide if the patient is deserving or not of receiving contraceptives, including as to which type. When women go to the public hospital to seek emergency contraceptives, they are stigmatized as “abusing the system,” and not given any additional information. For this reason I would recommend a sharing of information between hospitals and *consultorios* to help bridge the gap between emergency and regular contraceptive use. An example would be the ability for women to schedule a regular contraceptive *consultorio* appointment during the emergency contraceptive consult. As well, at the time of requesting an emergency contraceptive, women would receive pamphlets with basic information about all contraceptive options and procedures along with *consultorio* locations and hours. Bridging the gap between these two public health institutions would benefit women who are sexually active and want to control their fertility.
Chapter 5: Neoliberalism, Responsibility & Reproduction

The other day while walking by a bank in Santiago, I saw advertisements for personal loans posted in the windows. I couldn’t believe the interest rates; being advertised as “exclusive special offers” were interest rates between 20-25%. How did the economic system become so deregulated? Privatized water, privatized highways, privatized electricity... all generating huge profits for international companies at the expense of Chileans. Low wages, 19% sales tax, and underfunded social programs. Neoliberalism at its finest.

What is the function of this generalization of the ‘enterprise’ form?... [I]t involves extending the economic model of supply and demand and of investment costs-profit so as to make it a model of social relations and of existence itself, a form of relationship of the individual to himself, time, those around him, the group, and the family. (Foucault 2004/2008: 242. In Jim McGuigan, “The Neoliberal Self”, Culture Unbound, vol.6, 2014, 229)

In the previous chapter I argue that bureaucratic procedures reduce the accessibility of contraceptives within the public health system. However, when speaking with the participants in my study, both medical professionals and local women, there was a tendency to overlook problems of access within the system, and rather, to put the blame and responsibility on the individual using the system. In this chapter I argue that neoliberal ideologies and policies introduced in Chile during the dictatorship have reinforced reproductive responsibility as a woman’s duty, and furthermore, that individualistic reproductive responsibility has become incorporated into Chilean culture, as a manner to discipline, in particular, marginalized
women. At the same time, neoliberal economics has added to the economic apartheid that characterize Chilean society as women who have the means to access contraception privately can avoid some of the barriers experienced by those who must resort to the public system.

5.1 Neoliberalism in Chile

The implementation of neoliberal economic policies in Chile took place in the late 1970s, during the dictatorship. This new system, neoliberalism, was expected to stimulate economic growth for the country through a shift of power from the state to the market, and endorsed trade deregulation in an effort to make the country attractive to foreign investors. Beginning in 1956, the University of Chicago and the Universidad Católica de Chile made an agreement to send graduates from the School of Economics to complete graduate studies at the University of Chicago. Similar agreements were made with other Latin American countries, for example, Brazil. Harvey (2005) argues that these agreements were a strategy by the USA to combat leftist ideologies in Latin America during the time of the Cold War. These young economists, known as the “Chicago Boys,” were taught neoliberal theories under Milton Friedman and Arnold Harberger, among others. These students brought back with them new ultra-rightist ideologies and economic approaches.

After the coup d’état, dictator Pinochet appointed “Chicago Boy” graduate, Sergio de Castro, as the Minister of Economy and then as Minister of Finance. Other examples of “Chicago Boys” with significant participation during the dictatorship were Pablo Baraona, who was President of the Central Bank and Ministry of Economy, and Miguel Kast, Head of

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240 Harvey, *Brief History of Neoliberalism*, 7.
241 Ibid.
242 Ibid., 8. 
ODEPLAN and Ministry of Labour.\textsuperscript{243} Once in government, the “Chicago Boys” worked to implement a new political and economic system within Chile.\textsuperscript{244} By 1980 the regime consolidated neoliberalism under the guide of a Harvard trained economist, José Piñera. As Minister of Labour, Piñera implemented the \textit{Plan Laboral} and was the architect of the privatization of pensions, education and health.\textsuperscript{245} This included the formation of the privatized, for profit, pension funds (AFPs), the incorporation of a multitiered health insurance systems (FONASA and ISAPREs), and segregated education. These radical changes were known as the “\textit{siete modernizaciones}” (seven modernizations). These policies of reduce social spending, and therefore, the growth of the private system, disproportionately affected persons from lower socioeconomic groups.\textsuperscript{246}

As argued by Trumper & Phillips (1996), neoliberal ideologies are an effective tool for disciplining bodies, especially the bodies of people living poverty, removing responsibility away from government and back onto the individual.\textsuperscript{247} Clark (2013) argues that neoliberalism has also increased the opportunity for women to be part of the workforce, which, in turn, contributes to their economic independence.\textsuperscript{248} More so, she argues that the neoliberal system requires women’s labour to support it, both socially and economically.\textsuperscript{249} However, Clark also explains that with neoliberal capitalism, most of these jobs are

\begin{thebibliography}{99}
\bibitem{244} Harvey, 8.
\bibitem{247} Ricardo Trumper, & Lynne Phillips. “Give Me Discipline and Give Me Death: Neoliberalism and Health in Chile.” \textit{Race & Class} no.3 (37, 1996) 19-34.
\bibitem{248} Clark, \textit{Victims of Time, Warriors for Change}, 13-14.
\bibitem{249} Ibid., 14.
\end{thebibliography}
underpaid, hold little job security or upward mobility, and are often exploitative. This is further demonstrated by the fact that in 2015, seventy-four percent of all women workers’ monthly net earnings was less than $350,000 CLP ($700.00 CDN), and only three percent of women workers earned a monthly wage of over $1,000,000 CLP ($2,000.00 CDN).

Within the realm of reproductive choice, neoliberal ideologies have had an impact in a variety of ways. First, it locates the responsibility away from the institutions of the state, which results in lowered social spending, especially in the realm of health and education, which in the past were, in important ways, the responsibility of the state. In Chile, these cuts were especially apparent in the public health system and health policy. Second, neoliberalism focuses the responsibility on the individual. For example, promoting notions such as “cuidarse” or “ser responsable”, as I will discuss below, became important aspects of the jargon in the public healthcare system, in order to discipline women within the realm of reproduction.

In the case of reproduction, women are seen as solely responsible for their own reproductive functions. Feminized notions of reproductive responsibilities in Chile can be linked to religious teachings through the concept of marianismo. As argued by Herrera Rodriguez (2009), marianismo is centred through the Virgin Mary ideal, where women are conditioned to act as martyrs, or at least sacrifice their own desires and interests, in order to better serve others. In the realm of reproductive responsibility, although women are

250 Ibid.
251 Carla Brega, Gonzalo Durán & Benjamin Saez, “Mujeres Trabajando,” Fundación Sol (2015), 16-17
253 Rotarou & Sekellariou,”Neoliberal Reforms in Health Systems and the Contractions of Long-Lasting Inequalities in Health Care: A Case Study from Chile,” 498.
deviating from the chastity aspect of the Virgin Mary ideal (especially in the case of single women), and are participating in sexual activity outside the purview of marriage and reproduction, they are still withheld within the whore/saint dichotomy, which has been replaced with the jargon of *irresponsible/responsible* and moved (while re-legitimizing itself) into the domain of medicalization.

Therefore, due to feminized notions of reproduction through individual responsibility it is assumed that a woman can *choose*\(^\text{255}\) whether or not to use contraceptives to control her fertility. This is despite the fact that, as discussed in Chapter 4, women who need to rely on publicly funded facilities to access health services are often at a disadvantage due to bureaucratic constraints. Through neoliberal policies, these disadvantages are moot, because through the discourse of the free market, being poor or having to use publicly funded health facilities is a matter of free choice, not a question of circumstances beyond one’s control. This is precisely the reason why when a woman experiences an issue, such as an unwanted pregnancy, she is labeled “*irresponsible*”, as a form of victim blaming instead of critically evaluating the current systems in place and the obvious disadvantages to impoverished individuals. This is also why women living in poverty are up to five times more likely to experience a pregnancy during adolescent years than women from well to do families.\(^\text{256}\) Obviously in such a system, questions of class are exacerbated by gender.

\(^{255}\) The shift in responsibility away from institutions and onto the individual is reinforced through neoliberal ideologies which is seen, for example, in the “meritocracy” illusion component of neoliberalism. As Wilson (2018) argues, ideas of meritocracy are vital to the success of neoliberal ideologies as they reinforce ideas of personal responsibility and competition through notions of “personal empowerment” and “freedom of choice”. Julie Wilson, *Neoliberalism* (New York: Routledge, 2018), 100-101.

\(^{256}\) Casas & Ahumada, “Teenage Sexuality and Rights in Chile: From Denial to Punishment,” *Reproductive Health Matters* 17 (34, 2009), 88.
5.2 Una Tiene que Cuidarse

Reproductive responsibility has historically been left largely to women, with Chile being no exception. Avoiding unwanted pregnancies, child spacing, child rearing are all stereotypical women’s tasks, reinforced through notions of religious ideologies (such as marianismo) and, more recently, medicalization. In the case of an unwanted pregnancy, it is often only the woman that is labeled as “irresponsible” and stigmatized. Indeed, a woman is systematically blamed for having an unwanted pregnancy and for being “irresponsible”. Within all of my interviews, including both health professionals and women, the topic of “responsibility” appeared frequently. The entrenched discourse is that for a woman to be “responsible” she needs to “cuidarse”. Or in other words, for a woman to be a valued member of society (responsible) she needs to control her sexuality (cuidarse) by either using contraceptives or abstaining from sex. I must point out that the responsibility to “cuidarse” is generally only put onto women; it is not expected to be a man’s responsibility, nor a shared responsibility. Indeed, the topic of men’s responsibility on questions of reproduction does not often enter the conversation. Data showing that men receive less than one percent of the total contraceptive services within public health facilities, as discussed in the previous chapter, corroborates the gendered condition of reproduction.

258 Herrera, El aborto inducido, 85-86.
259 Reissman, 60.
259 “En los años 2011 y 2012, los hombres en Chile recibieron menos del 1% (0,67 y 0,71% respectivamente) del total de métodos anticonceptivos administrados en el sistema público de salud (condones).” Ministerio de Salud de Chile, Normas nacionales sobre regulación de la fertilidad, 2014 ,177.
When looking at the expectations and restrictions put on working class women within the realm of reproduction, it becomes clear that she is expected to have intrinsic knowledge of her duties of being responsible, with very limited support or resources. Yet, there is a huge vacuum in information and resources on matters related to women’s control of fertility, such as sex education (Chapter 7) and access to reproductive services (Chapter 4). During my interviews, the term “cuidarse”, literally meaning “to take care of oneself”, was regularly brought up. For women “cuidarse” in practice means the need to use contraceptives, the need to safeguard oneself from STIs, the need to limit the number of sexual partners, and even the need to abstain from sex. Responsible women know how to “cuidarse”; limiting the number of sexual partners, which in turn (should) reduce the chance of contracting an STI. Women take emergency contraceptives or have unwanted pregnancies because “no se cuidan”. Under the logics/discourse of neoliberalism, the notion of “cuidarse” ties directly with the concept of individual responsibility. In fact, it has been conditioned into young women that the responsibility of an unwanted pregnancy is, exclusively, a women’s issue. Women believe, and have been shown repeatedly, that they are solely responsible for not getting pregnant.

