Living on the margins : illness and healthcare among Peruvian migrants in Chile

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Illness and Healthcare among Peruvian Migrants in Chile

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Dedicado a la memoria de mi madre

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Summary

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This thesis analyzes the relationship between migration and health, in the context of Peruvian migrants in Chile. The aim of this study is to understand the effects of exclusion and discrimination on the mental and reproductive health of migrants in Chile. The problem is framed within two main theoretical perspectives; that of critical medical anthropology and that of social suffering. Both perspectives seek for a middle ground approach which brings together the social determinants of sickness and the individual illness or suffering experience; without loosing sight of the capacity for agency, creativity and resistance of individuals in the midst of social and economic challenges. It is through an analysis of illness narratives and idioms of distress that the various dimensions of illness experiences and the social determinants acting upon health and wellbeing are apprehended. The theoretical framework of this study also inquires into the relationship between migration and health as well as discrimination and physical and mental health. It offers an approach to capture this relationship which includes an understanding of the mechanisms through which discrimination operates in society and its effects on an individual's health.

The study uses an ethnographic approach to reach a more holistic understanding of migrants' conceptions of health and illness experiences. Participant observation was conducted by the researcher who shared the physical space of a community of migrants living in a derelict building in downtown Santiago. This approach led to the development of a multi-sited ethnography through which the existent linkages between migratory experiences and illness experiences were further explored. This strategy enabled a contextual understanding of the emotional and subjective world of migrants. In addition, a description of the life of the migrant community under study allowed the researcher to get closer to the migrants' ethos and enabled her to grasp the rationality of migrants' everyday decisions. The ethnographic description also includes the resources migrants employ when facing adversity, uprootedness and the hostile social climate of Chilean society. The ethnography is complemented with the inclusion of quantitative techniques, such as household surveys, which also establishes the transnational character of this migration.

The study delves into migrants' mental health through different research techniques. A mental health test is used to select a group of migrants among whom in-depth interviews are conducted and illness narratives are gathered. These interviews offer an understanding of the social context, and the emotional relationships in which migrant's emotional distress is embedded. These contexts are linked to their living conditions, uprootedness and the emotional and physical dislocation of migrants' lives. Through the interviews, data on the motives and forms that migrant's emotional distress takes are gathered, and the relationship of these with the underlying cultural matrix is established, including cultural conceptions of the self. The resources and mechanisms migrants put in motion to cope with emotional distress – mostly outside the medical system – are also discussed.

The last section of this study is devoted to healthcare among migrant women in the area of reproductive health. This section looks at the interaction between healthcare providers and migrant patients in family planning services and antenatal care, in two public health clinics in Santiago. Through interviews and focus groups with healthcare providers and migrant female patients, this section delves into the relationship between existent perceptions and responses implemented to address women's healthcare needs. The mismatch between migrants' needs and the services offered to them is analyzed in the light of an ongoing process of construction of migrant women as a new category of patients as well as with existent underlying models which guide healthcare providers in dealing with migrant women as 'different'. The study offers sufficient background to render healthcare models more culturally sensitive.

Samenvatting

Leven in de marges
Ziekte en gezondheidszorg onder Peruaanse migranten in Chili

Dit proefschrift analyseert de relatie tussen migratie en gezondheid onder Peruaanse migranten in Chili. De studie is er op gericht inzicht te krijgen in de effecten van uitsluiting en discriminatie op de geestelijke en reproductieve gezondheid van migranten in Chili. Het probleem wordt vanuit twee belangrijke theoretische perspectieven behandeld: het perspectief van de kritische medische antropologie en het medisch-antropologisch perspectief van sociaal lijden. Beide perspectieven richten de aandacht op de wederzijdse relatie tussen sociale determinanten van ziekte en de individuele ziektebeleving en het individuele lijden, zonder de mogelijkheden van individuen tot handelen, creativiteit en het bieden van weerstand te midden van sociale en economische uitdagingen uit het oog te verliezen. Via een analyse van ziektegeschiedenissen en de verwoording van het ondervinden van zorgen en pijn kunnen de verschillende dimensies van ziekte-ervaringen en de sociale determinanten die van invloed zijn op gezondheid en welzijn worden begrepen. Het theoretische kader van deze studie bevraagt tevens de relatie tussen migratie en gezondheid en de relatie tussen discriminatie en fysieke en geestelijke gezondheid. Het biedt een benadering die het mogelijk maakt deze relatie te vatten, hetgeen tevens een begrip inhoudt van de mechanismen waarmee discriminatie in de samenleving opereert en de effecten daarvan op individuele gezondheid.

De studie gebruikte de etnografische methode om te komen tot een meer holistische benadering van de perceptie van migranten ten aanzien van gezondheids- en ziekte-ervaringen. De onderzoeker hanteerde daarbij participerende observatie, door de fysieke ruimte van een slooppand in het centrum van Santiago met een migrantengemeenschap te delen. Deze benadering leidde tot *multi-sited* etnografie die de basis vormde om de verbanden tussen migratie- en ziekte-ervaringen uit te diepen. Deze strategie maakte het mogelijk te komen tot een gecontextualiseerd begrip van de emotionele en subjectieve wereld van de migranten.

Daarnaast heeft een beschrijving van het leven van deze gemeenschap de onderzoeker de mogelijkheid geboden dichter bij de 'ethos' van de migranten te komen en werd het mogelijk de rationaliteit van de dagelijkse beslissingen te vatten. De etnografische beschrijving richt zich tevens op de middelen die migranten gebruiken bij tegenslag, ontworteling en het vijandige sociale klimaat van de Chileense samenleving. De etnografie wordt aangevuld met kwantitatieve technieken, zoals enquêtes onder huishoudens, waardoor ook het transnationale karakter van de migratie aandacht krijgt.

In de studie zijn verschillende onderzoekstechnieken gebruikt om door te dringen tot de geestelijke gezondheid van de migranten. Een geestelijke-gezondheidstest is gehanteerd om de groep van migranten te selecteren met wie diepte-interviews zijn gedaan en van wie anamneses zijn opgetekend. De interviews maakten een beter begrip van de sociale context mogelijk en gaven zicht op de affectieve machtsrelaties waarin de emotionele problemen van de migranten zijn ingebed. Deze contexten zijn verbonden met de leefomstandigheden, de ontworteldheid en de emotionele en fysieke ontwrichting van het leven van de migranten. Door middel van de interviews werden gegevens verzameld over de aanleidingen tot het complex van emotionele problemen van de migranten, en werd de relatie hiervan met de onderliggende culturele patronen gelegd. De middelen en mechanismen die de migranten hanteren om – meestal buiten het medische systeem om – te kunnen omgaan met hun emotionele problemen worden eveneens besproken.

De laatste sectie van de studie is gericht op het gezondheidszorgsysteem voor migrantenvrouwen op het terrein van reproductieve gezondheid. Hier wordt gekeken naar de interactie tussen gezondheidswerkers en migranten patiënten op het gebied van gezinsplanning en zwangerschapszorg in twee gezondheidsklinieken in Santiago. Gebaseerd op individuele en focus-groep interviews met hulpverleners en vrouwelijke migranten patiënten gaat dit deel van het proefschrift in op de relatie tussen bestaande percepties van gezondheidszorgbehoeften van de vrouwen en de behandelingen die hun aangeboden worden. Het gebrek aan overeenstemming tussen de behoeften van de migranten en de geboden hulp wordt geanalyseerd in zowel het kader van het continue proces om migrantenvrouwen als een nieuwe categorie van patiënten te begrijpen, als vanuit het bestaande onderliggende model ten aanzien van het omgaan met het verschillend-zijn van migrantenvrouwen dat de gezondheidswerkers aanstuurt. De studie biedt aanknopingspunten voor het cultureel gevoeliger maken van gezondheidszorgmodellen.

Introduction

In the year 2000, a group of Chilean shopkeepers reacted strongly against the growing Peruvian community who had for the last decade settled in the Plaza de Armas, the main square in Santiago, using the area as their main gathering point. The shopkeepers argued that the Peruvians left the Plaza dirty, used the place for illegal trading and Chileans did not feel free to circulate in the area any longer. They demanded to see the Plaza returned to the way it was prior to the arrival of the Peruvian migrants and called upon the police to control the changed 'human geography' of the Plaza.

The police prohibited the Peruvians from sitting along the sides of the Cathedral; however, the Peruvians at the Plaza were kept under control for a very brief period. The Plaza had become a meaningful space for Peruvian migrants because it represents, for them as well as for many other Latino-American people, a familiar postcolonial landscape.[1]

Today, the Plaza de Armas functions significantly as a centre particularly utilised by Santiago's Peruvian migrant population and it is now commonly called "Little Lima". Organisations who seek to address this migrant community often come to the Plaza to spread their messages. One such example is that of a group of healthcare professionals from a public primary healthcare clinic, who after having observed an increase in cases of tuberculosis (TB) among their Peruvian patients, planned to implement a preventive measure in the Plaza and to take free blood samples to test for TB among the Peruvian citizens. This initiative was fortunately not implemented, as if it had, it would probably have reinforced generally held perceptions of Peruvian migrants as being prone to infectious diseases.

In the events described contradictory images of the Plaza emerge. The Plaza is at the centre of the polis, generally regarded as a place for the exercise of citizenship; where citizens meet and their voices are heard. But this Plaza has also become a space for the marginalised, a place where stereotypical views Chileans hold about migrants are enacted and reinforced for example, through public health concerns. Yet, equally important it has become a space where migrants are silently affirming neglected cultural differences and a lack of rights – a space for resistance. To some extent the Plaza acts as a metaphor of the place migrants have in Chilean society.

The Problem

Migration is a growing worldwide phenomenon. Despite the ever-tightening barriers imposed in developed countries to citizens from third world countries, the number of people who leave their homes to seek 'greener pastures' outside national boundaries

[1] The structure of the Plaza is part of the Spanish legacy, around which all the colonial cities in Hispano-America were founded. Today Plazas act as a geographical and symbolic reference to a common historical identity in Latin America. This 'transnationalised sense of place' should be understood as a geographic point of reference providing multiple communities with a sense of belonging to a postcolonial-cultural environment, as well as to a broken but significant past.

continues to increase. Illegal migration is becoming an issue of concern for receiver countries.

While most migrants continue to come from third world countries, countries of destination are growing in a variety of regions in the South. Factors such as interregional differentiation explain why countries in the South are being chosen as a destination by an increasing number of people. Countries in the South are, however often not prepared to adequately respond to the influx of newcomers.

Mechanisms of social protection in most of these countries are either nonexistent or very limited. Moreover, cultural similarities shared by populations of neighbouring countries often do not protect migrants from being marginalised and confronted with discrimination and xenophobic attitudes. In countries such as Argentina discrimination manifests itself against migrants from Bolivia and Peru, in Costa Rica against Salvadoran and Nicaraguan refugees, and more recently in Ecuador discrimination is directed towards Colombian migrants. These are just a few examples of the existent hostile climate towards migrants that seems to increase along with the same intraregional migration in Latin America.

Migrants in the South often confront violence, adversity and illness, which in the context of migration become a crucial event. The literature often stresses 'the healthy migrant effect', in reference to an observed trend where those who migrate tend to be healthier. While that may be true, once in the host country, maintenance of health is not always possible for migrants.

Most of the time migrants find themselves in deteriorated living and working conditions. Their vulnerability also increases when, as a result of illness, migrants are impeded to perform their work activities. In view of the lack of support mechanisms and social protection, illness jeopardises the very endeavour of migration and its whole economic purpose. Barriers to accessing healthcare for migrants are multiple; lack of rights, resources and information, which is not always accessible to them.

Various factors contribute to increase migrants' vulnerability in the new society; this is especially true if we consider migrant's lack of resources to recover health. Uprooteness and lack of social support often add to the difficulties migrants face to recover health and maintain their wellbeing. When people fall ill they attempt to recover their health using frames of reference and resources that are familiar and accessible to them. A familiar social milieu provides the sufferer with the resources and knowledge of how to address the illness, all of which contributes to diminishing the anxiety surrounding the experience of illness. For a growing number of migrants around the world this support disappears.

This study explores how people experience illness in foreign environments where they lack social support and suffer exclusion and discrimination. It addresses the question of how migrants perceive, interpret and deal with illness and what they do to keep themselves healthy in contexts of vulnerability, were resources to overcome illness are not always available. Framed within this context, this study focuses more generally on the social production of illness as well as on the State responses to migrants' need for healthcare. This last dimension reveals existent institutional – although non-formalised – policies towards migrants.

Indeed, when studying migration and healthcare, it is important to attend to how, through the provision of healthcare, attempts are made to transform migrants into disciplined subjects. Beyond the health of bodies, healthcare practitioners relate to migrants in reference to their cultural identity – to their right to reside in the country and entitlement to public healthcare. Through the provision of healthcare in public institutions, migrants may be subjected to State control and to the disciplining imposed over them. I will study the various dimensions of the relation between migration and health from the perspective of Peruvian migrants who have come to work in Chile since the 90's.

In general there is a lack of systematic knowledge about migrants' living and working conditions in Chile. There is also a lack of comprehensive policies aimed at protecting and promoting migrants' well-being and their integration into Chilean society.

Knowledge is required to disclose the various mechanisms which produce discrimination and exclusion of migrants as well as other minorities and how that conflictive experiences ultimately impact on migrants' health. A perspective towards the integration of migrants into various societies of destiny needs to pose questions regarding structural limitations which block migrants from accessing better housing and job opportunities in the labour market as well as how these limitations are affecting migrants' well-being. The study of illness in turn can shed light on what it ultimately means for migrants to live in conditions of displacement, as well as to work and live in hostile environments. If the experiences of those migrant men and women who have left their homes and families to work in Chile are not systematically studied, adequate polices cannot be implemented.

The Chilean experience is in this regard, a case in point. After more than ten years of migrants constantly flowing into Chile from Peru, migrants' cultural differences and their greater social vulnerability have only recently begun to be addressed. These initiatives as well as the extent and the way in which they are reaching migrants, need to be critically examined.

The Chilean State recently implemented an initiative which aims to assure access to healthcare to pregnant migrant women and their children up to six years old. However the vast majority of migrants still have great difficulty in accessing basic healthcare. In fact until recently it was estimated that half of the migrant population were of irregular legal status and, therefore, had not been covered by the health system. In order to provide a general – although transitory – solution to the problem of illegality and in this way target various vulnerabilities associated to that condition, current irregular migrants were given amnesty in 2007. While this is a very positive step, it does not necessarily solve the problem of access to healthcare for migrants. Indeed, in other instances, even when migrants are legal, they are not in possession of a work contract which limits their access to healthcare. Without such documentation, they are not covered by health insurance and as such, are not entitled to use the Chilean public healthcare system. Nevertheless, in the long term, access to legal status may involve an increase in migrant's demand for healthcare. Whether or not the Chilean public healthcare system is prepared to face such a challenge is at this stage, an imperative question.

There are certain areas of healthcare such as the existing asynchrony of perspectives on health and illness between Chilean caregivers and the migrant community that have not yet been sufficiently addressed by the State. Furthermore, the public responsibility to define needs and priorities for migrants' health relies on individual caregivers. This individual approach is insufficient when it lacks a socio-cultural perspective to migrants' social and economic conditions. Without this more integral perspective, there is a risk to medicalise[2] problems derived from migrants' social situation, which could be prevented by proper State policies.

In fact, the current lack of comprehensive State policies towards migrants in the area of healthcare, affords caregivers some degree of autonomy in delivering care, as well as in the quality of this care, to migrants.[3] Thus, healthcare workers act in part as independent agents, in response to medical ethical obligations or guided by their own subjectivity. Indeed, these health workers are influenced by general ideas and attitudes toward migrants. Competing frames of reference come into play, often influencing practitioners' attitudes towards migrants when dealing with them as patients.