Moreover, although more and more it is recognized in Chile that the labour involved in child-rearing should be the shared responsibility of both parents, oftentimes, women continue to be the main care providers. Many of the women participants accepted this as the norm. In order to justify the feminization of reproduction and childcare, stereotypes stemming

260 In June of 2013, Law 20.680 was modified to include that the wellbeing of children is “based on the principle of co-responsibility, in the virtue that both parents, whether living together or separated, participate in a permanent, equal and active form in the upbringing and education of their children.” (Introduce Modificaciones al Código Civil y a Otros Cuerpos Legales, Con el Objeto de Proteger la Integridad del Menor en Caso de que sus Padres Vivan Separados, Ley 20.680, 2013, translation mine).
from long standing *machista* ideologies\textsuperscript{261}, and reinforced by public policy (such as the “Mother-Child” unit promoted in the early twentieth century)\textsuperscript{262} which then manifests in statements such as “women mature faster than men,” reaffirm that by *nature* the majority of the responsibility of reproduction falls onto women. This leads back to ideas of *marianismo*, that sacrifice and feminized reproductive responsibility become natural phenomena manifested by “fate”, reinforces itself into internalized stereotypes. For example Cynthia stated,

Motherhood comes when it has to come, when it's one’s turn, for women I think that it's easier, because women mature faster than men.\textsuperscript{263}

In Cynthia’s statement, she very clearly demonstrates the ideology that women are the primary caregivers due to their nature. Furthermore, her position reflects ideas of *marianismo*, i.e., that women should take on the role because it is *easier* for her than for him (self-sacrifice). During my interviews I found evidence of this fact. For example, two of the interviewees, Ramona and Catalina, whose parents are separated, only received some financial help from their fathers. At the time of her interview, Ramona only received $50.000 CLP ($100.00 CDN) a month\textsuperscript{264} to go towards her studies, food, clothing, and other expenses. Both women were in their early twenties, students living at home, and not employed. Their mothers are the primary providers for them and their siblings. As Ramona states,

\[\text{\footnotesize 261} \text{ Susana Herrera Rodriguez. } El \text{ aborto inducido: } \text{¿Víctimas o victimarias?} \text{(Santiago:Catalonia, 2004), 47.}\]
\[\text{\footnotesize 262} \text{ Alejandra Peña et al. } “Ruling the Womb,”147-148.}\]
\[\text{\footnotesize 263} \text{ Cynthia Interview, 2015, translation mine.}\]
\[\text{\footnotesize 264} \text{ At this time minimum wage was $260.000 CLP ($520.00 CDN). The costs of living is comparable, in many aspects, to living in Canada.}\]
In my case, [the childcare responsibility] fell one hundred percent on my mom…

She separated from my dad when I was… I’m the eldest child, and I was fifteen, and my siblings were younger, and she took care of us one hundred percent. It’s heavy, it’s hard, it’s also discriminated against by much of society...

Ramona, in her statement, makes the point that not only are women expected to be the primary care providers, they are also discriminated against for the very same reasons. Meanwhile, it is accepted that men negate their childcare responsibilities.

As Paola explains it,

Here in Chile, the men disappear. When a man realizes that the baby is his, the mother can demand child support, but they never recognize the baby… I have seen many girls stop studying to go to work from having a baby. And the baby gets looked after by the girls’ moms and the guy just continues with his normal life….

The fact that men can (and do) “disappear”, or negate their responsibility in the case of pregnancies outside of wedlock, further reaffirms the discourse that by nature the care of children is a woman’s responsibility, which further liberates men from being held accountable in a vicious cycle. Therefore, neoliberal individual responsibility is transformed by gender. However, this does not mean that there are not men who do share in the responsibilities of reproduction, but within my interviews with women, they were viewed as the exception and

265 Paola Interview, 2015, translation mine.
266 There are paternity laws in Chile, but to sue a person for child support one needs to have them on the birth certificate, have their current address, and they have to accept the letter. Child support amounts vary widely depending on the financial situation of the person being sued, and if they have other children from other relationships. (Modifica el Código Civil y Otros Cuerpos Legales en Materia de Filación, Ley 19.585(1998)).
not the norm. For example, Cynthia admits that her situation is the exception; she and her partner have a four year old son, of whom they share childcare responsibilities.

In my case, both [share the responsibility]. But ya, I believe that the situation today in society is that the baby stays with the mom. In the majority of cases, it’s the woman who has the most responsibility, but in my case, personally, it’s both of us. We both share the responsibility for our child.267

Outside of the bureaucratic hurdles discussed in Chapter 4, women accessing contraceptives in the public sector also encounter other obstacles, which are reinforced by both neoliberalism and medicalization. For example, as previously discussed through a neoliberal framework, reproductive responsibility is a gendered and individualized issue; the responsibility falls basically on the woman. Furthermore, since reproduction and women’s bodies have been moved to the medical sphere, women face distinct challenges via the medicalization framework. Hormonal contraceptives and IUDs are a medical devices legitimized through medicalization.268 Health professionals have their authority legitimized also through medicalization.269 Therefore, although women are expected to be “responsable” and expected to “cuidarse”, they are not given autonomous control over their reproductive choices. Rather, they become the “patient” of the medical model, and at the mercy of the medical professionals. Within public health, this control and discipline of the health professional (matrona) over the patient (women seeking to cuidarse) begins with bureaucratic procedures, and is further reinforced with medicalized disciplining by the health professionals.

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267 Cynthia Interview, 2015, translation mine.
269 Reissman, 51.
professionals. For example, although Susana, a *matrona* in an Iquique based *consultorio*, repeated to me on several occasions in the interview that the *choice* of contraceptive method relies heavily on the desires of the patient, she often contradicted herself on this point.

What we do is let them know about the different contraceptives that exist so that *she* can be freely informed and decide with which method she feels best with from the information that we give her… she could feel more comfortable with pills, but has more than one sexual partner; this method is going to stop a pregnancy but not protect against STIs. So there are other methods that can prevent both… but it always depends on what the patients wants, and here we also give priority to the products we can give here for free…. It’s not always going to be what they want… because, for example, one could want oral contraceptives but they are patients who are very unstable with taking pills, so they will most likely soon have an accident for forgetting to take their pills … and have an unwanted pregnancy.\(^{270}\)

Susana’s testimony represents the discourse of medicalization shared by members of the health system in charge of attending to the needs of women of scarce resources. Not only do these discourses encompass ideas of contraceptive “choice” through a medicalized model, but also very clearly mark deviant behaviour in regards to women’s sexuality, which has also become under the purview of the clinical gaze. This results in that although the burden of contraceptive responsibility is seen as a women’s responsibility, they are perceived as lacking in their ability to choose which contraceptives fits their needs, and thus, are in need to be disciplined by the “experts” of the medicalized domain. For example, when the *matrona* talks

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\(^{270}\) Susana interview, 2015, translation and emphasis mine.
about contraceptives that would work for women with multiple sexual partners, not only is she taking away the right to choose from women living poverty, she is also stigmatizing their choice to have multiple sexual partners (deviant behaviour), and in the process, leaving them with less contraceptive options, such as condoms, which are not widely used among Chileans.\textsuperscript{271} Negating women choice on contraception measures, such as the possibility to opt for oral contraceptives or hormonal contraceptives through arguing that these are not adequate when the user of the public system has multiple partners (as well as negating women the option of multiple methods) may leave them unprotected from an unwanted pregnancy if they are in a situation without condoms or in instances such as rape. Furthermore, in the case of partners initiating a sexual relationship without prior STI testing, or in the case of unfaithful partners, having only the option of one form of contraceptive leaves women unprotected against sexually transmitted infections. Although there may be some clinical evidence in some cases as to why a certain contraceptive would be better suited for a particular person, restricting choice to women who depend on the public system to “\textit{cuida}rse” demonstrates a lack of trust on them to control their own bodies justifying the need to discipline and control them through the bureaucratic processes discussed earlier.

Given that the responsibilities linked to reproduction are mostly left onto women, I argue that women should have more choice and agency with their contraceptive use, as well as having available the option to receive multiple forms of contraception gratuitously, such as hormonal contraceptives in combination with condoms. As well, the system in place, informed by a classed and gendered discourse, which is reflected in its bureaucratic procedures, needs to be examined to understand its systematic attempts at disciplining women

\textsuperscript{271} Ministerio de Salud de Chile, \textit{Normas nacionales sobre regulación de la fertilidad}, 2014, 103.
through controlling their sexuality, for example, through stigmatizing those who have multiple partners. Furthermore, in the process, the role and responsibilities of men in the realm of reproduction should be redefined, where boys and men should be included in conversations of also needing to “cuidarse” against STIs and unwanted pregnancies. Furthermore, neoliberalism segregates access to reproductive services by class. Women with financial means (purchasing power) are able to avoid much of the hassle associated with free contraceptives, as well as purchase greater protection (such as multiple forms of contraceptives) in comparison to women needing to rely on public services.

5.3  

_Tu Soy Irresponsable_

If a woman fails to “cuidarse”, she is labeled as “irresponsable”. The burden of being “irresponsable”, and possibly being faced with an unwanted pregnancy, includes taking emergency contraceptives, seeking out an illegal abortion, or giving birth. Stigmatization from being “irresponsable” resulting in a reproductive mishap is reinforced at the institutional level by medical professionals, as well as by one’s peers. Ideas of irresponsibility, especially when leading to an unplanned/unwanted pregnancy, waivers and shifts at the personal level. On the personal level, women tend to negate their own “irresponsibility” and try to justify their own particular situation. Interestingly, women who have faced an unplanned pregnancy in their lives (and negated their own “irresponsibleness”), will still often blame and stigmatize other women in similar circumstances and label them as “irresponsable”.

As discussed in the previous chapter, all my research participants agreed that contraceptives were accessible as they were given for free in _consultorios_. When discussing potential ways to reduce unwanted pregnancies, both professionals and women alike, pointed
out that the problem was the irresponsible attitude of women. For example, one of my interviewees, Fernanda, affirms:

[Unwanted pregnancies] happen just because of pure irresponsibleness… having the consultorios and lots of ways to cuidarse… it’s just irresponsibility.272

Or as Maria, a matrona in the public hospital explains,

I put a lot of the blame on the people, because with the public health programs, there is a lot of access. There are lots, there are pills, implants, condoms, and all are free in the consultorios. So, the truth is, having an unwanted pregnancy is a decision… or because the person didn't try to “cuidarse” because the methods are available for whoever wants them. Now, thinking as a way to help… I do not know what else we could do as professionals to reduce the rate because there is availability for whoever wants to use them…. It’s more of a personal choice.273

Statements such as María’s, the matrona, where she amounts having an unwanted pregnancy as a personal choice, seems to demonstrate the trend for medical professionals to blame women in these circumstances as being “irresponsable”, instead of considering external or societal factors, such as the bureaucratic hurdles, discussed in the previous chapter, and the general feminization of reproductive responsibility, in general.274 This is problematic in that the same matronas treating (and ‘helping’) women in vulnerable situations (such as those seeking out emergency contraceptives), are the ones who participate in the

272 Fernanda Interview, 2015, translation mine.
273 Matrona Maria Interview, 2015, translation mine.
reproduction of the neoliberal discourse that puts the onus on the individual to protect themselves. This discourse has also influenced the views of the public in general, as my interviews demonstrate. The systematic tendency to blame women demonstrates how, through neoliberal discourse, ideas of personal responsibility in the realm of reproduction have become embodied within contemporary culture.

At the time of my research, two participants, Cynthia and Mercedes, had children at an early age as the result of an unplanned pregnancy. Both of them shared the view that irresponsibility was the cause of an unwanted pregnancy. However, when they spoke of their own experiences they were reluctant to admit their own “irresponsibleness,” and rather, reframed their own experience by shifting the responsibility to fate or circumstances beyond their control. For example, I heard statements such as “motherhood comes when it’s its time to arrive”\textsuperscript{275}, or, it happened just “\textit{por cosas de la vida}”\textsuperscript{276}. The reluctance to use the term “irresponsable” when referring to oneself further demonstrates the heavy weight associated to the stigma of irresponsibleness in this context.

The use of emergency contraceptives is also associated to notions of irresponsibility, especially when they are used repeatedly. In fact, in the public health system women of reproductive age are labeled irresponsible for not being on a regular contraceptive routine. However, as previously discussed, the barriers confronted by users of the public system, such as the convoluted bureaucratic processes they have to follow to access contraceptives and the reluctance by the health care professionals to prescribe/provide multiple forms of birth control in \textit{consultorios}, is never addressed when evaluating the reasons for the heavy demand of

\textsuperscript{275} Cynthia Interview, 2015, translation mine.
\textsuperscript{276} Mercedes Interview, 2015.
emergency contraceptives. Among medical professionals who work with emergency contraceptive requests daily, there is a highly negative view concerning emergency contraceptive distribution, as well as its repeat users.\textsuperscript{277} Josefina, a nurse in a \textit{consultorio}, shares her opinion on women seeking emergency contraceptives:

Look, the truth is that a lot of women come here, it’s what I’ve seen… that they went to a party and got drunk or did drugs and they realize the next day that they messed up… so they come and look for the pill because they know that they can avoid a pregnancy… but it’s because they got carried away… and like how it’s hard for people to come to the \textit{control}, especially for young people… so they use it like a safe measure to not get pregnant… but there are irresponsible people who know that they can get the pill and do not remember after, because they do not come back to get on a program…they are people with drug or alcohol problems or, they say, that they are people who are promiscuous…\textsuperscript{278}

Josefina’s statement directly associates the use of emergency contraceptives with irresponsibleness, in this case, stemming from substance abuse or promiscuity. She admits that it can be difficult for people to find the time afterwards to get onto a regular contraceptive program, but does not go into detail about limitations of access. Again, her statement reflects the neoliberal approach in place, as well as the discriminatory approach towards women who seek these services. Accordingly, with no hesitation, she is able to express her view claiming users’ personal irresponsible attitude and “choice” as the problem, instead of examining the flawed institutional programs in place.

\textsuperscript{277} Among the users of the system, I found a more open attitude to the use of emergency contraceptives. Also, I found that the general attitude is that the pill helps women, but not as the primary form of birth control. 

\textsuperscript{278} Nurse Josefina Interview, 2015, translation mine.
The relationship between class and medicalization within the neoliberal context can be seen within the realm of public health. The *matrona* and the clinical gaze have replaced the church and priest to become the oppressor, the marker of deviant sexual conduct, and the gatekeeper to reproductive services for women living in poverty. The *matrona’s* power is legitimized and reinforced by the medicalization of reproduction; in combination with notions of individualized responsibility, the medicalization of reproduction has led to disdain towards the women using these services. Through the Chilean classist society, the poor bodies that attend public services are resented, and are seen as in need of correction and discipline.\(^{279}\) This can be seen in previous examples of health professionals’ low regard and lack of empathy towards women requiring reproductive care such as emergency contraceptives. Furthermore, it can be demonstrated through the abuses and violence towards women experience at the hands of health professionals in the obstetrics ward, which have also been well documented through non-governmental organizations such as the *Observatorio de Violencia Obstétrica* (OVO).\(^ {280}\)

In sum, when looking at concepts of responsibility and irresponsibility in regards to reproduction, women are often stigmatized, by not only medical professionals, but also by their peers. Women who personally experience an unwanted pregnancy tend to reframe their own experience from one of “irresponsibleness” to being an act of fate. However, this reframing of “irresponsible” does not extend to outside of the sphere of the personal, first person experience. This form of victim blaming demonstrates how neoliberalism and neoliberal ideologies have become hegemonic within contemporary Chilean culture.

\(^{279}\) Ibid., 27.

Observatorio de Violencia Obstétrica, ovochile.cl.
Over the past forty years, neoliberal discourses have infiltrated the politics, structures, culture and everyday life of Chileans. Effects of neoliberal policies and practices in the area of reproduction, including those that operate on principles of ideas of personal responsibility over institutional responsibility, have become especially critical when discussing topics of health and reproduction. Ideas of women’s individual responsibility in regards to her reproductive capabilities has become internalized and entrenched into mainstream society by healthcare providers and also by people, in general. The disciplining of women forces them to feel solely responsible in the realm of reproduction, which not only includes her own bodily functions, but also those of her partner. This means that the burden of “cuidarse” is placed only on women. Actions such as seeking and using contraceptives, using caution on sexual activity, for example, by limiting the number of sexual partners, or even resorting to sexual abstinence, are seeing as women’s duties, exclusively. Women who deviate from the “cuidarse” model are hence stigmatized and labeled “irresponsable”. The stigmatizing effects through labeling women who experience a reproductive mishap as “irresponsable” must be measured against the fact that, at least in the public system, women are often not offered sufficient resources, access, information or power to control their reproductive capabilities adequately.
Chapter 6: Abortion in Chile: Two Steps Forwards, One Step Back

When discussing the legislation pertaining to abortion in Chile, it is important to note that it takes place all over the world, despite legality. It is estimated that 21.6 million unsafe abortions occur annually worldwide, contributing to about 200,000 maternal deaths every year. In Latin America, of the 4.4 million abortions performed annually, 95 percent are unsafe procedures, resulting in 1,100 preventable deaths every year. Culwell et al (2010) argue that the rate of abortion is not affected by the legal or illegal status of the procedure. Conversely, for Faúndes & Hardy (1999), the rate of abortion actually decreases in countries where abortion is legal and accessible. The legal status of abortion directly impacts on the rate of hospitalization due to undergoing unsafe procedures and maternal death. In developed countries maternal deaths associated with childbirth is 10 per 100,000, while deaths caused by abortion are only 0.3 per 100,000. Therefore, in developed countries where abortion is legal and accessible, abortion procedures are safer than childbirth.

In Chile, abortion has been at the center of media attention and controversy for the past few years, since during her second term in office, in January 2015, President Michelle Bachelet proposed a new law to decriminalize abortion in three strict circumstances: when the pregnancy poses a risk to the woman’s life, when the fetus is nonviable, and in the case of

285 Faúndes & Hardy “Illegal Abortion”, 82.
rape. On September 14, 2017, the law was promulgated as law 21.030. After almost sixty years of legal access to therapeutic abortion, before leaving office, in 1989, Augusto Pinochet criminalized abortion in all circumstances. All abortions were illegal in Chile during the time I was conducting this research, but the therapeutic abortion bill was already under debate. I had the opportunity to experience the process of the formulation of the bill first hand. These were exciting times for Chilean women (re)claiming the right to their own bodies. However, even with the passing of the new law, in September 2017, there are still issues with effectiveness and accessibility to legal abortions. In this chapter, I argue that the current legislation on abortion, although a big step forward for women’s reproductive rights within the Chilean context, is largely inefficient, restricts access disproportionately for working class women, and reinforces neoliberal ideologies, especially in regards to ideas of individual responsibility and the feminization of reproduction (as discussed in Chapter 5). Furthermore, I argue that the law does not effectively frame abortion as a human right. As a result, many women will continue to have to rely on illegal/unsafe abortion methods to terminate unwanted pregnancies and will continue to risk their personal safety, as well as prosecution.

6.1 Abortion in Chile: A Brief History

Therapeutic abortion was legal in Chile from 1931 until 1989. The legalization of therapeutic abortion was an initiative by the government of Carlos Ibáñez del Campo to combat high maternal mortality rates during the depression, thus when pregnancy posed a risk to the women’s life it was possible to secure a legal abortion. High maternal mortality rates were thought to be a reflection of underdevelopment, and therefore, the initiative to legalize some abortions stemmed from the government’s interest in modernization, rather than from
the will to defend the rights of women over their bodies. Yet, since early in the 20th century, and regardless of their class situation, Chilean women had access to legal abortions under certain very restricted circumstances. However, in 1989, in agreement with the pro-natalist politics of the dictatorship of Augusto Pinochet, all forms of abortion were criminalized.

Soon after the coup d’état, in 1974, Catholic lawyer Jaime Guzman first questioned the legal status of therapeutic abortion, but it continued to be legal for some time in the instance that the woman’s life was at risk. However, in the 1980 Constitution, Pinochet’s government added a “right to life” clause, which gave citizenship rights to the unborn. The addition of this clause was part of a strategy by the dictatorship to inhibit any attempt in expanding the purview of the 1931 abortion law (such as for elective abortion) on the grounds of it being unconstitutional. Yet, Pinochet’s final act in office in 1989 was to completely criminalize abortion, where conservative Catholics, including Jaime Guzman, replaced article 119 of the Sanitary Code (which previously allowed for therapeutic abortion), with the clause “[n]o action can be performed to invoke an abortion”. Therefore, the new version of article 119 would serve to complicate any future efforts to decriminalize it again. In this way, one of the legacies of the Pinochet’s regime was to frame abortion as a “moral issue.”

288 Jaime Jorge Guzmán Errázuriz was a close advisor to Pinochet during the dictatorship on judicial-political matters. He was a key committee member for the writing of the 1980 Constitution. He was assassinated in 1991. Guzman was quoted on his position on abortion as the following: “the mother should have the child even if it has abnormalities, even if she didn’t want it, even if it was the product of rape or even if having it will cause her death. A person cannot, ever, legitimately have an abortion, because it is murder and all of the negative or painful consequences are, precisely, what God has imposed on being human.” (“Jaime Guzmán:‘La madre debe tener el hijo aunque salga anormal, no lo haya deseado, sea producto de una violación o aunque de tenerlo, derive su muerte’” El mostrador, May 29, 2014, translation mine).
289 Haas, Feminist Policymaking in Chile, 124.
290 Casas Becerra, 29.
291 Peña et al. 150.
293 Haas, 123.
With the return to a civilian government in 1990, under President Patricio Aylwin of the *Concertación de Partidos por la Democracia*, feminist movements hoped to be able to overturn the recently instated criminalization of therapeutic abortion. In 1991, the first bill to reinstate therapeutic abortion was drafted, but the bill died without even being debated. This was largely due to the committee consisting of all men, many conservative and religious. Furthermore, the bill lacked support from the women’s movement at the time, because lack of unity on the topic. Subsequent bills, in 2001 and 2006, under the government of President Ricardo Lagos, were also dismissed early on in the process, due to lack of political or executive support. These facts reinforce the argument about “*machista* institutions” as outlined by Rodriguez Herrera (2009), where women-centred rights, especially in the realm of reproduction, are deprioritized, demonstrating women’s lack of full citizenship rights. This stems from institutions being male-centred and dominant, where women are neither adequately represented within the institution, nor are matters pertaining exclusively to women handled with the same importance as those which affect men. However, in the early years of democracy, there was some success in the struggle for women’s right with the creation of the National Women’s Service (*Servicio Nacional de la Mujer*-SERNAM). Nevertheless, even as SERNAM has been an important asset for changing laws pertaining to other concerns of women, such as domestic violence, SERNAM had refused to support any bills pertaining to abortion. This is in part due to conservative

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294 Maira et al., 27.
295 Haas, 119.
296 Ibid.,133.
297 Ibid., 132.
298 Shepard & Casas Becerra, 206.
300 Haas, 120.
religious influences in the parties that have formed the governments after the return to democracy, values that have become entrenched into institutions, even in those institutions that claim to be advocates of women.

In 2015, during her the second presidency, Michelle Bachelet proposed a new abortion bill. This bill, known as the “3 Causales” bill, aimed to decriminalize abortion in three, very specific, circumstances. The bill moved to decriminalize abortion when 1.) The pregnancy poses a risk to the women’s life, 2.) When the fetus is nonviable, and 3). When the pregnancy is a product of rape up until twelve weeks, or up until fourteen weeks for girls under the age of fourteen.\footnote{Regula la Despenalización de la Interrupción Voluntaria del Embarazo en Tres Causales, Ley 21.030 (2017).} Importantly, as I will show below the bill also proposed that individual doctors could refuse to perform abortions on “objection of conscience,” but in the proposed bill only the physician could refuse to perform the abortion while other medical team members or institutions could not.\footnote{Jonathan Flores & Monserrat Valenzuela,”Aborto: Colegio Médico pide ampliar la objeción de conciencia a todo el equipo de salud,”\textit{Biobiochile.cl} June 23, 2017.} However, doctors could not use the “objection of conscience” in emergency settings in the event of no other available doctor.\footnote{Regula la Despenalización de la Interrupción Voluntaria del Embarazo en Tres Causales, Ley 21.030 (2017).} This idea of exemption through “objection of conscience” would then be further complicated and extended by the Constitutional Court\footnote{The Constitutional Court is an ultra conservative institution which was implemented by the 1980 Constitution to preserve the logics of the dictatorship and conservative groups, as discussed in Chapter 4.} to include institutions.\footnote{Maria Paz Núñez, “Fallo del TC por aborto extiende objeción de conciencia a institutiones,”\textit{Tele13}, August 28, 2017.}

The 3 Causales bill passed the senate on July 18, 2017, but the parties in the opposition forced the government to also pass the bill by the Constitutional Court to test the “constitutionality” of the law.\footnote{Gobierno de Chile, “Historia” 3 Causales. http://3causales.gob.cl/historia/} Pushing for the bill to pass the Constitutional Court was a maneuver by the opposition. They hoped to have the bill thrown out for being
“unconstitutional” due to the Constitutional Court’s historically conservative position on reproductive matters, such as outlawing emergency contraceptives in 2008 (as discussed in Chapter 4). However, the Constitutional Court passed the bill as constitutional on August 21, 2017, but extended grounds for moral exemption to institutions, as will be discussed later on. The 3 Causales law was promulgated September 14, 2017, and was implemented in February 2018. As of the legalization date of the 3 Causales law, women can no longer be prosecuted for having abortions if within the purview of the new law.

In summary, the history of legislation dealing with abortion rights has in relative terms not have a linear trajectory, with therapeutic abortion being legalized in 1931, followed by a complete abortion ban in 1989, and currently legal again in three specific circumstances. Passing the 3 Causales bill has been a great example of progress in women’s rights in Chile in recent years; however, the restrictiveness of the law, including accessibility issues (as discuss further below), both still leave much to be desired.