Women and men find themselves in different places when they relate to the healthcare system. Reproductive needs place women in a more vulnerable position, particularly during pregnancy. It is then when ideas about gender, maternity, sexuality, family, health, hygiene and ethnicity, most manifest. Also, it is during pregnancy when most migrant women interact with healthcare providers. Cultural elements, without a doubt, play a central role in these encounters.

While the policies in place show a concern with the question of the State's appropriate role regarding migrant's well-being in Chile, a lack of general societal concern regarding migrants' vulnerable position is still visible; the existing project of law against discrimination that would protect migrants' in Chile was presented to the parliament in 2003 but has not yet been discussed. The UN International Convention of Protection of Migrant workers and their families, was signed by Chile in 2004 but it too, has not yet been implemented. It is expected this study will contribute to make visible migrants' predicaments and pose arguments to develop culturally sensitive initiatives to protect migrants' rights and well-being.

Research Objectives

This study aims to investigate the relationship between migration and health. Specifically, the study investigates the relationship between the exclusion and discrimination that Peruvian migrants are likely to encounter in Chile and how these conditions affect their health.

Two specific objectives are linked to this general objective:

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[2] "This process entails the absorption of ever-widening social arenas and behaviours into the jurisdiction of biomedical treatment through a constant extension of pathological terminology to cover new conditions and behaviours" (Baer *et al* 1997:57).

[3] Although migrants might not be entitled to public healthcare in Chile, under pressing circumstances (such as emergencies or pregnancy), migrants do receive healthcare. The provision of such a care often relies on the discretion of healthcare providers.

1. To explore, through the use of an ethnographic approach, the linkages between social, economic and cultural determinations of migrants' health, and their collective and personal experience of illness.

2. To contribute to Chilean State policies that are culturally sensitive and take the needs of migrants into account, including healthcare policies.

Given that Peruvian migrants interact with the public health system in varying degrees and that many of them attend to their healthcare needs outside the public health system, this study purposely distinguishes between migrants' interactions with Chilean society inside and outside the public health system. This distinction also responds to a primary interest in exploring the various dimensions of the relationship between migration, exclusion, discrimination and health. Thus, the decision to explore illness and health practices outside the healthcare system, among the community of migrants, is grounded in the need to specifically grasp the consequences upon health for migrants who have a marginal status in Chilean society.

The distinction between inside and outside the healthcare service also crosscuts the two health areas selected in this research: mental and reproductive health.

As observed, a relatively high demand for healthcare occurs in the area of reproductive health and comes mainly from women. On the other hand, in the area of mental health, the demand for care of men and women migrants is almost nonexistent. Therefore – although not exclusively – these two sets of goals run in parallel with the two health areas selected in this study. Thus, for the analysis of the relation between migration and illness experiences, I mainly focus on migrants' mental health. Whereas, for the analysis of health practices, access, interaction and use of the Chilean healthcare system by Peruvian migrants, I focus on the area of reproductive health.

Interactions between migrants and Chilean society, <u>outside</u> the public health system

Explaining the existing relationship between migration and health in contexts of exclusion and discrimination, involves the analysis of migrant's illness experiences as they arise in effect of the material living and working conditions they find themselves in, in the new country. The relationship between illness and migration can be also highlighted through an analysis of the experiences of Peruvians in their own country as compared to their illness experiences as migrants in Chile. Furthermore various aspects of migrants' identity ought to be taken into consideration when studying the relationship between migration and illness experiences. These aspects are gender, national/ethnic identity and class.

Interactions between migrants and the Chilean society, <u>inside</u> the public health system

As part of my general objective of studying the relationship between migration and health, I will study migrants' access to the official medical system. Studying of migrants' access and interactions with the public healthcare system in turn, allows examining the role the Chilean State plays in the cultural exclusion and discrimination of Peruvian migrants. This analysis should therefore attend to the re-negotiations of migrants' cultural identity that takes place when Peruvian migrants and healthcare workers meet and interact. Furthermore an analysis of the process involved in such

interaction also allows for identification of the forms discrimination may take inside the healthcare system.

Research questions

In order to achieve the objective proposed, leading questions are formulated to orientate the direction of this research. A central question of my study is how illness and suffering is socially produced, collectively interpreted and individually experienced. Linked to this question is the extent in which the State, through the provision of healthcare, contributes to modify or to reproduce the social roots of illness, and how in this process migrants' differences are dealt with. To address these general questions my study will inquire into three interrelated areas.

Questions about exclusion, discrimination and health

Firstly, the phenomenon of Peruvian migration to Chile is relatively new. Studies about this community are incipient and available information is scant. An initial area of my study addresses the characteristics of the migrant community living in Santiago. I assert that living and working conditions of migrants in Chile are the result and manifestation of social and economic exclusion and that such a condition has a gradual impact upon migrants' health.

Experiences of discrimination – an accompanying dimension of exclusion are a central concern of this study. Thus, a question to be raised is: whether discrimination is experienced by migrants (and, if so, how)?

My inquiry also delves into the strategies and resources of those migrants in coping with adversity, illness and discrimination as I look at migrants' agency in dealing with the constraints their circumstances impose upon them. Therefore, I also investigate: what those resources are that migrants use and how effective they are.

Questions about illness experiences and idioms of distress

Secondly, as we have seen, migrants' access to healthcare in Chile is restricted. This is particularly true in cases of mental health where, as observed, migrants' demand of care in this area is almost nonexistent.

My inquiry focuses on the ongoing process of change in illness experiences taking place along with this migration. I specifically look at the way in which oppressive social relations not only trigger but also transform migrants' experiences of emotional distress as well as the language they use to communicate this distress. Questions to be asked are: What uses do migrants make of idioms of distress? What common experiences among the migrant community residing in Chile are articulated and conveyed through these idioms of distress? Are the new terminologies of distress being incorporated by migrants into their account of feelings and experiences relevant to gain understanding in Chilean society?

It is also important to know how these idioms change in the process of migration to and settlement in Chile. Is there a relation between changes in experiences of emotional distress and changes in idioms of distress used by migrants? Is discrimination reflected in migrants' experiences of emotional distress?

Questions about access to healthcare in reproductive health

Thirdly, the economic and social exclusion of migrants is clearly displayed by the limitations they face getting medical care when care is needed. Specifically, I inquire into cases of migrant women requiring reproductive healthcare; what the nature of the existing barriers limiting migrant women in accessing family planning programs is. To what extent are these barriers affecting these women's reproductive health?

Despite the lack of consistent studies of the relationship between migrants and Chile's healthcare institutions, the scant available data on the subject suggest that Peruvian clients and Chilean healthcare providers have divergent goals and expectations. For instance, Chilean caregivers have a deeply rooted belief in the utility of preventive and public health measures. This belief clashes with migrants' possibilities to gain from these measures, as they need to maintain anonymity because their legal status may be of an irregular nature.

Cultural exclusion is also manifest in those aspects of migrants' illness experiences that are neglected in the medical consultation. In addition, the denial of migrants' cultural identity can also be expressed in the existent assumptions made by the healthcare practitioner during the doctor-patient interaction. Particularly crucial are those assumptions made on women's sexuality when reproductive healthcare is provided to them. Is there a mismatch between perceptions and explanations healthcare providers have on migrants and migrants' expectations and needs? Are the perceptions of migrant women held by healthcare providers, shaping the services provided to migrants?

Finally, it is important to explore, the existence and nature of experiences of discrimination Peruvian migrants are exposed to when making use of the Chilean healthcare system. How do migrants' general experiences of discrimination in Chile influence their interaction with the healthcare system?

In order to answer the research questions posed, information was gathered from illness narratives. This included data on cultural specificities in Peruvian's perceptions of illness and health, as well as the relationship of Peruvians with healthcare institutions in their own country. In this way, relevant differences and similarities between both countries could be established. The comparison assisted us to determine whether or not continuities in experiences of exclusion and discrimination could be found in changing contexts.

Structure and content

This thesis is structured into four parts and eleven chapters:

Part I: Displacement, Discrimination and Distress

Part I contains the theoretical approach and methodology used in this study. Chapters one and two discuss the theoretical framework and are divided into two main conceptual areas and chapter three deals with the methodology of the study.

Chapter One begins by discussing theories of migration with special attention to the cultural dynamics involved in the phenomenon of transnational migration and its effects on health. It also discusses various approaches to study the relationship between discrimination and health as well as some of the methodological challenges in measuring this relation. This discussion frames the approach of this study to the problem. Finally, this chapter provides some background to understanding the roots of the conflictive interactions between the Chilean society and Peruvian migrants.

Chapter Two discusses the theoretical approaches in medical anthropology framing the problem of the study. It discusses four main theoretical approaches; the interpretative approach; the political economy of health approach; the critical approach and the social suffering approach. The linkages between these various approaches are explored, creating a middle ground perspective of analysis. In this perspective, societal forces and individual's experiences are brought into analytical focus.

Chapter Three presents the methodology used in the fieldwork. It begins with a reference to ethnography as the main methodological strategy. It describes the process of implementation and the development of the ethnographic work and explains the logic and the stages involved in doing so. This chapter also explains the use of various complementary methods to gather information on migrants' mental and reproductive health.

Part II: Migration and its Discontents

Part two consists of an ethnographic account of the daily life of a community of migrants living in downtown Santiago. It characterizes the migrant community by giving details of their living conditions as well as their social and cultural world. The aim of the ethnography is to achieve a better understanding of their illness experiences and the resources migrants utilise to face illness and adversity. This section also explores the nature of their relationship with the Peruvian society as well as with the broader Chilean Society.

Chapter Four provides a profile of the socio-demographic characteristics and health status of a migrant community living in downtown Santiago. The chapter also explains the nature of the migratory movements of Peruvians to Chile and the character of their relation with the major society.

Chapter Five discusses various dimensions of life in the migrant community. It gives a detailed account of migrants' living conditions and portrays the cultural fabric and social relations around which their migrant lives are organised in Chile. The chapter looks at how migrants create a sense of community and support; a sense of purpose that allows them to share resources and resist the adversity of their lives as migrants in Chile.

Chapter Six looks closer into more subjective elements of migrant identity stemming from their community life. It explores the dynamics of trans-national families as part of the identity shared by migrants. In addition it discusses how elements of migrants' national identity are channelled through practices around food. It also looks at changes and continuities in gender practices and identities. It addresses existing differences among migrants themselves and with the broader Chilean society through discussion on changes in migrants' status in Chile and their experiences of discrimination.

Part III: Migrants' Mental Health Status in Chile: Old and new illness experiences, idioms of distress and coping mechanisms in a hostile Context

Part three explores migrants' mental health and in particular experiences of emotional distress as connected with their lives as migrants in Chile. Migrants' emotional distress is analysed in relation to experiences of displacement, exclusion and discrimination. It also looks at the coping mechanisms put in place by migrants to deal with illness and distress.

Chapter Seven links the rise of migrants' emotional distress with the position they occupy in the social and economic structure. It begins with a characterisation of their mental health status based on a medically validated mental health test. Subsequently, and based on the illness narratives of a smaller group of migrants, the chapter explores the symptoms of distress migrants experience and how these emerge in different spheres of migrants' lives and in their social interactions in various local contexts; the work environment, migrants' trans-national families and their love relationships.

Chapter Eight focuses on the continuities and changes observed in migrants' experiences of emotional distress in Chile, among the community and in interaction with various local agents and contexts. It also looks at the process of change resulting from migrants' interactions with different local agents which is manifest in the various languages migrants use to communicate their distress.

Chapter Nine explores coping mechanisms and resources migrants put into motion when dealing with their emotional distress in Chile. The chapter discusses the responses migrants get from the Chilean medical system; the incipient process of medicalisation of migrants' emotional distress and the resistance migrants put into this process.

Part IV: Migrants' Reproductive Health and the Chilean Healthcare System

Part four inquires into the role of the State in caring for migrants' well-being and migrants' access to public healthcare. Specifically, I look at migrant women in family planning programs as well as in antenatal care and explore barriers to their access of reproductive healthcare.

Chapter Ten deals with various forms of exclusion which are manifested in i) the barriers to access of reproductive healthcare services, ii) the existent offer of contraceptive methods which is discordant with the specific needs of migrant women and iii) the lack of acknowledgement of migrants' cultural specificity by the healthcare

providers, particularly cultural beliefs regarding reproduction and birth held by women which are not addressed, ignored or neglected by the healthcare providers. This chapter also deals with the forms in which women resist the use of the contraceptive methods available to them and the difficulties they face in adapting to the existent offer.

Chapter Eleven examines the situation of migrant women as patients of family planning services within the public healthcare system. It discusses the mismatch between the demands and offer of services in family planning programs and the (lack of) responses of the public healthcare system to the specific reproductive needs of migrant women.

The Conclusion presents a summary and a discussion of the main results. The discussion focuses on the relationship between illness as a social and cultural experience in relation to migration, in contexts of displacement, and discrimination.

Part 1

Displacement, Discrimination and Distress

Part one consists of three chapters and presents the theoretical framework and the methodology which guides this study.

Chapter one focuses on the relationship between migration and health. It specifically discusses the dynamics associated with transnational migration as migrant's everyday lives are framed within transnational social fields and it explores the linkages that exist between these dynamics and migrants' wellbeing. It also discusses discrimination that often accompanies migration and debates its effects on the health of migrants in the host society. Discrimination is based on an explicit devaluation of the other's difference – race, gender, sexual orientation, age or any other difference. Peruvian migrants in Chile are discriminated against on the basis of their national-racial identity. The variety of dimensions in which discrimination is manifest is discussed here, as well as the challenges these dimensions pose to its study. Chapter one presents the framework to study the effect of migration and discrimination on Peruvian migrants and presents some background to understanding the roots of the current discrimination against Peruvians in Chile.

Chapter two draws theoretical approaches and concepts from medical anthropology so as to frame an understanding of displacement and its effects on the individual. It starts with a brief chronological trajectory of the re-conceptualisation of illness in medical anthropology. Its objective is to place illness within the understanding of the interpretative approach. The theoretical approaches of Political Economy, the critical approach in Medical Anthropology and Social Suffering are also included with the purpose of building a middle ground approach. The middle ground approach allows delving into a micro-level of analysis, without losing perspective on social forces which determine individual experiences. The discussion focuses then on some of the cultural dynamics associated with migration. It debates the effects of displacement on individual bodies and subjectivities. It also explores idioms of distress as a means to communicate and represent personal and collective suffering.

Chapter three is devoted to the methodology used in this study. It describes the process of doing ethnography and participant observation and the different roles that I adopted in the field as, volunteer, researcher and lastly as migrants' neighbour. It discusses the scopes and limits of the information gathered throughout each one of these roles and the process of gradual engagement with the community studied. It further addresses the different facets involved in doing participant observation – entering into the field, building a relation of complicity and trust with the community. It discusses my own subjectivity

and status in the field, as manifested in my interaction with migrants, my personal involvement in community problems and the distance travelled in the process of getting in and out of the field. In doing so the gender dimensions in the fieldwork are also discussed. Other research techniques implemented in order to capture specific dimensions of migrants' health such as those used to study mental health as well as reproductive health are subsequently explained. A particular emphasis is given to illness narratives as a central method to capture migrants' experiences of suffering and emotional distress.