6.2 Abortion as a Moral Issue & the 3 Causales Debate

The contemporary debate on abortion in the western world can be loosely categorized as falling into two main conceptualizations, abortion as a human right and abortion as a moral issue. The human right conceptualization of abortion first gained popularity at the 1994 International Conference on Population and Development (ICPD) held in Cairo and the 1995 Fourth World Conference on Women (FWCW) in Beijing.307 These conventions and the conceptualization of abortion as a human right advanced women’s reproductive rights considerably at the international level.308

The defense of abortion as a human right is advanced by pro-choice advocates. Pro-choice groups believe that women should have autonomy over their own bodies, including in the realm of reproduction. Pro-Choice groups advocate for women to have the right to choose whether or not to continue a pregnancy, and also stand behind women who choose to continue with a pregnancy. Pro-Choice groups are traditionally also invested in trying to reduce the number of unwanted pregnancies through providing contraceptives, sex education, and support for those experiencing an unwanted pregnancy.

The framing of abortion as a moral issue is generally held by Pro-Life (Anti-Choice) groups. This stance is heavily rooted in religious teachings and sexism. The moral conceptualization of abortion is held primarily by religious institutions, as well as by many conservative right-wing political groups. Framing abortion as a moral issue often denies women autonomy over their own bodies, and is often fetus-centred instead of women-centred. As well, women are generally solely blamed for having an unwanted pregnancy and are reduced to only their reproductive capabilities, which reinforces the feminization of reproduction. In fact, Anti-Choice groups tend to focus on the assumed experience of the fetus and have little regard for the woman involved. Further, Anti-Choice groups advocate for citizenship rights for the fetus, and equate abortion with murder. Many Anti-Choice groups also disapprove of contraceptives and sex education. They are responsible for anti-abortion protests, harassing women at abortion facilities, and abortion provider assassinations.

As Haas argues, in the case of Chile, one of the legacies of the dictatorship was to frame abortion as a moral issue. Chile’s relationship to powerful religious institutions, such

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309 From here on out I will refer to “Pro-Life” groups as Anti-Choice groups, as I believe that it is a more accurate term.
310 Haas, 123.
as the Catholic Church and Pentecostal churches, as well the influence held by the ruling conservative elite, alongside neoliberal ideologies introduced in the late 1970s, have worked to further entrench the conceptualization of abortion as a moral issue within society and contemporary culture. The political transformations that started in the early 1990s with the return to democracy have not erased the legacy of the dictatorship in this and other aspects of Chilean culture. Moreover, it has left the 1980 Constitution almost untouched. Although in recent years the Chilean left has adopted aspects of the feminist discourse, such as in promoting Civil Union for same-sex couples, it remains decidedly non-liberal in reproductive matters. A consequence of this stance is that with controversial, women-centred topics such as abortion, conservative moralistic ideologies still dominate the discussion.

Moral conceptualizations of abortion were at the forefront, albeit to differing degrees, among the participants in my study, both among the health professionals and the users of the health system. No participant framed her views on abortion within the context of women having autonomy over their own bodies, or as a human right. This, again, is a reflection of the influence of the moralistic (and non-liberal) position surrounding women’s reproductive rights in Chile. Therefore, in order for feminist movements and supporters of the 3 Causales bill to rally in support for the bill, the own ideological and political positions of each supporting group were discarded, and focus between these diverse groups became centred around whether or not they could support the contents of the 3 Causales bill.\footnote{Claudia Dides, “One Step Beyond-How Victory was Won in Chile,”} This stance by supporters of the bill was taken during the period of its debate; however, the Anti-Choice perspective had considerable influence in civil society. Indeed, a significant majority of my interviewees considered that the rights of the fetus superseded the right of the women over

\footnote{Claudia Dides, “One Step Beyond-How Victory was Won in Chile,”Consience, 1(39, 2018), 23}
their bodies. More so, during the debate on the bill, rape was one of the circumstances in the 3 Causales bill that received most opposition from the ‘abortion as a moral issue’ side. Anti-Choice groups not only framed this causal as opening the door for “free abortion;” they argued that an “innocent” life would be terminated if women had legal access to abortion. Three out of eleven participants, matrona Susana and two of the women I interviewed, Fernanda and Ramona, were against the 3 Causales bill in all circumstances. Susana, the midwife, reasoned,

In the case of rape, there exists the morning after pill that can be used. And in cases of rape, there is the possibility that the unborn baby can then be put up for adoption. You can’t kill a person that is living for the actions of another person. It’s the same if someone does you wrong, so you go to do someone else wrong.\(^{312}\)

In her opinion, this health professional used a common Anti-Choice argument when justifying why a woman should continue a pregnancy that was the product of rape, even against her will. Furthermore, the fact that a medical professional working within the public system can so blatantly express her moral views on the subject, in itself demonstrates how moralistic frameworks of reproduction have become entrenched within contemporary society. First, she blames the woman for not having the foresight to take emergency contraception following her attack, without taking into account a multitude of circumstances or situations, for example, being unable, or not knowing how to access services. Women who are repeatedly raped, women who were using a contraceptive method that failed, or young girls who need to be accompanied by an adult, are all examples of situations that might result in a

\(^{312}\) Susana Interview, 2015, translation mine.
woman not seeking emergency contraceptives, not to mention other factors, such as inaccessibility to emergency contraceptives, trauma resulting from being raped, etc.

Midwife Susana also brings up another classic Anti-Choice moral argument: a baby resulting from rape can be put up for adoption. This fetus-centred approach negates women’s autonomy over their own bodies, and has little consideration for their lives or well-being. Under this perspective women who have been raped should be forced to bring the product of their rape to term. Lastly, this health professional brings up yet another classical Anti-Choice argument, that the fetus should not be “killed” through the fault of another person. This approach negates the personhood of the woman. In fact, while the emphasis is placed on demonizing the woman for not wanting to continue the pregnancy, there is no emphasis on the fact that the act of rape needs to stop.

Ramona, who identifies as Catholic, is also against the 3 Causales bill under the logic that the rights of the fetus supersede the rights of the woman:

I am totally against this law because for whatever motive, for whatever reason, the unborn baby isn’t guilty of anything. Really, there are many options, like adoption or that the family raises it... it can be done, and that’s why I am against abortion.313

However, other interviewees had a more positive opinion about the bill. Eight out of eleven participants agreed that abortion should be legal to at least some degree. For them, some sort of acceptable reason or justification (causal) was necessary for accessing the right to an abortion, although what was considered an acceptable reasons varied considerably between participants. For example, Cynthia thought that abortion should be available to

313 Ramona Interview, 2015, translation mine.
women experiencing psychological harm associated with an unwanted pregnancy, whereas Catalina included factors such as socioeconomic circumstances, as well as becoming pregnant as the result of failed contraceptives. However, one consideration was clear; all the participants in this group thought that abortion should not be legal in the case of a woman being “irresponsible.” As discussed in more depth in Chapter 5, notions of individual responsibility are resonant with neoliberal ideologies where, given the feminization of reproduction, women are solely blamed for any reproductive mishaps (framed as being *irresponsible*).

The Anti-Choice movement had access to significant media coverage to influence public opinion. One of the strategies used by this movement was fear. Throughout the time the bill was debated, false or misinformation was used in the fabrication of fear, such as that women would participate in eugenics or be forced to abort a nonviable pregnancy against her will. For example, Fernanda covered many of the key points of Anti-Choice misinformation and the fear surrounding its imagined effects:

[Abortion] is bad… They just have to accept the child that’s coming… it’s a gift too.. but it should be the decision of the individual… but they should have the option that if the baby is sick that they do not have to have an abortion…. and with that [law] they are going to abort like crazy…

In the above statement, Fernanda argues that women should be allowed to continue a nonviable pregnancy. In fact, the *3 Causales* bill was posed to give women the *option* to...

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314 Fernanda Interview, 2015, translation mine.
abort a nonviable pregnancy if she chooses.\textsuperscript{315} However, a common misconception was that a woman would be \textit{forced} to abort if she had a pregnancy that fell under the non-viable pregnancy condition in the 3 Causales bill. She also feared that if the bill passed abortions would happen in uncontrollable and catastrophic numbers. However, as previously discussed, the 3 Causales law is only valid in three narrow circumstances; any other type of abortion is still criminalized, and women and/or providers can still face prosecution. Furthermore, research worldwide indicates that abortion rates do not increase as result of abortion being legal.\textsuperscript{316}

Fears of eugenic action was another venue used by the Anti-Choice movement. Under this discourse, women would be able to selectively choose their offspring (based off of physical/genetic characteristics) and abort any pregnancy that they did not see as “adequate”. One of the promoters of this view was conservative politician Gustavo Hasbún, who took to social media to argue against the non-viability causal in the bill,

The article in itself is so permissive, it’s so general, that it is opens the door to the legalization of eugenics… legalizing eugenics means that there will be no more \textit{Teletón}, which means that there will be no more children with disabilities, which means that there is a front against those children or against those people that have suffered, that have been born with physical or psychological problems, and that today, obviously, women are going to choose to abort for abortion sake.\textsuperscript{317}

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\textsuperscript{315}Regula la Despenalización de la Interrupción Voluntaria del Embarazo en Tres Causales, Ley 21.030 (2017), emphasis mine.
\textsuperscript{317}“Aborto acabaría con la Teletón: polémica frase de Hasbún sacude a Twitter,” Publimetro, March 17, 2016.
\end{flushright}
Hasbún’s statement made national news arguing simply that in the event of legalization of abortion, women would abort pregnancies just because they could. Hasbún argues that allowing a legal abortion in case of a non-viable fetus will result in preventing the birth of any individual with physical or other defects. Most intriguing (and absurd) are his fears that the legal application of this imagined eugenic practice will threaten the Teletón’s existence, which is run and profited by Chilean elites. The Teletón is an annual fundraising initiative which was started in 1978 by Canal 13 personality Don Francisco, Mario Kreutzberger. The fundraiser aims to help children with disabilities, with most of the funds coming from donations from the public. Last year the Teletón raised over 32 billion pesos (over 64 million CDN). The allocation of Teletón funds has been a source of controversy and conspiracy for years. Furthermore, the directors of the Teletón are all owners of some of the most valuable enterprises within Chile. In short, the Teletón is an important financial event for the Chilean elites. Even with the passing of the 3 Causales law, women can only elect to have an abortion when the fetus is nonviable, and regardless, the Teletón will continue to generate huge corporate profits.

In conclusion, in Chile the moralistic framework has influenced the views of civil society in important ways when discussing topics related to abortion. Although the 3 Causales bill eventually was made into law, it did not have the power to reframe abortion in Chile as a woman’s right. Anti-Choice groups gained oppositional support by focusing on moralistic arguments, which is the result of the legacy of seventeen years of the military dictatorship where conservative values dominated important sectors of Chilean society. Ironically, one important strategies used by this movement to further their arguments was the fabrication of mis-information, in significant ways in the hands of dominant groups, spread out through the
media. Indeed, two corporations control most of the written press in Chile, El Mercurio and Copesa, both in the hands of ultra-conservatives linked to the right and the Catholic Church. The strong influence of the moralistic framework was evident in my interviews, where not a single participant framed abortion within a human right framework.

6.3 Legality vs. Accessibility: The Reality of the 3 Causales Law

The approval of the 3 Causales bill was an accomplishment for the groups who fought for abortion as women’s rights in Chile. However, amongst the rejoicing for this limited success, one must also consider how effective this new legislation will be, and how much impact it will have on the lived realities of women, especially women from lower socioeconomic groups. In this section I outline the state of the current legislation and its limitations.

First and foremost, when discussing legislation pertaining to women reproductive rights in Chile, one must be reminded that in Chile many laws do not affect all citizens equally, with differences determined by social class, as discussed in previous chapters. A prime example of this dual reality lies within abortion legislation. Women of higher socioeconomic status have seldom had to worry about accessing safe abortion, despite laws. Accessibility to safe illegal abortion by the wealthy throughout Chile is a well-known fact. For example, in Iquique the majority of my participants knew of the “famous” doctor that locally practiced abortions in his private clinic. As Catalina points out,

Look, I think [finding Misoprostol pills] is like hush-hush… just like there are doctors in Iquique that perform abortion and its also hush-hush …. and really,

318 Shepard & Casas Becerra, “Abortion Policies”, 203
there are doctors that perform clandestine abortions, so there would have to be a way to get their phone number and call…

And Mercedes adds,

Well if you do not have money then they aren't going to give you [an abortion], but if you pay a doctor a good amount of money- I know that they are expensive, then they will give you one...but not all doctors, I know of one in particular that [performs abortions].