Chapter I

Towards an Understanding of the Relation between Migration, Discrimination and Health

1.1 Introduction

This chapter introduces some of the relevant dimensions in the study of the relationship between migration and health in contexts of exclusion and discrimination. It begins by presenting various approaches to migration and reviews classic theories that explain this phenomenon as well as the shift in perspectives introduced by the approach of transnationalism. Elements of continuity and difference between previous and current forms of migration are addressed. Specifically, cultural dynamics at play in the encounter between the migrants and the receiving society are discussed.

The second section of this chapter discusses linkages between migration and health by presenting a model which captures the various factors influencing this relationship. This model is problematised in the light of the new transnational dynamics which shape migrants everyday lives as transnational social fields are created, which ultimately influence migrant's health and wellbeing. The third section of this chapter delves into the discussion of discrimination. It begins by explaining the various forms discrimination takes. Discrimination can range from daily hassles to major life events. It can also be institutional and take on covert or overt forms. In its institutional form, discrimination can become a structural barrier impeding the prosperity, self-esteem and power of minority groups. In this way, it creates and reinforces migrants' social and economic exclusion. Based on this distinction, the next section discusses the relation between discrimination and health as well as some theoretical and methodological problems associated with the measurement of this relationship.

The last section of this chapter draws from previous discussions and presents the approach this study will use to unpack the effects of discrimination upon the health of Peruvian migrants. Some historical and cultural backgrounds are also included here to assist in understanding the problem of discrimination suffered by Peruvian migrant workers living in Chile.

1.2 Migration

Anthropologists studying migration mostly use two distinctive analytical approaches. One is rooted in modernisation theory and the other in an historical-structuralist perspective grounded in a broader theory of political economy.

In general, studies conducted on migration have been significantly influenced by the modernist theory and its bipolar framework of analysis which distinguishes between sending and receiving areas. In this theory, migratory flows can be understood as driven by push factors of out-migration and pull factors of in-migration. The modernist approach to migration focuses on the motivations of individual migrants in their endeavours. It emphasises rational and progressive economic decisions made in response to disparities in land, labour and capital, between the areas where migrants live and where they choose to migrate.

Commonly identified push factors are economic hardship and political turmoil in sending areas. Pull factors are often related to more favourable economic conditions in the host country and can include migration for study purposes, as better institutions of learning can often be found in the receiving country. The existence of economic niches in the labour market, as well as social networks and migrant communities already settled in the host country are other attractive and valid pull-factors. These factors are frequently used to explain both internal (rural-urban) as well as international migration; this last dimension is the focus of my study.

Although push and pull factors as identified by modernisation theory are still relevant in understanding why people migrate, critics of this theory have pointed to its linear perspective. Indeed, modernisation theory is based upon an equilibrium model of development. This model espouses a balance between resources and population. In other words, a balance is expected to be attained between the populations of sending and receiving countries as well as differences between rural-agrarian and urban-industrial areas which are expected to be gradually eliminated.

The historical-structural approach of the political economy theory of migration instead shifts the attention from individual decision making, to the macro level processes that shape and sustain population movements. This approach understands migration in the context of global core-periphery relations of world system theory (Wallerstein 1974) as well as the linkages between development and underdevelopment of dependency theory (Frank 1967). Within this approach concepts such as "international division of labour" or the "internationalisation of the proletarians" have emerged to describe the inequalities between labour exporting, low-wage countries and labour-importing, high-wage countries" (Brettell 2000:103). Development in this analytical approach is seen as encouraging migration as it creates inequalities. It also enhances people's sense of relative deprivation and it raises awareness about opportunities in cities and in core productive areas.

The focus of attention is thus not placed on individual migrants but rather upon the global market and the way in which capitalist development, international economic and political policies have disrupted local systems, instigating migration streams (ibid:104). The emphasis of this macro-approach lacks sufficient attention to individual agency. Indeed, migrants are often portrayed not as active agents but as "passive rectors manipulated by the world capitalist system" (idem).

These approaches are useful to understanding why people migrate, however the question that concerns this study is what happens once they have migrated. In order to address this question, I find it necessary to refer to previous internal (rural- urban) migration in Peru, information which sheds light on the continuities and changes

affecting current international migration and the cultural dynamics at play. An element of comparison is the existence of distinctive cultural and ethnic factors which differentiate migrant groups from the major society at various times. In this context it is worth looking at migrants' attempts to bridge that distance and moderate its disturbing effects. Indeed, in circumstances of cultural contact and conflict it is possible to examine some of the 'adaptive structures' that previous generations of rural migrants created arriving in the city. Parallels can also be drawn with Chilean indigenous rural - urban migrants in the past. The relevance of the 'adaptive strategies' created by migrants –also called 'transitional structures' – lies in the fact that they provide migrants with a sense of continuity and belonging which assists them in facing the dramatic change of lifestyle when settling in urban contexts.

1.2.1 Rural–urban migration and the adaptation of migrants to the urban context

During the past century an important urbanisation process took place in Peru. The agricultural crisis of the 60's in Peru accentuated rural migration from the *sierra* (mountain range) area of Ancash, Cajamarca and La Libertad in the Peruvian north region. A large percentage of the indigenous population migrated from depressed rural areas to the costal cities, such as Lima and Chimbote attracted by the growing of the industrial productive centres. They put up their shacks and settled down in the margins of the cities. Indigenous peasants, who formerly produced for their own subsistence, undertook jobs as fishermen, mining workers and farmhands thus becoming urbanised workers in one generation, the proletarian and marginal population of the Peruvian productive urban centres. Many of the Peruvian migrants who arrived in Chile during the 1990's are the second or third generation of these internal migrants.

Earlier studies of urban anthropology in Peru had emphasised the different adaptive strategies of rural migrants in the cities. Attention was placed on the gradual acquisition of the Spanish language by the Quechua and Aymara speaking population. In the case of Peru, Escobar asserted that the dialect '*castellano andino'* spoken by the non native Spanish speaking population made it easier to identify and stigmatise migrants in the cities (Escobar 1978 quoted by Wallace 1984). However, the gradual mastery of the Spanish language by the *cholo* population did not result in a complete acculturation into the urban setting. In fact this was accompanied by the recreation, in the urban context, of the cultural and religious expression characteristic of the Andean world. "Celebration, dances and music from the Sierra such as the 'Huaynos' (highland-style songs) filled up the atmosphere of the marginal urban settings in the cities" (Wallace 1984). Rural social relations became rearticulated in the city and relations of *paisanaje* (term used to refer to people coming from the same region) became relevant.

Subsequent studies on adaptation of migrants to the urban context emphasised the role of 'regional associations.' Long for example, stressed not only the social and recreational nature of the regional association but its role in the re-articulation of rural urban networks as well as in economic and political terms (Long 1973). Regional association in urban settings had at least two functions; they served as acculturative and integrative mechanisms. In both cases associations provided support in the adaptive processes, assisted their members in learning the ways of urban dwellers and provided them with informal networks to jobs and services (Wallace 1984).

Similarly in the case of Chile in the 1960's, Munizaga (1961) described what he called 'transitional structures' that were created by an estimated number of 300.000 rural Mapuche that were migrating to Santiago in those years. These transitional structures served as "bridges or intermediate mechanisms through which the rural indigenous move into urban life" *(my translation)*. According to Munizaga, intermediate mechanisms included informal groups, as well voluntary associations in the city, which recreated the ethnic and cultural elements shared by these migrants. These structures provided support and moderated the social, cultural and psychosocial effect of the movement undertaken by culturally differentiated groups, assisting them in bridging rural and urban barriers.

Concepts coined to understand the rural-urban migratory movements of the past could be used today to understand international migratory movements. In particular, as they convey the efforts migrants in different times and contexts have made to create bridges in their transit to a different socio-cultural milieu. However, there are important elements of change in the features of new international migration which also requires examination, and this will be refered to next.

1.2.2 Contemporary transnational migration

New features of international migration, such as its transnational character, have stimulated the development of new analytical frames in which to understand this phenomenon. The transnational perspective poses critical views of previous bipolar migration models by addressing the increasing complexity of the linkages between receiving and sending societies. These linkages are facilitated by changes in world transport and communication systems worldwide. Bash (1994) referred to this process as 'transnationalism' and asserts that it is embedded in the creation of transnational social fields, defined as a "process by which migrants, through their daily life activities and social, economic, and political relations, create social fields that cross national boundaries" (ibid:27).

Transnationality has been defined by Portes "as a field occupied by an increasing number of people carrying on dual lives, having homes in two countries, speaking two [or more] languages and making their livelihood through continuous and regular contacts through the national frontiers" (2001:183). This perspective has involved efforts to conceptualise the transnational social dimension of migrants' everyday lives and to give accurate accounts of the implications of migrants' multiple locations, loyalties and belongings. Transnational migrants are said to have multiple home bases (Alicea 1997) as communities around the world are increasingly interwoven into transnational social fields (Basch *et al* 1994).

In anthropology, the concern for movement, change and interconnection of culture has been present for some time, among others, in James Clifford's work. Clifford invites us to look at practices of displacement as constitutive of cultural meaning rather than as their simple extension.

> Dwelling was understood to be local ground of collective life, travel as supplement, roots always precede routs. But what would happen, I began to ask if travel were untethered, seen as complex or pervasive spectrum of human experiences? Practices of displacement might emerge as constitutive of cultural meaning rather than as their simple transfer or

> extension. Cultural centres, discrete regions and territories, do not exist prior to contacts, but are sustained through them, appropriating and disciplining the restless movements of people and things (Clifford 1988:3).

Rosaldo in the same line of concern, calls attention to migrants as new subjects of analysis that subvert pre-existent categories which look at culture through a fiction of the uniformly shared culture. In a search for homogeneity, classic categories of anthropological analysis have often avoided the frontiers and blurred zones. Inhabiting multiple national and cultural frontiers, migrants have been treated as hybrid and invisible. Or, in Rosaldo's terms, "they seemed to be a little bit of this and a little of that, and not quite this or the other" (1993:209). For Rosaldo acculturation produces post-cultural citizens of nation-states, particularly in The United States, as social mobility and cultural loss become conflated. Under this scope, upwardly mobile migrants can only aspire to become part of the "culture invisible mainstream". Rosaldo acknowledges migrant resistance and calls to revisit their culture in borderlands where "such borderlands should be regarded not as analytical empty transitional zones but as sites of creative cultural production that require investigation (ibid:208).

These cultural dynamics render it important to address the effects a transnational engagement has on a migrant's health and wellbeing. For example, we need to understand the effects dual emotional embeddedness and dual loyalties – which characterise their transnational everyday lives – have on the mental health of these migrants.

However, while this inquiry remains a challenge, similarities can also be observed between settled migrants and transnational ones. Transnational migrants, as well as settled migrants, continue to experience uprootedness and isolation. They still suffer the negative effects of the distance from their own known world and close relationships. Additionally they are confronted with the challenges of interacting with a new culture and society. At the same time, they display great efforts to maintain their linkages back home. As permanent migrants, they are exposed to conflict and various forms of discrimination while simultaneously they are actively engaging in transnational practices and participating in transnational social spaces. These spaces supported by transitional structures allow room for creative cultural production.

While much research has been conducted on exploring the implications of migration on health, not much work has been done to study transnational migrants. The findings and perspectives presented hereafter will provide a base to problematise the multiple challenges faced by migrants when they lead transnational lives.

1.3 Migration and health

The question of how migration affects health has been mostly studied in first world countries, mainly among migrants from various European countries and among Afro and Hispanic populations in the United States. These studies have responded to an increasing concern among international organisations, state agencies and scholars for the well-being of those who migrated during the last few decades of the past century. This concern is extended to the long-term consequences of such migrations and their

effects upon migrants' mental and physical health.[4] Yet, studies on the effects of health among new migrant groups from third world to third world countries are still scarce.[5] As migratory movements within the Latin American region began to be noticeable in the nineties[6], an increasing interest in understanding this interegional phenomenon is observed. Studies about intraregional migrants have begun to proliferate; Salvadoran refugees in Costa Rica (Hayden 2006), Bolivians in Argentina arriving as early as the 80's have been studied in terms of the socio-economic characteristics of this migration (Sassone 2002, Bastia 2007), the transnational communities they create (Hinojosa 2002, Benencia 2007) as well as in terms of the sociocultural aspects this migration involves (Caggiano 2007). Other studies have focused on the situation of Colombians refugees and migrant workers in Ecuador (Pugh 2007). However the focus on health is not yet very pronounced, an exception is the study of Jelin (2006) in Argentina on health and intraregional migration in the Metropolitan area of Buenos Aires.

Similarly, in Chile over the last years there has been an increasing attention on various dimensions of the neighbouring migration into the country. Martinez (2003) concentrates on the demographic characteristics of this new migration. Stefoni (2005) focuses on the conformation and dynamics of Peruvians as a transnational community. Jimenez and Huantay (2007) focus on Peruvians' citizenship by looking at the creation of associations. Special attention has also been devoted to analyse the trend towards feminization of this migration and particularly the situation of migrant women working in domestic service in middle-class Chilean households (Araujo 2003, Zavala & Rojas 2005, Staab & Maher 2006). Migrant children and their particular needs and rights have also been also of special concern (Fundacion Anide & Colectivo sin Fronteras 2004). Gradually the health status of migrants is receiving more attention from scholars, NGO's as well as from Chilean authorities.[7]

[4] Western European countries, such as The Netherlands, Germany, France, Sweden, have a long history of immigration. Originally immigrants consisted of people from similar cultural backgrounds to the recipient society. Therefore, their assimilation was never problematic. Contrarily, migrant workers arriving in the 1960s and 70s came from very different cultural backgrounds. Often from rural and very traditional societies, many of these migrants had scarcely attended school. Integration of these groups into European societies have posed, over the years, many unforeseen difficulties and continue to be difficult, even today, for the grown-up children of these migrants. It is with regards to this last wave of migrants that the problematic relation of societies with ethnically differentiated groups has become an issue of public concern in many European countries.

[5] By this term, as well as by "south-south migration," I refer to economic migrants from third world countries whose countries of destination are neighbouring and in comparison less "underdeveloped countries".. Shared language, as well as cultural and historical backgrounds and a similar condition of development might have implications for the relationship between host societies and migrant groups. These particularities should be attended to and further explored in order to avoid mechanical reproduction of the models used to understand the migration south-north.

[6] Initially, in the 80's and 90's interregional emigration was directed mostly towards Venezuela and Argentina, as these countries offered at the time better perspectives to immigrants with respect to their countries of origin. Towards the end of the nineties and from then onwards intraregional migratory destinations have diversified.

[7] Berry acknowledges a bias in the literature on the topic. "The authors' experiences and interest have led us to emphasise literatures pertaining to immigrants, refugees, and indigenous people, specially in adaptation to North America, Australia, and to a lesser extent to Europe; largely absent are studies done in Asian, African and South American settings. This bias reflects the availability of literature for some peoples of the world but not for others" (Berry 1997:293).

Studies of the effects of living and working conditions upon the health of Peruvian migrants in Chile show the specificity of their problems.[8] Information available reveals mental and physical health problems such as respiratory illnesses and musculoskeletal complaints which are prevalent among this population (Corporacion Ayun 2000, Holper 2003).

Migrant men working in construction endure the demands of hard physical work in high risk jobs that often result in health problems, whereas migrant women working in domestic service – as one of the few existing studies about these women has shown – are often confronted with various forms of abuse and violence in their workplace. The latter result in severe consequences for these women as it affects their physical and mental health (Araujo 2002, Holper 2003). Recent studies on access to reproductive healthcare for migrant women, although in small scale (Instituto de la Mujer 2007), have addressed the difficulties these women face in accessing healthcare, as well as their perception of the quality of healthcare and their unmet demands by the public healthcare system.

While there is an increasing effort to address specific areas of the health status of migrants in Chile – with emphasis on Peruvian migrants – not much attention has been placed on understanding the relationship between migration and health; in other words questions about the implications of the migratory experience and its associated dynamics on migrant's health have not yet been addressed in these studies.

Studies in first world countries instead have extensively documented the effects of migration on the health of minority groups. Several factors influencing migrants' morbidity and mortality have been identified and can be summarised as; i) condition of migration (e.g. voluntary or involuntary); ii) migrant's origin (rural or urban); iii) the nature of the host society (e.g. pluralist, assimilationist); iv) the individual's characteristics (gender, age, education) and collective characteristics (ethnicity, religions). Factors regarded as mediating the relationship between migration and health will be referred to in the next section.

1.3.1 Explaining the relationship between migration, ethnicity and health

Various determinants of the health status of ethnic groups are contained in a model developed by H.P Uniken Venema (1995). The first level in the model encompasses biological/genetic, socio-cultural and economic factors.

a) *Biological and genetic factors:* the indirect influence of biological and genetic characteristics on the health status of ethnic groups. These factors in the author's view become evident through discrimination,[9] particularly when discrimination

[8] Special mention should be made to a recently created program, within the Department of Studies of the Chilean Ministry of Health devoted to the study of migration and health. Two main studies are being conducted at the moment by this department, one on mental health and another on the global health of migrants living in Santiago. Similarly, numerous undergraduate theses are being produced in disciplines of the social sciences especially psychology and social work, as well as in health sciences in reproductive health areas. The health status of migrants continues to gain interest as a research topic. Unfortunately that work remains unpublished and therefore still largely unaccesible.

[9] The authors stress that current use of the concept of ethnicity instead of race in specialised literature was oriented to enhance the influence of socio-cultural aspects in the study of health status of ethnic groups.

emerges in response to physical characteristics of individuals. Discrimination based on physical traits brings about a broader influence upon the health of minority groups and it places an extra strain on both material living conditions (access to goods and housing) as well as their psychosocial well-being.

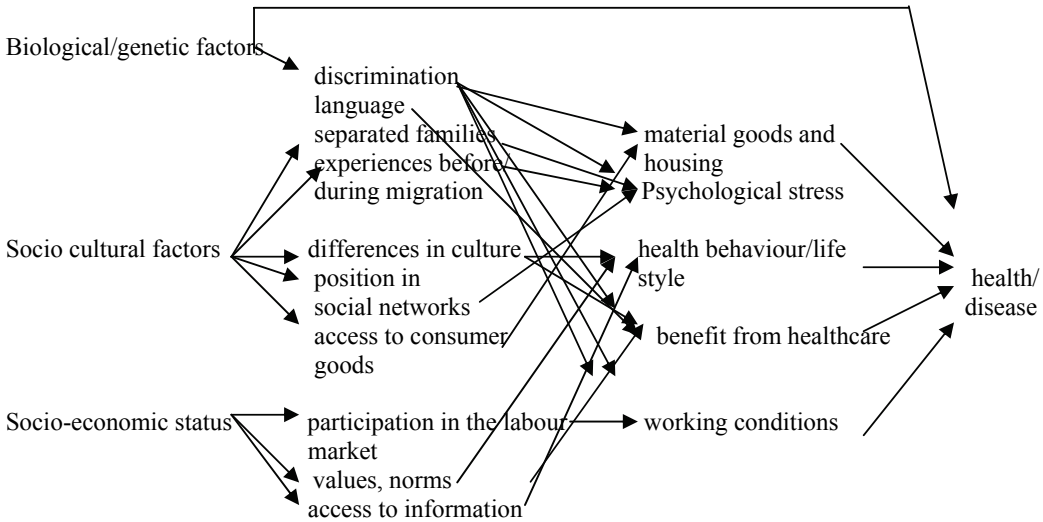
b) *Socio-cultural factors*: culture entails many health-related notions, such as nutrition, life-style and ideas on illness, its causes and adequate treatment. While culture under circumstances of migration is in constant change, some cultural beliefs might be more resistant to change than others. There is a potential source of stress in migration that can harm health, especially when the minority group originates from very a dissimilar culture from the one of the host society.

c) *Socio-economic factors*: Worker migrants in the host society take on low-skill positions in the labour market. Therefore, they are placed in the lower economic strata. Often, in the host country as illegal workers, migrants work in unprotected conditions and therefore are exposed to more workplace injuries.

In addition to these factors, several intermediate variables are added to the analysis. There are also more immediate levels of factors which directly influence the incidence and prognosis of disease. The next diagram explains the various layers of interrelation of factors influencing migrants' health, when migrants are differentiated by ethnicity.

The relationship between migration, ethnicity and health

Main Factors	Intermediary **Variables**	Factors determining **incidence and prognosis of disease**	Outcome



Source:Uniken Venema 1995

However, this emphasis has led to the discarding of genetic variations among these people, which in some cases, have shown to be of influence. While this may be true, the direct relation these authors establish between biological and genetic factors and discrimination obliterates socio-cultural and political factors that mediate in the construction of racist ideologies. These factors are more determinants of discrimination than phenotypical traits in isolation. This is explored in this study.

This model provides a good overview of all factors influencing outcomes of the interaction between ethnic minority groups and host societies. Even though useful for an understanding of the relationship between ethnicity and health, the model has some shortcomings.

It does not take into account the diverse characters of the ethnic groups (migrants, refugee, asylum seekers, native groups, sojourners) neither does it look at the character of their migration (e.g. voluntary or involuntary migration, permanent or temporary). It does not encompass a longitudinal and dynamic perspective to understand variations in the health status of migrants at various points in time. For example migrant workers are selected – and often select themselves – for their good health and ability to work. This is known as "the healthy migrant's effect" (Bollini 1995). However, evidence shows that further on, migrants might end up with a significant burden of disability; the so called "the exhausted migrant effect" (ibid). What happens between these two points in the lifetime of a migrant worker? What are the factors contributing to physical and mental exhaustion migrants suffer?[10]

Furthermore, the model contains the implicit understanding that migrant workers move into the host society in a rather permanent manner. Migrants' linkages with their home society are supposed to be either non-existent or non-relevant in terms of their wellbeing and consequently on their health. The unilinearity and single directionality of the migratory movement leads to focus on the host society, ignoring how transnational forms of living and belonging affect the emotional wellbeing of migrants through the course of a lifetime.

1.3.2 Transnational migration and migrants' health and wellbeing

In spite of these shortcomings the referred model is a good departure point to develop a more suited understanding of the effects of migration on health. Nevertheless additional questions need to be addressed in the light of transnational migration and the creation of transnational social fields; particularly as social reproduction of migrant families takes place across national borders. A relevant question is for example; what are the effects on migrants' health and general wellbeing of having their personal lives framed within transnational family relations? This section examines some of the dynamics of transnational migration as they shape migrants' social relations and family lives, creating critical conditions for migrants' health.[11]

One of the features of transnational migrational labour is the need for migrants to continue exercirsing parental roles from across borders. In particular migrant women, who engage in paid work in foreign countries often congregate in paid domestic work performing childrearing and domestic duties for others, find themselves temporally and

[10] A dynamic perspective can be addressed by including factors such as the nature of the relationship between migrants and the host society. In this model that is expressed in the inclusion of discrimination as an intermediate variable. In effect, discrimination influences four other elements – material goods and housing, psychological stress, benefit from healthcare and working conditions. Social exclusion – although not identified as such in the model – can be linked to discrimination. The various dimensions included in discrimination are discussed in detail further on in this chapter.

[11] The next chapter discusses the social and culturally shaped forms in which emotional distress resulting from the dynamics of this transnational migration is, experienced, interpreted and communicated.

spatially separated from their own children. As Hoshschild (1983) points out migrant women from poor countries are hired to perform domestic as well as 'emotional work'[12] in households in the first world and increasingly in households in the developing world. This devalued unskilled, easy and 'natural' emotional work represents a fundamental part of the domestic labour process, for many women this work is however emotionally draining and problematic (Ibarra 2000).

The condition of this economic enrolment –including the demands to perform emotional work on a full time basis for others – leads these women to enter into transnational motherhood arrangements, not exempted from great emotional costs for them as well as for the children left behind (Pareñas 2005). As Hondagneu-Sotelo and Avila (1997) point out; "transnational mothering radically rearranges mother-child interactions and requires concomitant reshaping and redefining of the meanings and definitions of appropriate mothering" (ibid:557). Transnational motherhood arrangements and motherhood redefinitions often create family fissures which are signed by the constant concern of these women who, besides worrying about some of the negative effects on their children, experience the absence of family life as "a deeply personal loss" (ibid:562). The authors depict the transnational motherhood of Latino women in Los Angeles as "tempered with sadness with which these women related their experiences and by the problems they sometimes encounter with their children and caregivers. A primary worry among transnational mothers is that their children are being neglected or abused in their absence" (ibid:560).

The emotional experience often associated with the dynamics of a transnational family life can be better understood by examining the axis of simultaneity in which it occurs. The distinction between 'ways of being' and 'ways of belonging' provided by Levitt and Schiller (2004); helps to elucidate the double orientation of everyday life of individuals in transnational social fields and is explained as follows; "if individuals engage in social relations and practices that cross borders as a regular feature of everyday life, then they exhibit transnational ways of being. When people explicitly recognize this and highlight the transnational elements of who they are. Then they are also expressing a transnational way of belonging" (2004:1008). This distinction can be reformulated to examine migrants's emotional struggles as they are part of transnational family relations, particularly for women in transnational motherhood situations for whom the notion of family in one place is painfully disrupted. Such distinction can be expressed as 'the impossibility of being' – part of a family as a localised unit of biological and social reproduction – and 'the imperative of belonging' – to the emotional ties that link family members together.

The emotional struggle of transnational migrants has been depicted through the notion of dislocation which describes the effects that leading a transnational life has on migrants' subjectivity and emotional wellbeing. Attention has been paid to the structurally constrained sources of emotional dislocation for Philipino women who migrate to the North to perform care jobs (Parreñas 2001). Emotional dislocation in this

[12] Emotional labour is defined by Hoshschild (1983:3 quoted by Ibarra 2002) as the "taken for granted effort of managing 'feeling to create a public observable facial and bodily display' that produces the proper state of mind in others" (ibid:554). This includes "spoken word, tone of voice and other efforts that are expressed through behaviour" (Ibarra 2002.)

context involves partial citizenship in both countries –sending and receiving– family separation, contradictory class mobility and feelings of social exclusion.

Emotional dislocation has also been depicted as resulting from conflictive notions of assimilation to the mainstream society, and has been examined by Menjivar among various generations of Salvadorean refugee women in diverse geographical locations (Menjivar 2000). Factors such as the pressure from parents to succeed; coping with racism and the dual nature of 'home' are identified as factors which predispose women to mental health risk.

Social networks have been understood as providing members with emotional support. Alicea found, among Puerto Rican in the U.S., the use of their ties to transnational homes to respond to the negative political and economic and social forces they have encountered, as she describes "their ties to Puerto Rican home communities enable them [transnational migrants] to resist inferior and demeaning definitions of their race and class position within the U.S. society" (1997:598). Alicea's analysis focuses on women and their pivotal role in the construction of transnational families and households through kin work and caring work; the creation of transnational kinship ties offers them a critical support to face adversity

> "…building extended family ties that transcend national boundaries and organizing family gatherings and traditional celebrations serve as an important way to resist race oppression. That is, gatherings, celebrations, and visits home serve to alleviate the feeling of alienation associated with the race oppression they experience within host societies (1997:621)

However, as the Alicea stresses, ties to home and homeland communities are contradictory and oppressive as women are "held accountable for doing and unshared fair of this [care and kin] work" (1997:621). Gender oppression is reproduced in the same social space and social relationships that nurture women's needs for recognition, belonging and connectedness. As the author explains it: "because the women need a sense of stability in their own individual family to resist the race oppression and disadvantaged class condition that accompany migration, they have to put up with gender oppression" (ibid:621).

The social networks migrants in general –and women in particular– create, have been explored as the constitute means to access healthcare and health treatments, in context of restricted resources, rights, and medical choices. Mejivar (2002) examines the complex informal "social networks –both local and transnational– through which ladina and indigenous Guatemalan immigrant women obtain treatment for their own and their families' illnesses" (ibid:437). The focus of this study is placed on immigrants' use of informal social networks as a means to deal with inaccessibility to formal healthcare resources. As found by Menjivar, the exchange of help through these networks takes the form of a variety of treatments, including drugs and traditional medicines which constitute something akin to a 'package' of biomedical treatments and traditional medicine acquired both locally and from contacts back home. Aid is however obtained and given in negotiated processes not exempted of "disillusionment, tension and frustration as well as by cohesiveness and support" (idem).

Moving away from the intersubjective dimension of migrants' experience, there are societal contexts which create the conditions for that experience to emerge that also

needs to be attended to. Migrant's experiences in the host society depend as much on the conditions of exit as on the context of reception. Structural constraints such as racism and discrimination are key aspects in the process and feeling of emotional embeddedness as they can also accentuate uprootednes and emotional dislocation. The next section looks at discrimination, a recurrent limitation migrants face in host societies and examines its effects on health.

1.4 Discrimination and health

> In this Convention, the term 'racial discrimination' shall mean any distinction, exclusion, restriction or preference based on race, colour, descendent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social and cultural or any other field of public life.
>
> *Unesco Convention against Discrimination (1960)*

Several studies in the area of public health and psychology dealing with the adverse effects of discrimination on people's health have documented the impact of racial prejudice and discrimination on the mental and physical well-being among various minority groups.

In general terms, racism and ethnic prejudices affect health in two broad dimensions. Firstly they operate within the structure of societies to produce inequalities in employment, housing and environment. This can translate into different health outcomes among diverse racial/ ethnic populations. Secondly, discrimination and ethnic/racial bias also act upon the individual, creating psycho-physiological responses that can ultimately result in negative health outcomes.

A comprehensive review of the studies on ethnic/racist discrimination and health is presented by Williams (2003).[13] The author reviewed a number of studies documenting the adverse impact of racial discrimination on health in first world countries. Although most of these studies were conducted in the United States with a particular focus on the African-American population, they are helpful if we are to understand the effects of discrimination on health. Recently though some studies have begun to look at the situation of immigrant populations in Canada, England, Ireland, the Netherlands and Finland.

The majority of these studies have based their measurements upon 'perceived discrimination.' They often used self-reported tests with scales of exposure to discriminatory events. This was followed by alternatives, to establish the frequency of exposure to these events. In general, as the mentioned review confirmed, these studies have shown a strong association between discrimination and multiple indicators of poor physical health – and especially – mental health status.

[13] Study based on a search of the MEDLINE database for the period 1998-2003, using *prejudice* as the key word. It also included a search of the same time period in the PSYCHINFO and SOCIOFILE databases, using the key words: *discrimination, race discrimination, social discrimination,* and *racism*. Fifty three studies were reviewed, among which 32 included measures on mental health.

Mental health status was mostly measured using scales of non-specific distress. This showed a strong, distinct association between discrimination and distress as well as a definite relation between discrimination and psychological well-being (e.g. happiness and life satisfaction, self-esteem and perceptions of mastery and control). A relation between perceived discrimination and depression was established. In addition, a strong correlation between mental health and discrimination was determined in the case of generalised anxiety disorder, early initiation of substance use, psychosis and anger.

With physical health, most of the studies were based on self-reported measures, using general indicators of physical health status. In general, as Williams observed (idem), studies that included a global self-rated health item as an outcome variable, reported that discrimination was strongly associated with poorer health. This included chronic conditions, indicators of disability and other general ratings of health status.