However, the “well known fact” that well to do families can afford safe abortions in Chile, is still not a subject that can be openly discussed on many platforms, as is evidenced by the former Minister of Health, Helia Molina’s forced resignation in December 2014 during the 3 Causales campaign. Molina stated that: "In all of the posh clinics, many conservative families have procured abortions for their daughters.” Molina voiced a fact that is well known but silenced in Chile. She was forced to resign by daring to break the silence. Women with financial means have also been known to travel out of country to seek abortion services, including in destinations such as Argentina, Cuba, and Colombia. However, Molina’s point was clear, when examining the 3 Causales law, one must remember that although it does apply to the large majority of Chilean women, it affects mostly women from lower socioeconomic groups.

319 Catalina Interview, 2015, translation mine.
320 Mercedes Interview, 2015, translation mine.
The *3 Causales* law in itself is very restrictive, as Teresa Flores, from the pro-choice feminist organization Pan y Rosa, argues. Indeed she point out that the law covers only a minuscule number of all the abortions performed in Chile.\[^{323}\] It can only be applied when the criteria of one of three specific circumstances is met, and needs to be explicitly sought in writing prior to the procedure.\[^{324}\] Even abortions that fall within the *3 causales* find many obstacles.

For the first circumstance, an abortion can only be sought when a doctor determines that the woman’s life is at risk, and that an abortion is necessary in order to save her life.\[^{325}\] The second circumstance, non-viability of the fetus, needs to be approved by two specialized physicians.\[^{326}\] Currently, there are only fifty-seven doctors in all of Chile with the capacity to sign off on an abortion in these circumstances.\[^{327}\] However, out of these fifty-seven doctors, only seventeen work within public health (FONASA) for the entire country.\[^{328}\] Notwithstanding the lack of qualified doctors, the parameters within which this circumstance can be applied are extremely narrow. The non-viability of the fetus requirement is defined as “the embryo or fetus suffers from an acquired, or genetic, congenital pathology, incompatible with independent extra-uterine life and of lethal character.”\[^{329}\] Therefore, the second circumstance of the *3 Causales* law can only be used in the cases where the pathology of the fetus is known to be lethal outside of the womb. Indeed, in particular for women who lack

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\[^{328}\] “Sólo 17 médicos pueden diagnosticar inviabilidad fetal en el sistema público,” *Cooperativa*, June 6, 2017.

economic means, the restrictiveness of the law, the shortage of qualified doctors and the inefficiency of the Chilean public health system will pose significant problems for women who wish to access these services under this circumstance.

Regarding the third circumstance, in the case of rape, there doesn’t need to be a police report filed prior to requesting an abortion under this circumstance.\textsuperscript{330} The number of rapes in Chile is staggering. According to the Centre of Reproductive Medicine and Adolescent Development (Centro de Medicina Reproductiva y Desarrollo Integral del Adolescente-CEMERA), the National Survey of Sexual Behavior found that seven percent of the women surveyed had been victims of rape, where half of them experienced rape as their sexual initiation.\textsuperscript{331} In order to determine the legitimacy of the victim’s rape claim, a committee formed by professionals employed at the hospital where the procedure is to take place will determine whether or not the woman is eligible for an abortion under this circumstance.\textsuperscript{333} If the committee determines that the pregnancy was indeed the product of rape, and if the gestation is under twelve weeks (or under fourteen weeks in the case of minor under the age of fourteen), then the crime of rape must be reported to the public ministry, and in the case of minors under the age of fourteen the crime must be reported to the public ministry, police, and National Service of Minors.\textsuperscript{334} In the event that after the procedure the girl or woman is found to have lied about being raped, she could face prosecution for having an illegal abortion.\textsuperscript{335}

\textsuperscript{331} República de Chile Senado Boletín No 9895-11, “ Aborto en tres causales: Fundaciones y centros de estudios explican por qué decir sí o no al proyecto,” Departamento de Prensa, Valparaiso, July 17, 2016.
\textsuperscript{332} The exact protocol surrounding the composition and formation of the committee has not yet been officially determined at the time of writing this thesis.
Women are expected to stand in front of a committee of medical professionals trying to convince them of her credibility when claiming that she had been raped. Due to the fact that the committee is unregulated and does not respond to any specific criteria other than weeks of gestation to determine eligibility, points to the fact that their decisions are based very much on subjectivity and personal values. This is especially problematic for women of lower socioeconomic status attending public hospitals, as patients living poverty often meet less sympathy from professionals than their well-to-do counterparts. Furthermore, many medical professionals are not expected to have specific knowledge pertaining to how evaluate the truthfulness of a rape claim, and details as to whether or not prior training will be provided to committee members has not yet been established. Therefore, women could be subject to whatever set of procedures or questions seen fit by a group of medical professionals with no specific training on the subject.

The last restriction to accessibility added to the 3 Causales law was the expansion by the Constitutional Court of the “objection of conscience” clause to include not only practitioners, but institutions as a whole, such as hospitals. Indeed, in the original bill, only practitioners were eligible to use the “objection of conscience” clause to refuse to practice abortions, and only in non-emergency situations. As indicated above, through pressure from right-wing groups, such as Chile Vamos, the Constitutional Court expanded this exception to include institutions. The result of this inclusion in the legislation is that now entire private hospitals or clinics can refuse to offer this service. However, public medical

centres, public hospitals and (as of yet) private facilities receiving public funding are prohibited from applying institutional “objection of conscience”.

All in all, the fact that once again some type of abortion law has been approved in Chile is a huge advancement for women’s rights locally. However, many women will still have to rely on unsafe or illegal measures to terminate unwanted pregnancies, regardless of whether or not their circumstance fits into the 3 Causales law. This has to do with inequality of access to medical services determined by social class, and is exacerbated by the literal inaccessibility of the law, stemming from the severe restrictiveness of the law, a shortage of qualified doctors, and the inclusion of institutions in “objection of conscience” exemption.

6.4 Illegal Abortion in Chile: A Continuing Practice

Prior to the passing of the 3 Causales law, from 1989 to 2017, there were no forms of legal abortion in Chile. Women from all walks of life have had to depend on illegal abortions, even though women with more financial means are able to access safe abortion services through different venues. Even with the passing of current abortion legislation, the restrictiveness of the law and other barriers to access most likely will not significantly impact rates of illegal and/or unsafe abortion.\textsuperscript{339} When women have to rely on clandestine methods to terminate an unwanted pregnancy, especially in the case of not having the means to pay the high premiums (that some women are able to afford) for adequate services, it increases the risk of life threatening problems for them, which can result in hospitalization and/or death.\textsuperscript{340} Every year in Chile an estimated 31,900 women are hospitalized from complications of

\textsuperscript{339} Pan y Rosas Teresa Flores, “Mujeres trabajadoras y pobres víctimas de la penalización del aborto en Chile,” \textit{La Izquierda Diario}, March 10, 2016.
\textsuperscript{340} Haas, \textit{Feminist Policymaking}, 122; Shepard, 202.
unsafe abortion. Women who have to seek treatment for botched abortions in public hospitals (in its majority women living poverty) are also more likely to be reported and face prosecution. Therefore abortion safety, and risk of prosecution, is directly related to social class, with working class and women living poverty being the most vulnerable.

In many countries, even where abortion is illegal, doctor-patient confidentiality is still upheld. Chile has been fairly unique in the fact that the 1980 Constitution outlaws both abortion and breaking medical confidentiality; until recently, there were no provisions on how these conflicting conditions should be resolved. In 2004, the Inter-American Human Rights Court ruled that in such situations, medical confidentiality should be given preference and priority over reporting abortion related crimes. Evidence of this confidentiality policy change was apparent within my interviews with health professionals. Throughout my interviews there was a strong consensus that patient confidentiality should be upheld, and that it is not the job of medical staff to conclude if an abortion was spontaneous or provoked. In fact, nurse Josefina stated that it was in the best interest of the medical professionals not to try to determine if an abortion was provoked, or report a provoked abortion, as to not become involved in a long juridical process. However, historically, public hospitals have had a higher rate of reporting women who come in with complications from an unsafe abortion, with some hospital personnel even withholding treatment to coerce dying women into

\begin{thebibliography}{9}
\bibitem{341} Susheela Singh. “Hospital Admissions Resulting From Unsafe Abortion” \textit{Lancet} (368, 2006), 1888.
\bibitem{342} Casas Becerra, 31;
\bibitem{343} Shepard & Casas Becerra, 204.
\bibitem{344} Casas Becerra, 33-34.
\bibitem{345} Shepard & Casas, 204.
\bibitem{346} Ibid., 204.
\bibitem{347} In Spanish the word “aborto” applies for both miscarriages and abortion. An abortion is “aborto provocado”.
\bibitem{347} Josefina Interview, 2015
\end{thebibliography}
admitting that they underwent an unsafe abortion, and by whom.\textsuperscript{348} This is, again, a reflection of the historical difference of care received in private versus public facilities, as outlined by Trumper & Phillips (1996), and discussed in previous chapters, where the poor are disciplined and punished, while the wealthy are cared for and healed.\textsuperscript{349}

Prosecution for interrupting a pregnancy does occur in Chile,\textsuperscript{350} with the majority of women being from lower socioeconomic backgrounds.\textsuperscript{351} The sentence for women seeking abortions can be up to five years, whereas the sentence for abortion practitioners has a maximum sentence of three years.\textsuperscript{352} Men are rarely held responsible.\textsuperscript{353} However, for the most part, women no longer have to serve sentences incarcerated, but rather, if found guilty, a woman is given a “conditional dismissal” where she has to check in every month at the prosecutor’s office for over a year.\textsuperscript{354} With the passing of the 3 Causales law women can no longer be prosecuted for having an abortion when adhering to one of the three circumstances. However, investigations of abortion and abortion related crimes still take place regularly.\textsuperscript{355}

As previously discussed, women with more financial means can access safe abortion services. For women with less financial means there are fewer options. However, new and safer methods have become accessible for women of less economic resources. Today, some

\textsuperscript{348} Shepard & Casas, 204.
\textsuperscript{350} Since 2007 there have been 520 people (362 women, 158 men) tried for abortion, and 166 (108 women, 58 men) convictions. Natalia Heusser, “En 10 años, el Estado chileno condenó a 108 mujeres por abortar,”La Hora, July 18, 2017.
\textsuperscript{351} Casas Becerra, 33.
\textsuperscript{352} Susana Herrera Rodríguez. El Aborto Inducido (Santiago de Chile: Catalonia, 2004),43.
\textsuperscript{353} Ibid., 43.
\textsuperscript{354} Ibid., 204.
\textsuperscript{355} Just in November 2017 during the writing of this chapter, there were two separate instances of abortion related investigations that appeared in the news.
women may get access to drugs with abortive effects, such as Misoprostol. Misoprostol is indicated for the treatment of gastric ulcers, but also has abortive effects. This method is referred to as a “medical abortion”, and can be quite effective when used under proper instruction early on during pregnancy. Yet, accessing Misoprostol can be a challenge as it is not commercially sold in pharmacies in Chile, and it is expensive. In Iquique, a local pharmacist told me that only the public hospital stocked Misoprostol, and that it is not stocked in any pharmacy. Misoprostol is generally sold on the black market in Iquique, where supplies have often been imported from Tacna, Peru. However, the pills can cost around 90,000 CLP ($180.00 CDN). Women in poorer communities have been known to financially help other women in order to buy medical abortion drugs. There are also opportunities for women to buy a medical abortion kit online. These kits are provided by organizations such as “Women on Web,” and include Mifepristone and Misoprostol, as well as instructions on how to use the drugs properly. The problem is that these kits are only available to women who have Internet access, a method to pay for kits, or knowledge of the websites.

Instructions regarding the use of Misoprostol vary, and most information regarding the drug is passed on by word of mouth, or via the Internet. Reliable information on using Misoprostol for early pregnancy termination can also be provided by abortion hotlines in Chile. However, these hotlines and websites, such as infoabortochile.org, are purely

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357 Zamberlin et al., 3.
358 I asked for misoprostol in every pharmacy that I passed by during my three months of fieldwork in Iquique. Not one admitted to stocking the drug. However, I also have to take into account that I am a foreigner (an outsider), and take into consideration how this could potentially have swayed my results.
359 Zamberlin et al., 6.
360 Mifepristone is a progesterone blocking agent that is often used in combination with Misoprostol to produce an abortion.
362 Kits are paid for by donation and the “recommended donation” amount is 70-90 EU ($50.000-66.000 CLP/ $100.00-132.00 CDN), which is only payable with credit card or paypal.
informational and do not sell the drug. Misoprostol can be taken either orally, vaginally, or a combination of both. Zamberlin et al (2012) argue that most women consider ingesting the medication orally as a manner to regulate menstruation, whereas inserting the drug vaginally is considered abortive in nature.\textsuperscript{363} Complications can occur with Misoprostol, but the rate of severe complications is much lower than with other methods.\textsuperscript{364} Many women, with limited instructions, sometimes worry that bleeding has become excessive, and seek medical treatment unnecessarily.\textsuperscript{365} Also unnecessarily, other women may be instructed to seek medical treatment once bleeding occurs.\textsuperscript{366} Women who have had children are less likely to become anxious and to seek medical treatment unnecessarily.\textsuperscript{367} Although many women feel stress from having an illegal abortion, for multiple reasons, including participating in illegal acts, it has been found that using Misoprostol, in the privacy of one’s own home can reduce the stress of the procedure significantly.\textsuperscript{368} In recent years over-dosages have been less frequent, which suggests that more women are being able to access accurate information.\textsuperscript{369}

Even with the 3 Causales law, many women will still have to rely on illegal abortion methods to end unwanted pregnancies. Due to having to rely on illegal and/or unsafe methods, women will still need to seek treatment in the event of an abortion gone wrong, and can still face prosecution.