Physiological reactions to exposure to racist events were reviewed by Harrell and colleagues (Harrell 2003). These studies used both self-reports by the participants and laboratory studies which exposed individuals to analogues of racist situations. These studies tested the proposition that "analogues of racist events or memories of these encounters result in physiological arousal or negative health sequelae" (ibid:243).

The association between blood pressure and discrimination and the potential of discrimination to account for the prevalence of hypertension has been studied among African Americans in the United States (idem). Subsequent studies tested other cardiovascular outcomes and racial discrimination, revealed that the development of atherosclerotic disease was definitely associated with experiences of everyday discrimination.

Other health outcomes have also been examined resulting in a positive association with perceived discrimination, such as low birth weight of children born to women who scored high on other health risks factors. There is also a definite association with cigarette smoking and alcohol abuse among people who regularly experience discrimination.

However, as it has also been found, there are a variety of factors moderating the effects of discrimination upon health. Williams found that "personality and coping processes moderate the relationship between discrimination and physiological variables" (2003:203). Krieger and Sidney, on the other hand, reported findings pointing towards the relationship between health and personal response to discrimination. They argued that "a passive posture and denial of discriminatory treatment were related to higher blood pressure readings" (Krieger 1996; Harrell 2003). With regards to social support, immigrants receiving high levels of social support had significantly lower blood pressure levels than those receiving less social support.

Even though existent studies give sufficient proof of the adverse effects of discrimination upon health, Williams (2003) pointed to some persistent gaps in knowledge within the field. For example, the difficulty to 'objectively' measure discrimination is visible in the studies reviewed, and renders the results questionable.

Additionally, the variety of methods used in these studies does not make it possible to determine the extent to which exposure to perceived discrimination leads to increased

risk of disease. Also, it does not allow one to establish whether this exposure "leads to patterns of habituation, such that the effect of perceived discrimination is minimized" (ibid:200). Studies seem to confirm the current challenge in the field; which is to reach a deeper understanding of the underlying processes.

The next section discusses some of the conceptual and methodological challenges of studying the effects of discrimination upon general health. This discussion will help to define my own approach to the study of the effects of discrimination upon Peruvian migrants' health.

1.4.1 Some theoretical and methodological challenges in measuring the effects of discrimination on health

Studies devoted to the analysis of adverse effects of discrimination on health as referred to above, have not only documented such a relationship but also have shown the existence of some conceptual and measurement problems (Meyer 2003). The suitability of methods and scopes, plus the feasibility to measure outcomes of discrimination will be discussed in this section.

Studies of the effects of discrimination on health have used 'the psychosocial stress model'. This is based on the sociological notion which sees racial discrimination and prejudice as stressors embedded within the social structure. This model has been used to explain health disparities emphasising stress associated with minority group status, and especially experiences of racism and discrimination.

In line with this model, discrimination can be seen as a twofold phenomenon; with objective and subjective dimensions. As an objective phenomenon, discrimination is viewed as "a stressful life event, real and observable phenomena that is experienced as stressors because of the adaptational demands they impose on most individuals under similar circumstances" (Dohrenwend 1993, quoted by Meyer 2003).

As a subjective phenomenon, discrimination is seen as "an experience that is contingent on the relationship between the individual and his or her environment. This relationship depends on properties of the external events but also, significantly, on appraisal processes applied by the individual" (Lazarus 1984, quoted by Meyer 2003).

As Cain put its, stressors have ultimate effects on health. "…Perceptions and experiences of racial/ethnic bias leading to unfair treatment can result in personal negative emotional and stress responses, which in turn, have been shown to relate to hypertension, cardiovascular disease, mental health and other negative states of health". (Cain 2003:191). Discrimination can affect an individual or it can be institutional. It can be expressed in the daily hassles or life events, as mentioned before. Each one of these dimensions should be consistently addressed in the methods used to measure discrimination.

Individual v/s structural measures

Many studies, which are intended to measure the health effects of discrimination, simply analyse the effects of broader social oppressive relations at the individual level.

This approach leads to limitations in capturing the broader impact of prejudice and discrimination. Meyer points to the fact that existent barriers to the improvement of certain groups can be hidden and are, therefore, difficult to detect at the individual level.

Thus, measurements relying upon individual reports of discriminatory practices run the risk of under-representing the phenomenon, simply because individuals are not always aware of the existence of such barriers (Meyer 2003). This is especially true in cases where institutional barriers are illegal, hidden and therefore, not easily detected.

On the other hand, when structural discrimination is not hidden and widely practiced, these practices are likely to affect many or all members of a minority group (ibid). Therefore, there is little use in studying its variability at the individual/personal level. This is more prevalent in cases where only members of the affected group are considered. In this situation, "within-group variability" is identified. However, this approach fails "to detect the potentially stronger manifestation of structural prejudice" (ibid:263). For Meyer "the impact of institutional stressor may best be documented via the assessment of differences in population parameters (including economics and health) at the group rather than the individual level" (ibid:264).

Subjective v/s objective measurements

A second problem noted by Meyer is that most studies measuring discrimination – either in the form of daily hassle or life events – are based on subjective perceptions. According to the author, "individual reports of discrimination depend on perception, which produces discrepancies in findings" (ibid:264). In fact, the cognitive dimension of 'perceived discrimination' leads to the need to scrutinise those factors influencing the subjective appraisal of discriminatory events.

Contrada (2000) tells us there is a set of motivational factors that influence the recognition of discrimination among minority groups. The author states that "although minority group members are motivated by self-protection in detecting discrimination, they are also motivated to ignore evidence of discrimination through a desire to avoid false alarms which can disrupt social relations and undermine life satisfaction" (Contrada 2000 quoted by Meyer 2003:263). He further reminds us that "in ambiguous situations, people tend to maximise perception of personal control and minimise recognition of discrimination" (ibid:263).

Meyer draws some conclusions from these observations in terms of health, arguing that "healthier individuals may use strategies that lead them to underestimate prejudice and discriminative events" (Meyer 2003:264). Furthermore there seems to be variations in perception of discrimination, according to the coping strategies used by the individuals affected.

Cognitive studies have shown that people who are resilient to prejudice have a stronger tendency to notice, recall and report prejudice events. Members of a minority group "have strong motivations to ignore prejudice-related events in some instances but to be 'hyper-vigilant' of such prejudicial instances" (ibid:264). These motivational factors represent challenges to researchers who are interested in an objective account of what actually occurred, as they can lead to inaccurate reports of events of discrimination and prejudice.

There is also another risk involved in the subjective measurement of discrimination specifically in the area of mental health. This is the confounding of the measurement of perceived discrimination as an independent variable with its outcomes. For Meyer, it is problematic to rely only upon subjective perceptions of stress as confounding can occur between an individual's health and his or her perception of stressors.

This problem is particularly evident in the case of research which examines the association between life events and mental disorders. Such studies, according to the author, require a methodological approach which is able to conceptualise and measure stress as an objective phenomenon, independent of an individual's own view and feelings (Meyer 2003).

Daily hassles v/s life events

Discrimination as a major life event versus daily life hassles brings a third challenge to its measurement. Meyer states: "daily hassles are ubiquitous; most people perceive hassles as an unavoidable part of life and are expected to recover relatively quickly from such experiences". However, "the association between daily hassles and mental health outcomes are likely to be underestimated, because the state of one's mood probably affect perceptions and reports of daily hassles as well as outcomes measures" (ibid:264). This distinction between major life events and minor repetitive ones should be looked at from the perspective of what these events may convey in the collective history of a minority group.

For Williams (2003), the implication of everyday discrimination is what such acts of discrimination mean in a social context. They, in fact, are more significant than other differently rooted and traditionally defined daily hassles. Meyer points to the fact that they can evoke painful memories which relate to personal and collective history of prejudice against minority groups.

These minor discriminative events can have a negative and cumulative effect on health outcomes. For example, the effects of these events on cardiovascular health, via activation of the sympathetic nervous system, have been examined (Meyer 2003). An additional point is made by Meyer on ethical problems involved in looking at discrimination and prejudice solely based on subjective perceptions. That is: it indirectly undermines the notion that racism and other forms of prejudice are social and not individual stressors.

1.5 An approach to discrimination and its effects on migrants' health in Chile

Various issues raised in the previous section need to be considered in order to define the scope of this study. Firstly, perceived discrimination should not be considered in isolation, but rather, in combination with other oppressive situations affecting individual lives. Racial discrimination often does not act as a single factor, but comes together with other oppressive societal forces affecting minority groups. This can, and often does, include exclusion and poverty. "Racism shapes other important determinants of

health outcomes, including economic resources and the availability and nature of healthcare" (Harrell 2003:244)

A context specific perspective should be provided to account for the various factors affecting the health of minority groups. Such a perspective must incorporate various forms of discrimination including the institutional form. This form of discrimination should be accounted for, not only based upon individual's perceptions but also measured and documented by a group approach.

Issues such as equal access to job opportunities and other such forms hindering upward socio-economic mobility and group development should be incorporated when assessing the effects of discrimination on minority groups. As mentioned at the beginning of this chapter, institutional discrimination is often covert and individuals may not be aware of its existence. This dimension of the phenomenon imposes specific challenges to its measurement.

Secondly, criticism of the lack of accuracy of subjective measures related to discrimination underpins an 'objectivist' standpoint as a vantage point in the intention of measuring health outcomes of racial discrimination. Meyer raises the problem of validity in the subjective appraisal of discrimination and argues that this measurement may contain a bias that diminishes the detected impact of discrimination on health.

The question is whether the aim of measuring the effect of discrimination on an individual's health becomes invalidated when discrimination is not perceived. I contend that, whether perceived or not, discrimination does have an impact on an individual's health and efforts should be made to seize it, irrespective of the individual's acknowledgement of its existence or not.

The challenge is, therefore, to develop a sensitive approach to detect the impact of discrimination on individuals, whether they are aware of and openly declare it or not. This also applies to the debate on whether discrimination should be studied as life events or daily hassles. I argue that both forms of discrimination can be equally adverse to peoples' well-being and both should be considered.

Looking at the phenomenon from a people's perspective and experience, involves taking an *emic* standpoint. Holding an *emic* approach involves the person. She or he would have to identify which practices are discriminatory. However, from the researcher's perspective, efforts should be made to map out the different forms in which discrimination becomes part of the lived experience of those subjected to it. This also includes methods of unveiling motivations and circumstances in which individuals ignore these events or acknowledge them. In addition, an institutional and a group approach to discrimination should be included in order to counterbalance possible underestimation resulting from solely taking an individual perspective. Such a combination of perspectives provides a better understanding of how discrimination may lead to changes in health status.

Two central dimensions in the study of discrimination against migrants are addressed in this study. One is the way in which discrimination operates within a society to produce inequality and social exclusion directed at migrants. The other is how discrimination affects the health of the individual migrants.

The first dimension involves considering the structural character of discrimination. Both overt as well as covert forms of institutional discrimination will be examined. The second dimension involves considering a subjective appraisal of discrimination. This means considering whether discrimination is perceived by the sufferers and if so, how it is experienced by them. Studying discrimination from the perspective of those affected, also involves examining whether or not discrimination takes the form of daily hassles or life events. Although the forms of discrimination may be quite evident, the way in which they are experienced by migrants, needs to be investigated.

However, while it is possible that discrimination might not be perceived or acknowledged by the sufferers; discrimination still exists. It can still be a significant hindrance as it can impinge upon an individual's capacity to act in the world. In my perspective, what is relevant are migrant's narratives and interpretations of circumstances surrounding their illness experiences. This view takes into consideration the extent to which – whether acknowledged or not – discrimination impacts on migrant's physical and mental health. In examining how experiences of discrimination affect the health of those targeted, attention should be paid to the way in which it produces a symbolic and efficient enclosure around people's lives.

In this study, discrimination is seen as a field of meanings and interpretations around the violence of everyday practices. When perceived, discrimination produces a symbolic and efficient enclosure around people's lives. It undermines their sense of self worth, produces emotional suffering and it limits the capacity of the individuals to act in the world. I contend that even if not perceived, discrimination confirms existent relations of inequality and ultimately it reinforces the subordinated position the discriminated group has in the society.

This study explores discrimination in two social spaces. Firstly, as it manifests in the Chilean society in general, as well as in the daily interactions migrants have with members of the host society. Secondly as it manifests in the public medical system – when as patients – migrants interact with Chilean health practitioners.

The next section explains the dimensions considered in the study of discrimination of Peruvian migrant workers in Chile and its effects upon health.

1.5.1 Structural discrimination as exclusion

From a societal perspective, discrimination can be appraised in the existing mechanisms reinforcing the social exclusion of migrants. Thus, exclusion is used here to refer to the effects structural forms of discrimination have on individuals' lives and ultimately on their health.

It should be stated that Chile does not have a comprehensive immigration policy. Instead, there is a rather outdated migratory regulation in place. This makes it difficult for foreign workers to obtain legal status in the country. Furthermore, as will be explained next, the lack of legal instruments to manage migration reinforces the vulnerable position in which migrants find themselves in the labour market. It also presents obstacles to their incorporation into Chilean society.

The existing immigration legislation dates from 1975 and was drawn during the military Government of Pinochet as part of his broader efforts to control immigration. Embedded in the repressive political atmosphere at the time, this legislation viewed immigration through the lens of national security.[14] Not only is this immigration legislation outdated, but also it is full of loopholes, leaving migrants unprotected from abuse on the part of the police and other State agencies. As will be explained next, migrants are not protected against possible employer abuse.[15]

Most Peruvian migrants enter Chile with a tourist visa[16], without a work permit or a secured job and struggle to settle down. Sooner or later, they face both legal and economic instability. Typically, their temporary visas[17] are bound to specific work positions or contracts, and employment in Chile is not easy to find or maintain.

As a consequence of Pinochet's neoliberal model applied in Chile in the 1980s, the Chilean labour market became more flexible and the laws oriented towards labour protection were weakened. Because of this, a large proportion of workers, both Chileans and migrants, work while holding temporary contracts, without benefits such as health insurance and social security. However Peruvian workers find themselves in an even more precarious position in the labour market than their Chilean counterparts. This is accentuated by their lack of access to social welfare, healthcare and housing. Because of their generally unstable legal situation[18], migrant workers become more dependent on their employers and can be subjected to abuse.

Existing Chilean labour regulations place migrant workers in a structurally weaker position in the labour market. In addition, the existent legislation dealing with migrants contributes to or creates structural conditions which perpetuate abusive work relations between migrant workers and their employers.

The fact that migrants are obliged to remain with the same employer in order to regularise their legal status, often gives extra power over the migrant worker to the employer.[19] It also limits migrants' options to look for better jobs and often times it compels them to endure unfair working conditions. This, compounded with a lack of

[14] The regulation Decreto Ley Nº 1.094 or Ley de Extranjeria has been modified since its initial formulation in 1975, to tune in with the changing dynamics of the migratory phenomenon. The current regulation establishes that foreigners need to procure one of the three different types of visa: tourist, residence or permanent. Within the "resident" category, there are five different subcategories: contract, student, temporary, official and refugee or asylee. Visitors with contract visas need to be sponsored by a Chilean employer. Temporary visas are given to people considered to be beneficial for the development of the country, such as scientists, businessmen and other professionals. However, most migrants do not qualify for this last category and their residential permits depend heavily upon the sponsorship of a Chilean employer.

[15] Existing legislation is not only vague regarding different categories of residence, but it also fails to specify procedures to follow when in contact with illegal immigrants, and has mechanisms that cannot be adequately implemented (personal communication Legal expert Jorge Varela).