\textsuperscript{363} Zamberlin et al., 7.
\textsuperscript{364} Ibid., 7.
\textsuperscript{366} Zamberlin et al., 7.
\textsuperscript{367} Ibid., 7.
\textsuperscript{368} Ibid., 8.
\textsuperscript{369} Ibid., 8.
Although the passing of the 3 Causales law is an important step forward for those who see abortion as a human right and for women’s reproductive rights as in Chile, it is not perfect. Through moral conceptualizations of abortion and strong opposition by Anti-Choice groups, the 3 Causales law was not able to reframe abortion as a human right in Chile. Through the narrow provisions as to when the law can be applied, as well as the Constitutional Court amplifying the “objection of conscience” to include institutions, there will still be significant numbers of illegal abortions in Chile in the future. In recent years there has been success with medical abortions using drugs such as Misoprostol, which has proven to cause less complications for women who need to resort to illegal measures to terminate a pregnancy. However, Misoprostol is still quite costly for the groups of women who will need it the most. Women who procure an illegal and/or unsafe abortion, or lie to align themselves within one of the 3 Causales circumstances, still face the chance of being prosecuted under the criminal code. Despite legislation, well-to-do women will continue to access safe illegal abortions in private clinics or by travelling abroad.
Chapter 7: Healthy Relationships & Sex Education: The Faulty Equation

I arrived to the Ministry of Education building in Iquique, and walked over to the General Information desk. The day before, in my interview with a pharmacist, he had told me that I should go and request a copy of the Sex Education curriculum, which should be available to me through Chilean “Transparency Laws.” I figured that it was a long shot, due to the fact that I had never heard of a “Sex Ed Curriculum,” however, I was assured that there had to be one [because of law N° 20.418]. I was directed by the woman at General Information to head upstairs and see if someone there could get me a copy. I went upstairs to a small office, introduced myself to the first person I saw, and explained what I had come for. There was an obvious tension as she went to work looking for the file. After awhile she consulted with a coworker, who then also searched to see if she could find the file. The coworker then consulted with another coworker to see if he was able to locate the file. After about 15 minutes of backing and forthing between the three coworkers, they came back to inform me that there wasn’t an official curriculum, but I could search on the Ministry of Education webpage for a “Suggested Curriculum.” So I returned home empty handed yet again...

As discussed previously, Chile has historically been portrayed as a conservative country, deeply influenced by the Catholic Church. This has resulted in heavily gendered traditionalist expectations placed onto women’s lives, most notably in areas concerning sexuality, marriage, bearing children, and premarital sex. Therefore, it is paramount to

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examine deviations women have made in recent years from traditionalist conceptions. This can be seen through a variety of outlets, but especially in their rejection of marriage, and placing the importance of their career over having a family, as well as embracing their sexuality more freely. However, there are still important fallbacks to this progress in Chile, which, in my view is mainly situated in reproductive responsibility being largely feminized and lack of reliable information when it comes to sex related issue due to unregulated and unreliable sex education programs.

Up until this point I have mainly focused on institutional factors inhibiting working class women’s success in controlling their own reproductive capabilities. In this chapter I focus on sex education and cultural changes over the last decade that have influenced women’s lived realities when making decisions about marriage and having children. Due to a shift away from traditional conservative practices that have long dominated Chilean culture, I argue that institutional change, such as access to resources and information, and in particular, reliable sex education, are necessary for women to continue their progress in gaining autonomy over their own bodies.

7.1 Relationship Priorities: Love ≠ Marriage

At the core of Chilean culture and society are ideas over what constitutes as a family. Ideas of family have shifted over time, from the ideas of the nucleus including extended family living together up until the time when mass urbanization took root during the end of the 19th century, when ideas of family shifted to the “conjugal” family.\(^{371}\) Olavarria (2014) argues that the idea of the conjugal family in Chile was encouraged and implemented by the

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state as a way to socially control (domesticate) young men coming to urban centres to work, who were seen as potentially dangerous.\textsuperscript{372} Essential to the idea (or ideal) of the conjugal family, were separate and dichotomous gender roles, with the man/husband viewed as the provider and authoritative figure, and the woman/wife assigned exclusively to the domestic sphere, taking care of the house and children.\textsuperscript{373}

Barrientos (2006) argues that during the 1960s and 1970s the western world was experiencing a “sexual revolution”, where gender roles were reconsidered; women began to leave the domestic sphere to enter the workforce, as well as participate in the public sphere in more significant numbers.\textsuperscript{374} During this time in Chile there was a significant increase in the number of women entering the university.\textsuperscript{375} However, later on, factors including the military dictatorship changed the course of this “sexual revolution” in Chile. In particular, during the period of the military dictatorship, women were targeted to be returned to the domestic sphere.\textsuperscript{376} Although since redemocratization there has been an increase in women’s participation in the public sphere, in general, and in the workforce, domestic work and childcare still remain feminized.\textsuperscript{377}

Among other cultural and structural transformations, Chile experienced a sharp decrease in the number of marriages taking place post dictatorship. Marriage rates fell from approximately 8/1000 inhabitants in 1990 to only 3.8/1000 in 2015.\textsuperscript{378} There are a few trains

\begin{footnotesize}
\begin{enumerate}
\item[372] Olavarría, “Transformaciones de la familia conyugal en Chile,” 475.
\item[373] Ibíd., 476.
\item[374] Jaime Barrientos Delgado, “Nueva normatividad del comportamiento sexual juvenil en Chile?” Última Década (24, 2006), 83-84.
\item[375] Ana María Stuven “La mujer ayer y hoy: Un recorrido de incorporación social y política” Centro de Políticas Públicas UC, Julio 2013, 12.
\item[376] Barrientos Delgado, “Nueva normatividad del comportamiento sexual juvenil en Chile?”, 84-85.
\item[377] Ibíd., 84.
\end{enumerate}
\end{footnotesize}
of thought as to why rates of marriage have declined so substantially in such a short period of time. Cox (2011) argues that the decline in marriage is related to the fact that many women have achieved economic independence from entering the workforce, and do not inevitably require a husband for economic support. Herrera Ponce (2006) argues that the Ley de Filación (Paternity Laws) may also have had an effect on the decline in the rates of marriage. This piece of legislation stipulates that children born outside of marriage have the same rights (such as to inheritance), as a child born within marriage. It may be that women today have less need to marry in the case of being pregnant in order to avoid having an “illegitimate” child in the purview of the law. In fact, since the changes in legislation, it seems that having children outside of wedlock has become increasingly prevalent and less stigmatized. According to Cox (2011), in Chile in the early 1970s children born outside of wedlock represented just twenty-four percent of births. In 2009, the number of these births had risen to sixty-seven percent of all births (in Canada in 2007 it was thirty-six percent), and in 2016 rose to an all time high of seventy-three percent.

Another significant change related to the concept of family in Chile is the reintroduction of the 19th Century religious marriage as an option for Chileans. Indeed, since 2004, in Chile one can opt for a religious or civil marriage. Prior to 2004, a religious marriage ceremony was not legally considered as a valid marriage, but rather, a civil marriage

380 This is withstanding the fact that women are often discriminated against in the workplace, such as with their salaries, as discussed in Chapter 5.
381 Maria Soledad Herrera Ponce, “Proyectos familiares y de pareja entre los jóvenes de Santiago de Chile” Última Década 25(14, 2006), 54.
382 Cox, “Divorcio en Chile: Un análisis preliminar tras la nueva Ley de Matrimonio Civil,” 134.
383 Ibid.
384 Carlos González Isla, “El 73% de los niños nació fuera del matrimonio, la cifra más alta de la historia,” La Tercera, Sept. 21, 2016.
ceremony had to accompany it. The civil marriage was legislated in 1884 to aid in the
secularization of the state. Three decades later, in 1925, the Chilean government
implemented a new constitution that furthered the separation of Church and state. Since the
implementation of civil marriage, religious actors had made several attempts to have the
religious marriage defined as a legal marriage, to no success. Yet, in 2004, at the same
time that the newly passed divorce clause was being instated, the law regarding the validity of
religious marriage was finally revised. Today, a religious marriage can be registered at the
civil registry as a valid legal marriage within eight days of taking place. Due to the timing
of the status change of religious marriage to coincide with the legalization of the divorce law,
critics have speculated that religious marriage became a valid legal marriage only to help
satisfy the Catholic Church (although other denominations can also participate in the new
legislations) in the wake of passing the divorce bill, which they had fiercely opposed. There
was no divorce law in Chile prior to 2004, however, persons with the sufficient funds to hire a
lawyer could get their marriage annulled by showing some sort of error (wrong address,
incorrect spelling of name, etc.) on their marriage certificate.

As well, it is worth mentioning that since 2015, Civil Unions (common-law marriage)
have existed in Chile under Law 20.830, although the topic of Civil Union was not brought up
during my interviews due to the timing of the law. In order to have a civil union in Chile, one

385 Jorge del Picó Rubio, “El matrimonio religioso en el régimen jurídico chileno: El sistema matrimonial
consagrado por el artículo 20 de la ley Nº 19.947” Revista Ius et Praxis 2 (15, 2009), 52.
386 Salinas Araneda, “El reconocimiento del matrimonio religioso en el derecho positivo del estado de Chile,” 63.
387 Carlos Salinas Araneda, “El reconocimiento del matrimonio religioso en el derecho positivo del estado de Chile:
un viejo tema aún pendiente,” Revista de Derecho 1(23, 2010), 62.
388 Chile Atiende, “Matrimonio civil o inscripción del matrimonio religioso”,
https://www.chileatiende.gob.cl/fichas/ver/3373
390 Jose V. Gallegos & Jan I. Ondrich, “The Effects of the Chilean Divorce Law on Women’s First Birth
must be over eighteen years old, have not been married or in another civil union for at least 270 days prior, and not be pregnant by another person. The couple must go to the civil registry to perform the necessary paperwork; there also exists the option to perform the ceremony in another location at a greater cost. It is important to mention that this law is a huge advancement for same-sex couples, who are now able to formalize their relationships through a Civil Union contract (same-sex marriage still does not exist in Chile).\footnote{Chile Atiende, “Acuerdo de Union Civil” https://www.chileatiende.gob.cl/fichas/37532-acuerdo-de-union-civil} When discussing the importance of marriage in Chile with my participants, a legal marriage was not an aspiration for the majority of them. In fact, only one participant, Ramona, directly stated that it would be important for her to marry, but only after she has established her career.\footnote{Ramona Interview, 2015} Out of all the women I interviewed, only one was married, and she stated that for her it was “just a signature.”\footnote{Mercedes interview 2015} Some participants such as Paola and Cynthia stated that they had no interest in marriage, unless it was to make their partners happy. Marriage was not often equated to a healthy relationship, nor was its presence or absence a reflection of the amount of love within a relationship.

Paola stated:

I do not ever want to get married, or I do not know… maybe one day I’ll marry, but it wouldn't be for my beliefs, but rather to make the other person happy.\footnote{Paola Interview, 2015, translation mine.}
Then, Cynthia,

Actually, I do not think that “marriage” even exists, because it's not important, doing some paperwork isn't going to make someone more happy nor more sad in a relationship.\(^\text{395}\)

Also when discussing the importance of religious marriage as an option to get married, only one participant, Ramona, considered both types of marriage important. Most of the participants in my study saw marriage within the Church as “old fashioned” and “outdated.”\(^\text{396}\) This rejection of religious marriage could not only be the result of the decline in importance that marriage is having for Chileans, but also it may be also a reflection of the decline of the Catholic faith in Chile as a whole. Within the general population, seventy four percent of Chileans identified as Catholic in 1995, while only fifty-seven percent did in 2013.\(^\text{397}\) In my study, only one third of the women I interviewed identified as religious, all of them identified as Catholic.

Moreover, it seems that Chile is experiencing other significant changes with respect to traditional views about family and relationships. A study by Herrera Ponce (2006) found that in recent decades ideas of “family” revolved less around traditional notions of marriage and more around those favoring stable, loving relationships, especially when children were involved.\(^\text{398}\) Not surprisingly, when I discussed the topic of relationship priorities with my participants, most of them gave the top priority to love. Love was seen as the cornerstone of any relationship, being closely related to other key factors such as affection, respect,

\(^{395}\) Cynthia Interview, 2015, translation mine.  
\(^{396}\) Catalina Interview 2015; Fernanda Interview 2015.  
\(^{397}\) Latinobarometro, Las religiones en tiempos del Papa Francisco (Santiago de Chile: 2014), 17.  
\(^{398}\) Maria Soledad Herrera Ponce, “Proyectos familiares y de pareja entre los jovenes de Santiago de Chile” Ultima Decada 25(14, 2006), 46-47.
consensual sex, stability and fidelity, and not necessarily, a marriage certificate. Indeed, the majority of my participants agreed on the notion that marriage was not as important as love. Especially when children were involved, a stable relationship was highly valued.

As Cynthia describes it,

“I believe that, obviously, love [is the most important]... love, respect, affection... children too, because they are the fruit of the love and respect in a relationship.”

Moreover, money was not seeing as a critical factor in achieving a healthy relationship.

As stated by Fernanda,

If there is love, everything is possible. Sex and money aren't that necessary.

Ramona also felt the same,

First, [my partner] has to make me happy, and be good for me... love [is the most important]... I think money would be like the last part... I proved that in the relationship that I'm in now. I realized that money just isn't that - it comes last.

In my interpretation, this somewhat reinforces the idea I argued above, that economic freedom has allowed women to shift the focus of a relationship away from a search for economic support and towards a more egalitarian and mutually supportive union.

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399 Cynthia Interview, 2015, translation mine.
400 Fernanda Interview, 2015, translation mine.
401 Ramona Interview, 2015, translation mine.
More so, in my interviews, most women valued love, respect and stability in a relationship, but at least some of them thought that holding control over the life of their children may also be an important priority. Yet, most participants stated that having children was better when the parents are together (as in living together, not necessarily married), such as Catalina states,

I think that the ideal situation to have children is when the father and mother are together, and can raise them together, even though, obviously, I do not have any problem that a father raises his daughter or a mother raises her son.\textsuperscript{402}

Fernanda, for example, pointed out, that for some mothers, depending on their circumstance, keeping full control over their children’s lives is important.

It really depends on every person, because there are some women who like to be more alone [with their children], and for others it’s ideal that their partner is at their side… to each their own.\textsuperscript{403}

As I pointed out above, the paternity laws (Leyes de Filiación) approved in 1998 under President Eduardo Frei Ruiz-Tagle, ended the historical discrimination of children born out of wedlock, giving them the same rights as children born from married couples. According to the law, if a father is listed on the birth certificate he is financially responsible for his child, regardless of the marital status of the parents. Then, since the passing of the law, the stigma of illegitimacy is not, legally, a concern for a mother who decides to not list the name of the biological father of the child in the birth certificate (or is unable to it). She keeps for herself all the rights and responsibilities over her child. In the event of separation, this law also

\textsuperscript{402} Catalina Interview, 2015, translation mine.

\textsuperscript{403} Fernanda Interview, 2015, translation mine.
protects the couple’s offspring, yet, it may constrain the mother’s rights over the child. The law mandates that both parents are financially responsible for the children and therefore, in the case that the children reside with the mother, the father is responsible for child support payments (if he can be found), while the mother would require his consent in a variety of situations, such as when leaving the country. In many situations, the father is an absent father and difficult to locate to sign permission. Furthermore, the consent form must be signed in front of a notary public. This point is especially important in settings such as Iquique, which is a five-hour bus ride away from the Peruvian border, and a popular vacation spot, even for families with less financial means. Ramona relates her experience:

   My siblings are minors still, and if they want to go out of Chile, they need to have the authorization of my mom and dad, and my dad a lot of the time simply doesn't give the signature… even though our father doesn't even live with us and doesn’t worry about us, we still need his signature to go…

In conclusion, when viewing relationships in the context of women’s lived realities loving relationship are of great importance, while traditional and institutional formalizations of these relationships have lost popularity. A number of factors have influenced these changes, such as a decrease in religious followers, and economic autonomy, where many women are not basing their relationships on the need of economic support. As well, since 2004 there also exists the possibility to divorce in Chile.

404 Introduce Modificaciones al Código Civil y a Otros Cuerpos Legales, con el Objeto de Proteger la Integridad del Menor en Caso de que Sus Padres Vivan Separados, Ley 20.680 (2013).
405 Ramona Interview, 2015, translation mine.
7.2 Ideal Maternity: Career > Motherhood

Another factor, deeply rooted in Chilean traditionalism, is the notion of motherhood. As argued by Pieper-Mooney (2009), historically, women in Chile have been often considered only for their reproductive capabilities, with matters pertaining to women rarely escaping the sphere of the “mother-child unit”. However, like in the case with marriage, birth rates in Chile have been on a downward trend since the 1970s. Cox (2011) argues that this downward trend is linked to women entering the workforce, the availability of contraceptives, and the decrease of marriage.

More so, Castilla (2009) argues that in South America, ideas of modernity --which have affected rates of women in the workforce and ideologies related to motherhood-- have stemmed from the process of “individualization” within society since the 1970s. Therefore, through ideas of “individualization”, which I argue also stem from neoliberal policies, women have become less prone to ideas of motherhood as a necessity for the collective good of society, and rather, have begun to place an emphasis on their own personal development, such as prioritizing their careers. This surfaced in my interviews when discussing ideal times and situations to have children. All the women I interviewed thought that having children must occur after completing their studies.

408 Ibid.
409 Maria Victoria Castilla, “Individualización, dilemas de la maternidad y desarrollo laboral: continuidades y cambios,” Intersecciones en Antropologia (10, 2009), 345.
410 Through neoliberal policies, the privatization of education has increased the overall accessibility of post-secondary education across social classes. However, it is important to note that this accessibility is in due part to the ability to pay in cuotas (read: debt trap), and more so, as argued by Espinoza & Gonzalez (2013), the overall quality
As Fernanda states,

Well, I believe that [ideal maternity is] after finishing your studies, because now, for example, having a child at 17 or 16 is a huge weight because you do not have a house, you do not have a career and you do not have anything. It’s best that you're done all your studies and are working.\textsuperscript{412}

As Fernanda explains, having finished one’s studies and being employed are important factors when wanting to form a family. However, it is also interesting that Fernanda includes economic reasons, such as economic autonomy, for postponing having children, but does not mention the presence or absence of a partner. Another participant, Ramona, who wants to marry, but after establishing her career, age is an important consideration in the decision to postpone maternity or not.

I think that [ideal maternity is] before turning 30… because after you are 30, it’s like you're older and when your child is around 18, you're already going to be very old to be able to support them… like in the part of initiating their lives where they will need you with them and you'll be too old to do that… more than our own liberty, as future parents we need to also think the needs that come with having children.\textsuperscript{413}

Indeed, when girls or young women are faced with an unwanted pregnancies, especially before they have established a career, it can be very difficult. The two women participants with children, Mercedes and Cynthia, had not been able to finish their studies before becoming mothers. As discussed during the interviews, having to juggle with both

\textsuperscript{412} Fernanda Interview, 2015, translation mine.
\textsuperscript{413} Ramona interview, 2015, translation mine.
Responsibilities at once may be challenging, particularly when access to resources is limited. Mercedes was 18 when she had her first daughter, and as she states her experience:

When I had my eldest daughter, I was a single mother and everyone living in the house helped me… my cousins, everyone. My aunt stayed to sleep at our house here to help me with my baby so that I could go to school and study… I arrived at 1pm from school and studied and took care of my baby. Later on, my husband helped with my two daughters and stayed at home while I went to do my practicum to finish my degree. It was nice that the whole family helped, but this depends on the family because there are parents [of young mothers] who say ‘I’m not here to look after your babies,’ but everyone helped me…

Although Mercedes was able to eventually finish her studies, a technical diploma, it was the support and help received from her family that made that possible. However, as Mercedes also brought up, family support is not always an option. As I mentioned before, Cynthia is able to share childcare responsibilities with her partner, which has allowed her to continue her university studies in administration and human resources, but this seems not to be the norm.

In conclusion, when analyzing maternity situations with the research participants it became clear that the ability to choose when to have children is essential. With women increasingly prioritizing careers over having a family, there has to be systems in place where women are not going to be surprised with an unwanted pregnancy. As Mercedes and Cynthia’s testimonies seem to indicate, there is an urgent need for better information.

\[414\] Mercedes Interview, 2015, translation mine.
regarding reproduction and correct contraceptive use before an unwanted pregnancy occurs, especially during schooling years.

7.3 Safe Sex and Sex Education: The Missing Part of the Equation

In Chile, the main attempt for a standard sex education curriculum began after the return to democracy. In 1995, during the government of Christian Democrat Eduardo Frei Ruiz-Tagle, the Ministry of Education established Jornadas de Conversación sobre Afectividad y Sexualidad (JOCAS). JOCAS were implemented with the intention of getting students talking about sex and sex related issues in a safe environment. In 1996, a campaign was put in place to encourage the introduction of JOCAS within the school’s curriculums. It was a political decision to allow schools to implement the JOCAS on a completely individual and voluntary basis. Furthermore, in schools where JOCAS were implemented, attendance by students depended on permission by each student’s parent. By 1999, less than 37 percent of public schools were offering JOCAS.

The Catholic Church was strongly opposed to the JOCAS program, and accused the government of “attacking the family's rights to make decisions about their children’s education.” Ultimately, due to pressures from the Catholic Church, JOCAS was reformatted to be only instructional in order to exclude students from participating in discussions, even though these changes were protested by both, educators and parents. Eventually, in 2000, the JOCAS were suspended due to conservative pressures in reaction to a

415 Virginia Guzmán et al. “Democracy in the Country but not in the Home” Third World Quarterly no. 31 (6, 2010), 976.
416 Guzman et al., 977.
417 Ibid.
418 Ibid., 978.
419 Ibid., 978.
420 Casas & Ahumada, 90.
demonstration where proper condom application was taught using bananas.\textsuperscript{421} In 2001, under newly elected President Ricardo Lagos, the funding for the program was cut completely, mainly due to “the public costs of public controversies.”\textsuperscript{422} Although the program was cut that year, in 2002 the Chilean government still used the program as evidence that they were fulfilling their international law obligations to protect adolescents’ health.\textsuperscript{423} Since the Lagos government discontinued the JOCAS program, there have not been any official attempts by government in implementing an integral sex education system. Yet, in 2010, law N° 20.418 was passed stating that “[e]very person has the right to receive education, information and orientation in material about the regulation of fertility, in clear, comprehensible and complete form, and confidentially.”\textsuperscript{424}

As stated at the beginning of this chapter, I went to the ministry of education in search for a sex education curriculum as in accordance with law N° 20.418, only to be directed to a “suggested” curriculum available on the MINEDUC website.\textsuperscript{425} The suggested curriculum, dating from 2013, is comprehensive in nature, however, there is no data on how often this suggested curriculum is consulted or utilized in class planning in Chilean public or private schools. Many schools do have some sort of sex education, but some of the most

\textsuperscript{421} Ibid., 90.
\textsuperscript{422} Bonnie Shephard (2006) Running the Obstacle Course to Sexual and Reproductive Health: Lessons from Latin America. 169.
\textsuperscript{423} Ibid., 170.
\textsuperscript{424} Fija Normas Sobre Informacion, Orientacion y Prestaciones en Materia de Regulación de la Fertilidad, Ley 20.418, 2010.translation mine.
conservative schools, as well as some poorly funded schools do not offer any sort of sex education classes.\textsuperscript{426}

Even the small group of women whom I interviewed, differed in the degree of sex education that they received, as well as personal knowledge. Out of the women I interviewed, two-thirds had some form of sex education in school. Of the women who did have sex education classes in school, there was a great variation in their opinions of the quality of the education they received. Cynthia commented that her classes in sex education were rushed to get through the material.\textsuperscript{427} Whereas Fernanda and Mercedes had workshops on sexuality given by a matrona (ie. the medicalization of sexuality and sex education).