[16] Tourist visas last only three months.

[17] Migrants are entitled to temporary visas once they have a work contract and these visas expire after one year. To renew their visas they need to have another work contract.

[18] Migrants can easily fall into illegality when their work contracts are not renewed.

[19] Only by the signing of a work contract with a same employer for three successive years is a foreigner entitled to permanent residence and a work permit. In many cases, the employer delays signing the contract with the worker, placing the migrant in an illegal situation. The worker is compelled to remain in service without a contract because there is the hope the documentation will be signed and he/she will then no longer be an illegal.

information regarding foreign workers' rights, further reinforces such vulnerability. Illegality often obliges migrants to accept low skilled jobs and poor working conditions.

Fear of being fired or reported to the police also prevents these workers from claiming their legal rights. Migrant workers' urgent need of income is an additional factor that increases their vulnerability to employers, as often they are the only economic support of their families in Peru. Pressured by the need to send money home, migrants tend to live in cheap and deteriorated housing. They also tend to live in very crowded conditions and suffer from residential segregation, as their options of finding housing are restricted to rundown areas of the city.

The above-mentioned mechanisms of structural discrimination contribute to the reinforcement of migrants' exclusion. As discussed before, institutional discrimination may be hidden or overt. However, when reviewing these effects, this form of discrimination ultimately limits the development and advancement of specific groups within the society. In the case studied here, existent structural mechanisms create economic, social and physical pathways which ultimately harm migrants' health.

In spite of the increase of migrants into the country over the last several years, official legislation dealing with migration has remained virtually unchanged and immigration continues to be a 'non-issue' for politicians and government institutions.[20]

1.5.2 Discrimination in the public healthcare system

The public healthcare system is a sector of society where discrimination is articulated in a special way. This section discusses the approach to the study of the forms discrimination takes in the public health system and how it affects migrants' health.

From the perspective of the healthcare providers

Migrants represent a new subject of care for the Chilean public healthcare system. As such, they are often defined as patients placed in a distinct category, separate from those patients who are Chilean citizens. Although, to a limited extent, contested by the migrants themselves, societal perceptions about the place migrants have within Chilean society are shaping the place assigned to them in the medical setting. Moreover, migrants, rather than being passive, are actively participating in the ongoing process of being constructed as a different category of patients. This classification of patients is being created with migrants either rebelling against or complying with the place assigned to them within the medical system.

Indeed, existing racial prejudices and stereotyping prevalent in Chilean society may permeate perspectives of healthcare practitioners who treat migrants. Researchers of 'social cognition' – a sub-field of social psychology dealing with 'how people make sense of other people' (mental representations, process underlying social perception) – have studied how racial characteristics of individuals influence provider behaviour (Van Ryn 2003).

[20] Together with the Chilean Ministry of the Interior, the Governmental Office of Foreigners sponsored a project of law to regulate migration. This project was submitted in 2003 to the Senate for discussion where it has remained tabled since then (Muñoz 2005).

It was found that healthcare "providers may influence help seekers' views of themselves and their relation to the world" (ibid:249). Providers unintentionally or intentionally communicate lower expectations. Secondly, "the potential influence of providers on help seekers' health-related cognition and behaviour has been well documented" (idem). These are aspects to be attended to when assessing the effect of health promotion and illness prevention behaviours as they may account for health disparities among minority groups.

A third element is that "providers are powerful gatekeepers and may influence health disparities via such mechanisms as differential access to treatment or services and loss of benefits and rights" (ibid:249).

The elements listed above may play a role in health disparities among minority groups. Particularly, in analysing the case of Peruvian women in Chile, the question to be dealt with is to what extent preconceived notions of healthcare providers of migrant patients plays a role in the health outcomes of this group. Outcomes of the interaction between healthcare providers and migrant patients may be such that many of these women's reproductive health needs may remain unattended to.

The analysis of institutional discrimination will be conducted by examining two dimensions. Firstly, what effects institutional barriers may have upon migrant women's health which limits their access to reproductive healthcare? Secondly, in which ways perceptions of racial and ethnic identity permeate healthcare institutions, particularly in reproductive healthcare? Attention will also be placed upon how these perceptions influence the quality of care provided to migrant women.

From the perspective of migrants

It can be rightly assumed that experiences of discrimination in the society affect migrants' interaction with healthcare providers. As previously discussed, discrimination can be experienced as a 'first hand life event' or as 'daily hassles.' It is known through the media; and reported by few studies conducted on the topic (Esteves 2004; Jimenez 2006) that in everyday life Peruvian migrants often suffer verbal and physical violence.

Oftentimes, when Peruvians are "singled out" – as their nationality becomes evident because of their indigenous physical features and their accent – they are treated badly in shops or insulted when using public transportation or other services. Their children also become targets of scorn when attending Chilean schools.

The extent and way in which the interaction between migrants and healthcare providers is affected by migrants' everyday experiences of discrimination is still unknown. One consequence of discriminatory experiences may be fear and mistrust of the Chilean healthcare system, in general, and healthcare practitioners, in particular.

Discrimination against migrants in the public healthcare system is not an easy matter to prove as a factual reality. From the migrant's perspective, discrimination may be interpreted as the underlying reason for mistreatment from Chilean healthcare practitioners. In this process, being discriminated against emerges as a possibility that exists along with the way their difference is addressed when care is provided to them.

Migrants' efforts to make sense of their lived experiences may be manifested in their narratives where discrimination can become a plot articulating the events which surround their illness experiences and explain the difficulties they face when attempting to access healthcare. These are stories portraying discrimination as an 'imminent possibility'. They are feasible explanations for their lack of opportunities or the difficulties experienced by them in what is perceived as a hostile environment. In this sense, discrimination transforms into gossip or a story. These stories transmit those 'things that might happen to an individual by the sole fact of being a member of a target group' (Manderson 2003). These efforts, however, must be seen as entrenched deep within migrants' lack of power but also as their attempts to reposition themselves in a structure which is seen and experienced as adverse.

Discrimination, even though it is a ubiquitous reality, is also a rather elusive phenomenon. Consequently, my attempt is to understand how discrimination creates a symbolic and practical enclosure to the migrant's self and how this affects their psychological well-being.

1.5.3 Some background to the problem of discrimination in Chilean society

Chilean society, in general, does not welcome itinerant newcomer Peruvians. They are seen as more indigenous than the Chilean population and therefore, inferior. Their 'Indian-ness' (ethnic/racial identity) is associated with backwardness, and their country with underdevelopment. It can be said then, that Peruvians represent the opposite of the Chilean general self-image of being a population possessing more European traits and of being more modern and developed than its neighbouring country.[21] Peruvian immigration represents a threat to Chileans – both economically and culturally. Firstly because Peruvians supposedly take jobs away from and create instability for Chilean workers. The second bias comes from the Peruvian presence itself; in Moulian's view they are "challenging traditional cultural and ethnic concepts of national identity which binds whiteness to development" (Moulian 1997).

General discriminative attitudes among the Chilean population have been systematically researched over the last years. This has been carried out in three consecutive surveys in three main cities of the country during 1996, 2000 and 2003 (Santiago, Iquique and Arica). The 2003 survey showed that one third of the population holds both discriminative attitudes and stereotyping ideas regarding migrants, race, and their supposedly deviant behaviour; as the following statements illustrate:

[21] In a 2004 survey carried out in Chile's three main cities, the majority of those polled supported the statement that *"physical characteristics (of people) are influential in the(ir) social success"*. To the question of which ethnic group does he or she think they belong to; 80% identified themselves within categories which included a white component: These included *White-Latino American, White-Mestizo, White-European, White-North American*. When asked to compare themselves with Peruvians, Chileans consider themselves to be absolutely more white than Peruvians (91, 4%), and 85% believed themselves to be taller. Furthermore, Chileans see themselves as more intelligent, harder working, more affectionate and braver than Peruvians. As well, 86% of polled Chileans believed they are more attractive. Yet, they also recognised themselves as being more intolerant and having a more violent attitude than Peruvians (Aymerich *et al* 2003).

- *Chile is more developed than its neighbouring countries because it has less indigenous population.* (agree 34,1%, disagree 65,9%)
- *The problem of opening up to the Latin American immigration is that many of them (Latin American immigrants) are indigenous.* (agree 35,8%, disagree 64,2%)
- *Some races are better than others"* (agree 32,9% disagree 67,1%)
- *It is true that Peruvians need employment but Chilean entrepreneurs should always prefer Chileans* (agree 69,4%, disagree 30,6%)
- *If Peruvians get too mixed with Chileans the quality of our people will worsen* (agree 33,4%, disagree 66,6%)
- *Peruvian immigrants that come to our country are more likely to commit crimes* (agree 43,8%, disagree 56,2%).[22]

Peruvian migrant workers in Chile are discriminated against on the base of their physical traits and their class Class is a wide spread form of discrimination in Chilean society. In fact discrimination based on class may even be stronger than racial discrimination; however both systems of discrimination are often concurrent and reinforce each other. Race and class based discrimination now exerted against the Peruvian, has been previously –and continues to be– exerted against the indigenous Mapuche population and more generally against the poor. Class and race based on derogative terms are very prevalent in Chilean society. Indeed terms such as *chulo* and *roto* are - both demeaning terms used to refer to low class individuals. Likewise, terms such as *indio* and now *cholo* both have racial connotations. The first one is used to refer to Mapuches and the last one is used to refer to Peruvians.[23]

Racial discrimination against Peruvians in Chile encompasses historical political and economic factors.[24] The acknowledgment of these dimensions therefore requires an understanding of the concept of race and the ability to grasp those dimensions and transcend its practical classificatory uses. As far back as 1937 the scientist Alejandro Lipschutz discussed the uses of the concept of race in Chile; while race to some extent is biological, argues Lipschutz (as it refers to hereditary physical features that characterise various groups in the human species), race is rather a social issue. Lipshutz

[22] Ibid.

[23] Staab and Maher contend that Peruvian domestic workers constitute "a new roto class, one that lacks historical baggage of native born workers" (2006:8). The author reminds us of the intensity of the classs conflict in Chile during the 60s and Allende regime (1970-1973) and the open divisions between upper class- economic interest and the workers. The unsolved and persistant class conflict within the Chilean society, may explain why Chilean employers praise Peruvian domestic workers for being more submissive and less resentful than the native domestic workers, who know their rights too well, lack a "nanny attitude". In their study the authors also describe how prejudices against indigenous peoples held by Chilean employers of Peruvian domestic workers extended not only across national boundaries (against Peruvians) but also within them (against Mapuche people). Nevertheless, racial prejudices against Peruvian take up a nationalist fashion and internal ethnic differences are denied "when directed at Peruvians, however such prejudices tended to be expressed in national tersm that represented Chile as homogeneous and white population" (Staab *et al* 2006:10).

[24] The perception of Chileans on Peruvian migrants needs to be seen in the light of other migratory flows between neighbouring countries in Latin America. As Hayden discusses in the case of Salvadorean refugees in Costa Rica, discrimination or negative representation of Salvadoreans – and of Nicaraguans- in that country is not sufficiently explained by the fact that refugees represent an anomalous category in the national order, therefore are easy scapegoats for social problems. It is also important, the author reminds us, to consider the context within which refugees and other migrants live and the places different nations occupy in the national order "countries are experienced in different ways, have different statuses in the international order, and different symbolic values within the nationalist discourses of their counterpart states – values that adhere to citizens" (Hayden 2006:21).

saw the problems of the indigenous people in Latin America not as related to race but linked to the revindication of their economic and cultural rights in front of the more powerful groups of mestizos and European (1937). Similarly, much later, De la Cadena points out that race "exceeds the classificatory empiricity that it enacts through 'biology' or 'culture', as much as it exceeds the bodies to which it also lays claim" (2005:259).

While some differences in ethnic/racial composition do exist when comparing the populations of Chile and Peru, there is also a shared racist ideology at play in the relationship between the two countries. Both have their roots firmly planted in the colonial past of Latin America.

In general, both countries consist of an indigenous population, *mestizos* – a term, which in its restricted sense, describes the empirical hybridity of European and indigenous mix[25] – and "pure" European descendents. In addition, Peru has a population of Afro-descended ethnic origin. In both countries, ethnic differences overlay social classes and urban-rural distinctions. In rather broad terms, the difference between the populations of the two countries is that the Peruvian population is more indigenous and rural than the Chilean population. Chileans are in turn more urban and mostly *mestizo*.[26]

In both countries, ethnic-racial differences are critical markers of power and social prestige.[27] But since the indigenous presence is more evident in Peru, ethnic-racial differences are a more present distinction there. An example of the visibility of these ethnic/racial differences can be found in the ongoing process of internal migration within Peru. There, the population moves from small villages to bigger cities as part of an effort to improve social and ethnic status. Once in the city, these migrants become urbanised. However, their indigenous origin is constantly highlighted as they are frequently identified by the term *cholo*. This derogatory word is used by the *criollo* (people of European descent) to classify and discriminate against Andean migrants (Paerregaard 1997:45). Even though this migration can actually fluctuate and migrants to the city may eventually return to their villages, in the city these indigenous migrants will always be seen as *cholos*.

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[25] De la Cadena argues against the notion *empirical hybrids* contained in the term mestizos. This notion is not "a plain result of the biological or cultural 'mixture' of two (formerly discrete) entities" (2005:262). The term mestizo, she argues, "evokes a complex *conceptual hybridity* epistemologically inscribed in the notion mestizo itself" (ibid). The author reviews the genealogy of the term mestizo as starting in the sixteenth century – with the arrival of the Spaniard Conquerors to the New World – and emerging in the present. As a conceptual hybrid mestizaje "houses social taxonomies embedded in different forms of consciousness and regimes of knowledge. Among these, the two most obvious Western ones are 'Holy faith' – later known as religion – and 'scientific reason'. Holy faith arrived in the 'New World 'with the Conquistadores, and met Enlightened reason in the last decades of Spanish control of the Americas" (ibid). De la Cadena further discusses how these apparently bifurcating notions have historically overlapped and in the present coexist; "as with a genealogy, the earlier manifold faith-based features imputed to 'mestizos' were not simply displaced by notions of 'racial mixture' dictated by rational science. Instead, through a dynamic of 'rupture'and 'reinscription' emerging from the previous faith-based taxonomies, 'mestizo' acquired new scientific racial meanings without necessarily shedding the old ones" (ibid:263).

[26] Approximately 40% of the Peruvian Population is indigenous, whereas the indigenous population in Chile is 10%.

[27] Regarding the uses of the category of race in Latin America, De la Cadena asserts: "Its power to disqualify is genealogically instilled in a structure of feelings that intertwines beliefs in hierarchies of skin colour and beliefs in the natural superiority of 'Western' forms of knowledge, ruling, and being" (2005:24).

In Chile, ethnic differences are present but in a slightly different manner. Ethnic-racial differences emerge more elusively than they do in Peru. This is, perhaps, due to Chileans' general self-perception of being a racially and ethnically homogeneous society. So even though race/ethnicity is a differentiating category, such a distinction applies mainly to clearly defined indigenous groups, which are a minority in Chile.

Among the Chilean *mestizo* population, there is a supposed racial homogeneity however, even within this group. Differences in skin colour play a major role as a marker of differentiation. To be of a whiter skin colour is a clear marker of a positive distinction. Colour also operates in Peru as a racial marker. However, in both countries colour differences are very mobile. This is particularly true when it is associated with different forms of prestige, material wealth, or symbolic power.

The close interrelation between class, ethnicity/race and colour is characteristic of the Latin American racial ideology. Latin American racism is linked to, and for this reason, is often confounded (and excuses itself) with, the idea of social class, given that, as stated before, ethnic differences overlay class differences. Latin American racial ideology is linked to the Spaniard influence upon the continent and rooted in the imposition of a colonial order.

> ....back to the sixteenth century, a world-creating historical moment when (the articulating force we conceptualise as) power, acquired what Aníbal Quijano has labelled its coloniality. This feature has its origins in Iberian colonial regimes in the Americas but outlasts it; it articulates national regimes, even democracies. Legitimised by beliefs in (self) declared superiority, it consists in the right and might (self) assigned by a privileged social group to impose its image among those it deems inferior. In Latin America, the coloniality of power was enabled by Iberian beliefs in the absolute superiority of Christianity vis-à-vis indigenous forms of being (De la Cadena 2005:282).

At present the mainstream Latin American population associates 'class hierarchy' with 'colour hierarchy.' People of Amerindian or African appearance are often poorer. In general their access to scarce social resources and their control over them are greatly diminished. The complex association between race and class inequity also means class status and other forms of material or symbolic power can, to some extent, compensate for race inequality. For example, a rich and famous black person can be considered in some context as a "less black" person and is likely to be treated with more respect and given more privileges (Van Dijk 2007).

Due to their darker complexion and their pronounced phenotypic features (e.g. smaller physical stature compared to Chileans) Peruvians in Chile are perceived by the general Chilean population as more 'indigenous.' Chileans in general simply identify Peruvians as 'Peruvians,' but often descriptions of skin colour and facial features are added to point out their 'Indian-ness.'

A variety of unspoken and negative meanings are associated with such a depiction. In addition, most Peruvians who come to Chile are in great economic need and remain in the lower strata of the Chilean labour market. Thus, racial discrimination against Peruvian migrants within Chile is tacitly endorsed by the Peruvian lower social class.

Both systems of hierarchies reinforce each other.[28] Indeed, 'upward economic and racial mobility'[29] in the new context does not occur. However, particular elements of the two countries' past history need to be examined to better comprehend the underlying elements of the discrimination towards Peruvians as well as hostile feelings held by Peruvians towards Chileans.

Historical background to present day discrimination

The feelings of superiority Chileans hold over Peruvians became cemented in the national consciousness during the 1879-1893 War of the Pacific, fought against the Peruvian-Bolivian coalition. As a result of the Chilean victory, Chile's northern borders were redrawn and territory belonging to these two countries was annexed by Chile.[30]

At that time, national and racial feelings between Chile and Peru were crystallised around two stereotypes – the *roto* (Chileans) and the *cholo* (Peruvians). However, the term *cholo* had, from the beginning, always been used with a racial connotation. It is a demeaning term – which is still used today – to refer to the indigenous and any other racial mixture of white, indigenous and black population. Klaiber (1978:31) observes that the term *'roto'* (down-and-out) did not have racial connotation. In fact, this term referred to the scarcity of clothing endured by the early Spanish colonial population in Chile. Chile was a far cry geographically as well as in terms of wealth from Lima, which was the opulent centre of the Spaniard empire in South America.

For Klaiber (1978) the Chilean victory in the War of the Pacific was seen, at the time, as confirmation of the myth that the Chilean whiter race was superior to the mostly indigenous population in those countries. Having overpowered neighbouring countries, Chileans also associated the idea of *defeated* to the racial connotation of the term '*cholo.*' The Chilean racist attitude was largely reinforced in the construction of a nationalist discourse based on the country's aggressive and militaristic expansionism. At the time, this was believed to be supported and validated by the Chileans supposed racial superiority.

The memory of the conflictive relations in the past continues to fuel racist ideas and antagonistic sentiments between both nations. The Peruvian perception of Chile as an expansionist aggressive nation has currently been reinvigorated by the economic penetration of Chilean capitals and business enterprises into the Peruvian market.

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[28] Interestingly, the existent discriminatory and racist discourse against Bolivians in Argentina contains elements that convey the existence of different racial conceptions. As Caggiano argues, in this discourse it is possible to identify immanent references to the body of the 'other' which functions as an explanation of the other's values as well as sociocultural moral and ethical capacities. Caggiano identifies in such a discourse references to a supposed 'Bolivian character' which anchors moral virtues and their capacity to endure painful work regimes as well as the hardship of extreme weather conditions. For Caggiano, this understanding obliterates the economic, social and juridical conditions that help to explain that same 'endurance' of Bolivians. Furthermore this form of racist discourse, as the author argues, allows and legitimises exploitation as well as gives origin to a relation of domination which shapes and gives contents to class relations (Caggiano 2007).

[29] By upward racial mobility, I refer to what I described before as the process of 'whitening.' This may happen when the person in question may be of 'indigenous' appearance or darker complexion but possesses money, education or other forms of social prestige which makes him or her to be perceived and treated by others as 'whiter.' Therefore, this person moves 'higher' within the racial hierarchy.

[30] The Chilean northern cities of Arica and Antofagasta were once located in Peruvian and Bolivian territories respectively. Controversies around this continue today, troubling relations with these countries.

Feelings of resentment and mistrust towards Chileans often emerge at various levels of Peruvian society, from the common citizen to elected politicians. These sentiments are usually triggered by issues involving the countries' bilateral relations.[31] Or they may simply be triggered by a football match between the two countries' national teams. This demonstrates that memories of Peru's defeat in the War of the Pacific remains a symbolic open wound in the Peruvian national consciousness, and periodically feeds nationalistic discourses. For Chileans, these memories also feed current racial attitudes and feelings of superiority towards Peruvians. These feelings have grown stronger with the knowledge that Peruvians have fled their own country in search of better economic prospects in Chile.

[31] During the administration of former president Alejandro Toledo, the Peruvian government claimed for a reinterpretation of the two countries maritime limits. These originally had been determined following the War of the Pacific. In addition, Peruvian parliamentarians requested the return of historical monuments taken by Chileans during the Pacific war as trophies. These claims are being now pursued during the current administration of President Alan Garcia through the International Court, The Hague.

Chapter II

Theoretical Approaches and Key Concepts in Medical Anthropology

2.1 Introduction

This chapter presents theoretical approaches and concepts that will assist me in studying how migrants' health is affected by exclusion and discrimination from the host society. By discussing these theoretical approaches, I address the broader social, cultural, political and economic conditions which contextualise migrants' experiences of illness and distress. Throughout this discussion, I will emphasise the links between these individuals' experiences and the societal forces acting upon them, without losing the perspective of individuals' capacity for agency and resistance.

The first part of this chapter entitled: *'Developments in medical anthropology: In search of the middle ground',* discusses four theoretical perspectives. These are: the interpretive approach in medical anthropology, the political economy of health approach, the critical approach in medical anthropology and the social suffering approach. Contributions from these theoretical perspectives highlight various dimensions relevant in the analysis of my research problem and assist me in the construction of a middle ground perspective which brings macro societal forces and processes, as well as individuals' experiences together.

The discussion starts by introducing the interpretative approach which entails a relevant epistemological turn in medical anthropology, shifting from where various other approaches in medical anthropology have departed. In order to reach this middle ground approach I continue by discussing the political economy of health approach. The importance of this approach lays in its emphasis upon societal forces and their influence on health, introducing the dimension of the social production of sickness into the debate. This dimension is particularly relevant to my problem of study as it allows addressing the societal and macro structural factors that impact upon migrant workers' health.

The critical approach in medical anthropology integrates the macro perspective of the political economy approach, without losing sight of individual experiences and agency. This double focus is central to the analysis of migrants' illness experiences. The approach of social suffering continues the line of analysis proposed by the critical approach, integrating into its analysis a wider range of forms of human suffering including experiences of emotional distress. Also, it establishes links between experience and social practices, both relevant dimensions of my analyisis.

The second part of this chapter entitled: '*The self, embodiment and agency in the context of illness and suffering',* presents a conceptual approach which delves into a micro-level of analysis. This approach deals with the ways in which oppressive

structures of society and conflictive interactions affect individuals' subjectivities and bodies. It looks into people's shared experiences and notions of suffering and their capacity for agency over their own experiences of emotional distress. The concept of self as a cultural construct is discussed, vis-à-vis processes of social and personal displacement which results from migration. It is argued, that while Andean notions of identity – the self and body – emphasises interconnectedness, migration, exclusion and discrimination trigger feelings of loss, uprooted-ness and personal dislocation in migrants.

The concept of agency comes into play when migrants attempt to maintain control over their productive bodies; to be able to continue engaging in paid work. As it is argued, agency over bodies allows migrants to regain their sense of self and reinvest their bodies for work. This is a central dimension of their migration endeavours and self worth.

The third and final part of this chapter entitled: *'Making sense of suffering in shifting contexts'* discusses the use of various idioms to communicate experiences of distress. Idioms of distress used by migrants are hybrid and context related. They may be somatic and rooted in Andean conceptions of illness and the body. Alternatively, they are also framed within newly emerging experiences and meanings. Idioms take the form of discursive accounts, used by migrants to rework the self and their identities. In the use of these idioms, migrants reveal their own efforts to make sense of a disrupted world in a foreign society.

2.2 Developments in medical anthropology: In search of the middle ground

2.2.1 Changes in the conceptualisation of illness in medical anthropology: Towards an interpretive approach

Recent approaches in medical anthropology have departed from the epistemological turn proposed by the interpretive approach. This approach moved the debate from the previous rationalist epistemological stand, to one that conceptualises disease as belonging to the cultural domain. This claim has since been the source of much recent theoretical and empirical work in the field. To better understand the epistemological turn of the interpretive approach I will first introduce the trajectory of the concepts of illness and disease in medical anthropology.

Illness and its relation with disease has been conceptualised in medical anthropology in various ways. Initially, illness – the subjective experience – was understood as a domain separate from disease – the biological dimension. This particular understanding of illness (which did not differ from the biomedical view) prevailed especially during the 1950s and 60s when medical anthropology had a strong applied emphasis.

Medical anthropology – then an emerging field – played a role in facilitating medical science's understanding of 'other cultures'. Indeed, the main aim of medical anthropology was, then, to contribute to and improve the efficiency of public health campaigns implemented in third world countries, following the Second World War.

Disease under this scope was understood and treated as 'paradigmatically biological', and unchallenged by the anthropological inquiry. The anthropological knowledge remained at the time in the terrain of culture and culture was understood in this tradition as separate from the biological dimension of disease.

An example of this theoretical stand can be found in the ecological approach, which sees illness representations as 'cultural beliefs'. Culture in this perspective plays an adaptive role in relation to disease. Medical systems within the ecological approach are understood as the sum of cumulative socio-cultural adaptive strategies while culture was conceived as 'a set of adaptive responses to diseases'. Under the ecological approach, the division between disease and illness became separated realms and continues to exist as such.

Subsequent perspectives in medical anthropology, such as the cognitive approach, maintained the distinction between disease and illness. Illness representations in this perspective are seen as perceptions; as a domain structured by language and culture which convey "the apparent order in the natural and social world" (Good 1994, quoted by Meyer 2003). Culture would explain illness conceptions and beliefs around health and illness, which in turn, explain human behaviour. However, disease was still considered to belong to the medical domain.

In the 1960s, cognitive influences of the psychological sciences in medical anthropology were expressed as 'ethnosciences' and 'ethnosemantics'. Both anthropological projects dealt with disease classification, 'ethnotheories' of illness and the structure of illness narratives.

2.2.2 The interpretive approach in medical anthropology

The interpretive approach, which emerged with Arthur Kleinman's foundational work (1980), departs from an epistemological stand that differs from earlier approaches such as the ecological and cognitive. The concept of explanatory models of illness proposed by Kleinman (1978:187) to elicit what he referred to as the 'native's point of view', introduced a radical change of perspective in the understanding of the relation between the cultural domain and the domain of disease. Kleinman's explanatory model also pertains to the domain of disease. He argued that *disease is not an entity but an explanatory model* (Kleinman 1973 quoted by Good 1994:53). Disease, in this perspective, belongs to culture in particular to "the specialized culture of medicine. And culture is not only a means of representing disease but is essential to its very constitution as a human reality*"* (idem).

Kleinman unveils the 'category fallacy' present in the currently dominant view of disease as belonging to the order of nature and asserts: "it is the mistaken belief that our categories belong to nature and that disease as we know is natural and therefore above or beyond (or deeper than) culture…" (Keinman 1977 quoted by Good 1994:53).

This claim has been the basis for much of the theorising and empirical research in this interpretive tradition. For Good, understanding disease as an explanatory model

"was not an idealist counter to biological reductionism, but a constructivist argument that sickness is constituted and only knowable through interpretive activities" (idem).[32]

The interpretive activities according to Good involve interaction of biology, social practices and culturally constituted frames of meanings, through which "clinical realities" are constructed" (idem). According to Baer (1997), interpretive medical anthropology has verified how various biomedical subspecialties reach different conclusions about the same clinical episode. The interpretive tradition examines the construction of interpretations in different social contexts. That is: "how meaning and interpretive practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness trajectories" (Good 1994:54). Good's work is part of this tradition. Together with Mary-Jo Delvecchio-Good, he conducted an analysis of semantic networks associated with 'heart distress' in Iran and America (Good 1977). Through this study, they achieved an understanding of how meanings and symbols attached to symptoms compress a reflection and, at the same time, both motivate experiences of illness and social relations.

Good's semantic network analysis has "provided a means of systematically recording the domains of meaning associated with core symbols and symptoms in a medical lexicon. These are domains which reflect and provoke forms of experience and social relations, and which constitute illness as a 'syndrome of meaning and experience"(1994:54).

Within the interpretive theoretical orientation emerges the perspective of embodied experiences. The departure point of this perspective is that sickness is present in the human body as 'traces of history and social relations'. From a phenomenological perspective these traces constitute 'memoirs' to interpret distress, illness and suffering (ibid:55). Efforts to achieve experience-near accounts have used the phenomenological approach to study the medium and structure of experience. Here, the body is conceived as "subject of knowledge and meaning and experience as prior to representation" (idem).

The interpretive approach has been dealing with problems of adequately representing illness, suffering and experience in ethnographic accounts. It also deals with the problematic relation of experience to cultural forms such as narratives and the grounding of such experience in local moral worlds (Kleinman 1991). However, the main shortcoming of the interpretive approach has been its failure to provide a critical stance.

Critical views of the interpretive approach – which later resulted into the formulation of the 'critical approach' – pointed to a central flaw: the lack of attention to the role of asymmetrical power relations in the construction of the same clinical realities which this perspective has contributed to disclose. Indeed, those realities constituted through interpretation and representational processes have largely been treated as consensual by the interpretive approach, while usually, in reality, they are not.

[32] In this assertion, Good uses the concept of sickness as encompassing illness and disease. Sickness is here used as a neutral term. The concept of sickness is used differently in approaches such as the political economy of health, discussed further in this chapter.

The interpretive perspective, Baer (1997) asserted, lacks attention to societal structural determinations of the experience and its interpretations. This problem was also found in Good's account, Baer maintains that:

> The role of political economy (e.g., class relations) in shaping the formative activities through which illness is constituted, made the object of knowledge, and embedded in experience, for example, is largely ignored in Good's account (ibid:25).

Hence illness from the perspective of the interpretive approach provides a better understanding of illness as an inter-subjectively interpreted experience. However critical views of the interpretive approach point to its overemphasising illness individual experiences as well as to its lack of attention to the role of societal forces and structural determinations. Economic migration to Chile from neighbouring countries, responds to global economic trends and changing economic/social structures forcing people to search for low skilled jobs beyond the national frontiers. Consequently, related problems such as structural forms of exclusion and societal discrimination against migrants in Chile ought to be understood in the light of the analysis of the political economy of health, an approach to be discussed next.