Other sources of learning sex education and safe sex information for these participants were either the family, friends, television, or later on, in consultorios. Notwithstanding the amount of the sex education received by participants, many of them correlated ideas of “safe sex” with being in monogamous relationships and not necessarily with utilizing birth control methods.

As Ramona states,

First of all, [safe sex] is with being a couple, I mean, not having more than one partner, only being exclusive and faithful. Protecting yourself [also with contraceptives] is ideal … personally I do not do it and neither does my partner…\textsuperscript{428}

\textsuperscript{426} “Sin Educación Sexual” \textit{Ahora Noticias Reportajes}, April 11, 2017.
\textsuperscript{427} Cynthia Interview, 2015, translation mine.
\textsuperscript{428} Ramona Interview, 2015, translation mine.
And Fernanda,

Obviously [safe sex] is taking care of yourself, and having only one partner that you have relations with, because there are also diseases… if one is with one person and then another…there are diseases that are transmitted sexually, like AIDS and HPV and all that…\(^{429}\)

In this sense, the participants in this study view safe sex as related more closely to disease prevention than as a method to prevent unwanted pregnancies. With the alarming increase of HIV occurrence among the younger generations in Chile in recent years, HIV awareness and prevention have taken precedence over pregnancy prevention. Indeed, a report by The Joint United Nations Programme on HIV and AIDS (2017), found that in Chile HIV infections have gone up 66 percent between 2010 and 2016, with the age group of under thirty years old being most afflicted.\(^{430}\) Within the region of Latin America, Chile has the highest rate of new HIV cases.\(^{431}\) With these alarming statistics, the fact that many participants were aware of the occurrence and transmission of STIs is a positive one. However, as discussed in previous chapters, limiting the number of sexual partners does not protect one from unwanted pregnancies, nor does, necessarily, protect one from STIs and HIV and AIDS.

In September 2016, a new textbook funded by the Municipality of Santiago and authored by a panel of *matronas*, psychologists and other health professionals entitled “*100 preguntas de sexualidad adolescente*” (*100 questions about adolescent sexuality*) surfaced

\(^{429}\) Fernanda Interview, 2015, translation mine.  
\(^{430}\) Cecilia Yañez, “Chile es el país en que más aumentó el número de casos nuevos de VIH en Latinoamérica,” *La Tercera* July 21, 2017.  
\(^{431}\) Yañez, “Chile es el país en que más aumentó el número de casos nuevos de VIH en Latinoamérica.”
with the purpose to provide reliable information to adolescents about safe sex practices. The text was met with great backlash. It has been controversial, especially, in regards to its focus on both, heterosexual and homosexual safe sex practices, and also because its inclusion of anal sex. However, it has been successful in bringing forth the discussion of sex education. In April of 2017, MEGA, a popular for-profit Chilean television station, during their news segment aired a special report on the lack of sex education in Chile. In the report, certain issues, such as lack of sex education in public schools and the difficulties associated with teen pregnancy were discussed.

Currently, individual schools have the freedom to shape their curriculum as they see fit, as well as parents have the right to remove their children from class. In a study by Casas & Ahumada (2004), they found that over sixty percent of Chilean adolescents relied on television for getting information regarding sex. Although somewhat dated, these numbers are astonishingly high, especially when sex portrayed in the media is often romanticized and lacks safe sex content. The women I interviewed learned about safe sex in a variety of settings, such as from their mothers and family, and from professionals in consultorios. As well, few learned sex education in their schools and from television.

Sex education is fundamental for adolescents as most young Chileans begin having sexual relationships during their secondary school years. Furthermore, Montero (2011) points out correlations between initiation of sexual activity and socioeconomic status, where

432 Municipalidad de Santiago. 100 Preguntas Sobre Sexualidad Adolescente. Municipalidad de Santiago, Santiago de Chile; 2016.
435 Guzman et al., 977.
436 Casas & Ahumada, 91.
adolescents from lower socioeconomic backgrounds generally initiate sexual activity approximately two years earlier than youth of higher socio-economic status, with an average of 15.5 years of age as the initiation time.\textsuperscript{438} Furthermore, she found that, across all regions and social classes of the country, no more than seven percent of adolescents used a condom during their first sexual relation.\textsuperscript{439} Therefore, it is imperative that proper education be provided to all adolescents independent of the individual schools’ political makeup.\textsuperscript{440}

When considering the lived realities of women in Chile it is important to examine how cultural and societal shifts overtime have impacted the current gender politics of the region. In the case of Chile, women are demonstrating greater control over their lives than ever before. Through factors such as being integrated into the workforce women have gained economic freedom, and do not necessarily need to marry in order to survive economically. Legislation in recent years, such as the Ley de Filación, have also awarded women more autonomy over their lives, which has eased the pressure to marry in the case of becoming pregnant out of wedlock. With births out of wedlock now making up over half of all births, acceptability with regards to premarital sex has also had to shift within society. The shift in the acceptability of premarital sex has further paved the way for women to be more autonomous over their sexuality. However, certain aspects of women’s lives have not kept pace with cultural shifts, in particular, reforms for standardized sex education. Although sex education was legally made a right for all Chileans in 2010, there has not been sufficient effort to carry through with

\textsuperscript{438} Adela Montero. “Educación sexual”, 1250.
\textsuperscript{439} Ibid.
\textsuperscript{440} In Chile there are a few different schooling options, which are generally determined by socioeconomic status. Children of families from higher socioeconomic backgrounds generally attend either private and/or religious schools, while families with less economic means have to rely mainly on public education.
implementing an adequate sex education system. Furthermore, the fact that individual schools can independently choose which material (if any) they teach on sex education also leaves adolescents attending poorly funded, conservative and/or religious schools at an unfair disadvantage. Even though birth rates have continued to decline, there are still significant cases of girls having unwanted pregnancies every year, yet many could be prevented by accessing adequate sex education classes. As well, although there has been a decrease in unwanted pregnancies, there has been a steady increase of HIV/AIDS and STI’s in the region, which has also been directly linked with inadequate sex education practices.
Chapter 8: Conclusion

Throughout this thesis a constant theme has been legislation that results in the illusion of women’s reproductive rights in Chile. This applies to legislation pertaining to contraceptives, emergency contraceptives, sex education and abortion. Although there have been various policy changes in recent years with regards to women’s reproductive rights, health and choice in Chile, reliable accessibility to reproductive services is wanting, which disproportionately affects women living in marginalized situations. Through bureaucratic roadblocks, which are reinforced by neoliberal and classist ideologies, women with less financial means have to navigate healthcare systems where procedures include various mechanisms to discipline women into submission. Therefore, there does exist accessibility to reproductive services in public health in Chile, but that accessibility comes with the price of submitting to institutional mechanisms of discipline and control.

The lived reality of a woman living in Chile today is dramatically related to her class positioning. As discussed in previous chapters, every obstacle confronted by women trying to access reproductive services is influenced by her class status. Women with financial resources are able to avoid some of the bureaucratic hurdles entrenched in Chilean society. They can access private health care insurance, private facilities, as well as purchase drugs in pharmacies, and therefore, bypass many of the time consuming bureaucratic obstacles faced by those forced to use the public system exclusively. Well-to-do women can simply buy their contraceptives in the pharmacy, and therefore, are not subjected to the matrona’s disciplinary procedures. In the case of needing emergency contraceptives, they are not faced with the stigma associated with accessing the drug in the public system, because again, they can
simply go and buy the pill in the pharmacy without a prescription. Furthermore, in the case of unwanted pregnancy, they have the option of a safe (albeit illegal) abortion performed by a doctor within a health facility, and most likely will not risk prosecution for it.\textsuperscript{441}

In turn, women with few resources do not share the same reality. They are forced to use slow moving public facilities, becoming “patients of the state”,\textsuperscript{442} where they are treated as “nobodies”,\textsuperscript{443} with a heavy hand,\textsuperscript{444} and disdained. They are punished and disciplined at every point of access due to their class status. When trying to access reproductive services in public health centres, notwithstanding factors of access found within these institutions (such as wait times and the need for multiple appointments), other factors such as transportation costs, and lack of job security also contribute to the likelihood of a woman not using “gratuitous” contraceptives, which, in turn, increases her chances of an unwanted pregnancy. For women lacking financial resources in the case of an unwanted pregnancy, or even in the case of a pregnancy which falls under the purview of the 3 Causales law, legal or safe abortion services will remain largely inaccessible to these women due to financial and time constraints, as well as other bureaucratic and political roadblocks (such as “objection of conscious” legislation, and rape committee procedures). Therefore, illegal and, oftentimes unsafe, abortion methods will still be largely utilized.

The hostility and disdain felt towards vulnerable women in public healthcare centres and labels such as “irresponsible” stem from the same neoliberal ideology that allow well-to-

\textsuperscript{441} Lidia Casas, \textit{Women Behind Bars} (New York: Centre For Reproductive Care and Policy, 1998), 9.
do women better services. The introduction of neoliberalism not only lent to the commoditization of health services, but it also instated the illusion of choice while covertly reinforcing medicalization and the disciplining of women's bodies, in particular, of poor women’s bodies. Through neoliberal ideologies combined with medicalization, the *matrona* has become a powerful figure, and gatekeeper, for reproductive services in the public system. As well, through classism, disciplinary power of medicalization, and the *matrona*, FONASA users are stigmatized for being part of FONASA. Neoliberalism supports, and thrives on this model as it promotes ISAPRE profits through ideas of meritocracy, where using the public system (and furthermore, being poor) becomes a choice.

More so, the relationship between medicalization and neoliberal ideology, within the realm of reproductive health, are reinforced by the clinical gaze,⁴⁴⁵ which has manifested in contemporary culture through ideas of “*cuidarse*” and “*ser responsable*”. Through these manifestations, the feminization of reproduction has been reinforced as a woman’s duty, where not only her own reproductive functions, but also those of her partner, are solely her responsibility. Yet, the feminization of reproduction is reinforced not only by ideas of medicalization and neoliberalism, but also ideas of *marianismo*, where women must act as martyrs for their families.⁴⁴⁶

In recent years, cultural and societal changes have shifted gender politics away from traditionalist ideals as women are demonstrating greater control over their lives and economic freedom. Women are placing more emphasis on their careers, and therefore do not need to necessarily marry in order to access economic means. More recent legislation, such as the *Ley*

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*de Filiacion* has also lent itself to women’s autonomy when becoming pregnant outside of wedlock. Through societal shifts and a decrease in marriage, premarital sex has also become more prevalent, and acceptable. However, access to reliable information on sex education and safe sex has not kept pace with contemporary gender politics. Sex education is a pivotal point in determining the likelihood that a woman will or will not experience an unwanted pregnancy. Unfortunately due to conservative institutions, *marianismo*, and neoliberal ideologies, there still does not exist a proper sex education curriculum.

In conclusion, although in Chile it would appear that reproductive legislation has well advanced in recent years, accessibility to these services is still lacking, especially for women with fewer resources. Institutional and ideological powers have reinforced a system where women are blamed for their reproductive capabilities, and expected to have intrinsic knowledge of their bodily functions with little to no support or resources. However, in recent years women have been shifting away from traditionalist ideals, and are claiming more autonomy over their own bodies.

### 8.1 Limitations, Further Studies & Contributions

Limitations for this study included that as a North American researcher, I was not considered enough of an “insider” at the time of my research. This proved problematic during discussions on the topic of abortion, as participants were reluctant to share details of the experiences of people close to them. Furthermore, I did not conduct any interviews with working class men, which could provide an interesting element to the discussion, especially in regards to the feminization of reproduction.

The inclusion of foreigners was outside the scope of my research. However, various health professionals indicated that “*extranjeras*” (foreign women) made up a large part of the
population of women searching out emergency contraceptives and information on how to obtain an illegal abortion. Therefore, further research on impacts of being a foreign woman navigating health could prove interesting. Furthermore, research in regards to sex education programs in schools is crucial, where individual schools are examined in regards to what information is actually taught to (and perceived by) adolescents.

This study is aimed at shedding light on the current situation in Chile in regards to working class women’s reproductive rights, health and choice. It contributes to the discourse on reproductive health in the Chilean context. Specifically, this thesis is centred around notions of access and demonstrates the relationship between institutional factors such as neoliberalism, bureaucracy, marianismo and medicalization, and its impact on reproductive health and reproductive outcomes for women in contemporary Chilean society. Furthermore, it critically evaluates new abortion legislation, and analyzes its shortcomings for practical use. This thesis also depicts the lived reality of working class women in contemporary times, and documents the shift away from traditionalist patterns that when making decisions about marriage and motherhood.
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