2.2.3 Political economy of health approach

Concerned with the macro societal determinants impacting health, the political economy of health approach places its attention on the economic and political structures lying at the base of the social production of morbidity or the rate of disease incidence in a population group.

Morgan defines the political economy of health approach as a "macro-analytic, critical, and historical perspective for analysing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political, and economic relations within the world economic system" (Morgan 1984:132).

Although concerned with a variety of economic systems, centrally, the political economy of health addresses the process of development and expansion of the capitalist world-system and the way biomedicine operates within this context. Both systems, capitalism and biomedicine, are seen as having concomitant logics: "(T)he profit-making orientation caused biomedicine to evolve into a capital-intensive endeavour heavily oriented to high technology, the massive use of drugs, and the concentration of services in medical complexes" (Baer 1997:28). This perspective takes into account the economic and political interests involved in administration and provision of health services under the capitalist system.

Indeed, the expansion of the capitalist system is recognised by the political economy of health approach as the most significant, transcending contemporary process and increasingly shaping and reshaping social life. Moreover macro-economic transformations create economic and social exclusion of large social groups, manifested in their marginal access to economic and social resources, security, housing and health.

In this particular case of study, the economic migration of Peruvian workers into Chile is a consequence of the expansion of capitalism and the emergence of new forms

of labour such as labour provided by transnational migrant workers. Such workers' increasing vulnerability is the result of the weakening of the laws and structures that protect workers' well-being (e.g. labour legislation, social security provisions) and new labour-flexible schemes in tune with the changing needs of the capitalist system for expansion. These factors have increased the precarious work/economic conditions of migrant workers and ultimately impact upon their health.

Although very influential, the perspective of political economy of health showed some shortcomings when used within the anthropological analysis. Its emphasis on societal macro forces has resulted in a tendency to "depersonalise the subject matter and the content of medical anthropology by focusing on the analysis of social system and *things*, and by neglecting the particular, the subjective content of illness, suffering and healing as lived events and experiences" (ibid:32).

Not only particular and subjective experiences need to be addressed but also, the different identities existing among worker groups must be considered when scrutinising the way in which a subordinated position impacts their health. These differences often become visible along lines of gender, ethnicity and national identities.

In general, factors that impact upon migrant workers' health are forms of exclusion and societal discrimination which should be understood in the light of political economy of health. This, as stated before, is because this phenomenon responds to global economic trends and changing economic/social structures. While this is true, recently, the possibility to apprehend empirically and conceptually the world system or global perspective has been debated by anthropologists.

Moore (2004) for instance, discusses how the world system has become an elusive dimension when anthropologists call for its examination in concrete terms. Although Moore does not discard the global perspective, she defines it as a concept-metaphor; as "a space of theoretical abstraction and processes, experiences and connections in the world, important not only to social scientists but now part of most people imagined and experienced worlds" (2004:71).

As Moore points out, one of the problems anthropologists face when dealing with the global perspective is that often the processes, experiences and connections encompassing it "do not involve face-to-face interactions, and are extended over space and time; flows of capital and financial transactions" (ibid:75). As a general consensus in the social sciences, the global perspective exists in contra-distinction and interrelation with the local perspective. However, for the anthropologic inquiry, it represents a less debatable scale of analysis.

This general critic also encompasses anthropological efforts to analyse illness and health from the perspective of political economy and led to the development of a new middle range theoretical approach. The development of a middle ground perspective has been expressed by Lindenbaum (2005) as follows:

> Anthropological theories, once split between models of change based either on political–economic determinism or on changing beliefs and cultural values, have given away to an emphasis on an approach that brings the two sides together. Attention now focuses on the productive middle ground, on the analysis of material forces as well as economic and political factors in relation to cultural and subjective orientations (2005:752).

In summary, from an anthropological stand, shortcomings of the political economy of health specifically are divided into three areas. Its emphasis focuses upon the overarching social system. It pays little attention to individual-subjective experiences. And it does not take culture into account. Acknowledgement of these gaps contributed to the development of the critical approach in medical anthropology; middle ground approach that is discussed next.

2.2.4 The critical approach in medical anthropology

The critical approach in medical anthropology emerged as a distinctive theoretical conceptualisation, mainly for two reasons. Firstly, as a criticism against the interpretive approach, and secondly, as an attempt to redirect the analysis of the medical anthropology towards broader societal and economic dimensions, much in the line proposed by the political economy of health.

Indeed, what of late is called the critical approach in medical anthropology was introduced by Soheir Morsy in 1979 in a paper titled "The missing link in medical anthropology: the political economy of health" (Morsy 1979). This was an early effort to bring the analysis of political economy of health into the anthropological perspective. This theoretical endeavour aimed to overcome the inherent shortcomings of the one sided and macro perspective of the political economy of health.

Ten years later, Morsy (1990) gave an account of the developments of the critical medical anthropology, stressing its particularities and differences with the political economy of health.

The critical medical anthropology retained emphasis on the connection of health related issues with the economic order and social forces. However, this concern has gone beyond merely focusing upon 'grand' and modern capitalist orders to address the nature of health-related issues in indigenous and pre-capitalist societies, as well as socialist oriented-state societies.

The emphasis on individuals and the place culture has come to signify within the critical analysis, had not been present either in political economy of health. The focus on linkages between individual actions and social/structural determination is based upon the understanding of individual actions as "culturally informed interactions between social actors and political economic relationships as dialectically related" (Morsy 1990:22).

The centrality of culture is also manifested in the relation with 'the Other' seen as "different but connected; a product of a particular history that is itself intertwined with a larger set of economic, political, social and cultural process" (idem). Culture is seen in the critical approach as a system of symbols of an institutional order. The interpretation of these symbols, Morsy argues, involves simultaneous consideration of the political context where these symbols are inscribed. Culture is, therefore, understood in connection with issues of "power, control, resistance and defiance surrounding health, sickness, and healing" (ibid:23).

The critical approach also distinguishes itself from conventional medical anthropological studies as its analysis goes beyond the classic depiction of ethnomedical conceptions as historically free conceptions. The critical approach sees them both – ethnomedical and biomedical constructs – as historically situated social products.

The perspective of the local – as discussed before, more in tune with the anthropological view – has been a relevant and productive field of the critical analysis. Empirically less problematic, in a critical account, the local is usually contextualised within the broader political setting an often situated within an imaginary global paradigm.

The priority to the local context becomes especially important when conducting ethnography. Indeed, Lindenbaum has acknowledged the development of a critical ethnographic engagement with concepts of 'health' and 'human rights'. Such commitment has been embraced by the critical approach since it "provides a powerful entry point for understanding and confronting inequalities at home and abroad" (2005:753).

The value of the local has been also demonstrated by the critical approach in terms of creative powers of its analysis, reformulation and resistance. Agency and resistance are key concepts of the critical approach. In the critical analysis, recognising the powerful role of economic and social forces "does not imply that individuals are passive or impersonal objects but rather, they respond to the material conditions they face in light of the possibility created by the existing configuration of social relations"(Baer 1997:32).

Particularly important is the attention the critical approach pays to the agency of those whose experiences have been alienated by dominant biomedical discourse. Within the critical approach, the term 'resistance' has served to bring attention to cultural forms and activities which resist the increasing medicalisation of lives (Good 1994).

Studies in the critical approach have also emphasised the need to maintain close attention to sufferers' experience which is not seen as isolated from the social and economic forces which determine this same experience. "…Sufferer experience is a social product, one that is constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the context of daily life" (Baer 1997:187).

In summary, as a middle ground perspective, the critical approach departs from the political economy of health approach to address shortcomings as well as critical views of the interpretive approach. As a result, the critical approach developed a more encompassing understanding of illness. Indeed, the epistemological stand of the critical approach holds an interpretive understanding of illness, but its analysis goes beyond that framework. It points to power relations and social interactions in which illness experiences are embedded. These dimensions are also central to my own analysis.

A pivotal element of the problem under study is the connection between macro-societal determinations and an individual's subjective experiences. This is a connection to which the critical approach also adheres. The critical approach also addresses the

importance of understanding the experience of the sufferer in social contexts which is a central dimension of my own problem.

In the next section I discuss the social suffering approach, which not only focuses on illness but also includes in its analysis, various forms of human suffering. This includes emotional suffering and sees these various forms as embedded in broader societal relations. In this approach, illnesses as well as other forms of human suffering are seen as a consequence of existent structural inequality and various other forms of violence. Hence, in this approach, migrants' emotional distress is placed within the framework of various forms of suffering which results from structural, economic and political violence.

2.2.5 The social suffering approach

A call to explore the ways in which social relations and ideologies encourage diverse experiences of suffering was articulated by various authors in the field. Kleinman (1991, 1997) and Farmer (1989, 1990) have explored the ways in which structural violence and social suffering construct the social relations of everyday life. According to them, social suffering is understood as resulting from "what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems" (Kleinman 1997:ix). However, suffering in this approach is a more all-encompassing concept. It can also take the form of grieving, frustration, desperation, impotence, desolation as well as other forms of human suffering.

Perspectives on social suffering interrogate aspects of human experience that are usually considered separately, and bring together conditions that simultaneously involve health, welfare, legal, moral and religious issues. This approach necessarily challenges dichotomised approaches to the mental and physical, or the individual and the collective. It highlights, instead, the interconnections needed to grasp the political economic and social origin of illness as well as other forms of human suffering. As Kleinman asserted "we put in that category of social suffering every different kind of human problem that creates pain, distress, and other trials for people to undergo and endure. We do not, for example, separate illness from political violence or from other forms of misery…" (Kleinman 1995:15). This approach provides for a grouping of human problems which highlight the issue this study deals with. That is, how suffering derived from exclusion and discrimination is transformed into emotional distress, or through its embodiment, transformed into a physical experience.

Causes of suffering, as collectively rooted, make it a social experience which Kleinman defines as "the often close linkage of personal problems with societal problems. It reveals, too, the interpersonal grounds of suffering: in other words suffering is a social experience" (Kleinman 1997:ix).

Three themes are highlighted within the perspective of social suffering; the cultural representation of suffering; suffering as social – and changing – experience as well as the political and professional processes placed in motion to respond to suffering.

Firstly, cultural representations of suffering refer to "– images, prototypical tales, metaphors, models – can be (and frequently are) appropriated in the popular culture or by particular social institutions for political and moral purposes" (ibid:xi). In that sense it is possible to affirm that suffering has social and political use. Furthermore, collective suffering is a core component of the global political economy. Kleinman point out how in the modern, capitalist and interconnected world there is even a market for suffering. For instance, "victimhood becomes commodified" (idem), and global media campaigns are a case in point. The cultural representations of suffering shape different modes of suffering which, in turn, are authorised by a moral community and its institutions.

Secondly, the cultural representation of suffering shapes it as a form of social experience. As a social experience, suffering is understood in at least two ways:1) as collective modes of experience which shape individual perceptions and expression. Modes are visible in "collective patterns of how to undergo troubles and they are taught and learned, sometimes openly, often indirectly," (Kleinman 1997b:2) and (2) as social interactions that enter into an illness experience (idem).

Relationships and interactions are visible in the involvement of the social milieu in individual suffering. This means taking part in the experience of suffering. Suffering, the authors assert, although grounded in the human condition, may also undergo changes. These changes result from its connection with the moral symbolic system, with the political economy. Therefore, suffering is subject to societal transformations. Social experiences are viewed in the perspective of its transformation which, in turn, they impact upon the way individuals experience suffering "…Changing societal practices," Kleinman says, "transform individual lives and ways of being-in-the-world" (1997:xii). What is ultimately transformed is the way in which individuals experience suffering.

Thirdly, political and professional processes powerfully shape the responses to the many types of social suffering. In other words, institutional efforts directed toward managing and regulating suffering take on the form of medicalisation and public policies as well as programs tailored to respond to social suffering. According to Kleinman, these processes involve both authorised and contested appropriations of collective suffering. Appropriation refers to the representation on behalf of the victims assumed by leaders, organisations or institutional agents.

In summary, the approaches previously discussed provide an understanding of migrants' illness experiences. These can be described as being both an inter-subjective interpreted reality as well as resulting from social and economic structures and political forces.

Understanding illness as inter-subjective experience allows us to grasp changes in perceptions of illness resulting from migrants' interaction with members of the host society as well as with member of their own community. In addition, and equally central to my analysis, is the connection between illness – as well as emotional distress – with macro societal processes linked to economic structures. The social suffering approach ultimately discussed, has added a perspective to my analysis, which recognises various forms of human suffering. This includes emotional distress as engrained in the subordinated position migrants occupy within the host society.

The next section builds a micro level of analysis by means of various concepts; the self, embodiment and body-agency. These concepts lead to an understanding of the way in which societal forces ultimately impact upon individual's experiences – on their bodies and subjectivities.

2.3 The self, embodiment and agency in the context of illness and suffering

2.3.1 The self in the context of culture

One basic orientation of contemporary psychological anthropology – not excepted from controversy – is the dichotomy according to which a distinction is made in self constructs among those cultures which are individually centred and those which are socio-centric. The former cultures foster an independent, autonomic, egocentric construal of the self. The latter cultures favour an interdependent self.

Self constructs are therefore thought to be organised in two types – an independent self, characteristic of western societies and an interdependent self as characteristic of non-western societies. Markus and Kitayama (1991) explain this last construe in the following terms: "in some cultures, on certain occasions, the individual, in the sense of a set of significant inner attributes of the person, may cease to be a primary unit of consciousness. Instead, the sense of belongingness to a social relation may become so strong that it makes better sense to think of the relationship as the functional unit of conscious reflection" (ibid:5). Markus and Kitayama's understanding of connectedness and interdependence of the self, is "seeing oneself as part of an encompassing social relationship and recognising that ones' behaviour is determined, contingent on, and to a large extent organised by what the actor perceives to be thoughts, feelings and actions of others in the relationship" (1991:7).

The above definition has been criticised by Spiro (1993) who argues that the authors are confusing cultural conceptions of self with individual or actor 'self conceptions' or 'self representation'.[33] Spiro raises the critical question to Markus and Kitayama's perspective on the interdependent self by asking where are the others in the self? Spiro distinguishes the existence of an 'I' (a psychic structure, an ego, a soul) and its self representation as the 'me', which he calls the 'I' objectified. This distinction is related to what Hallowell described as a fundamental process of self-awareness. "One of the distinguishing features of human adjustment rests upon the fact that the human adult, in the course of ontogenetic development, has learned to discriminate himself as an object in a world of objects other than himself" (Hallowell 1955:75 quoted by Spiro 1993:110).

[33] Spiro refers to Hartman's distinction between two dimensions; the 'person' referred holistically to the psycho-socio-biological individual and 'self' referred to the individual's own person". Then Spiro asserts, that typically anthropologists (and comparative social psychologists) do not investigate the self or the individual's conception of his/her self (the self representation) but the cultural conception of the person (Spiro 1993:117) "Is the western conception of the self 'peculiar' within the context of the world cultures?" (ibid:153). I claim here that anthropologists are concerned with the individual's self representation to the extent in which this representation is influenced by culture.

Hallowell (1955) defined the self as a notion "people everywhere are likely to develop an understanding of themselves as physically distinct and separable from others" (Hallowell 1955:80 quoted by Spiro 1993:110). In Hallowell's understanding, the capacity of self-awareness, the ability to distinguish self from others (self-identity) and the concern of self continuity are essential for basic human and cultural functioning. For Hallowell the concept of the self – and not the self itself – is "in part culturally derived" (idem).

While these theoretical stands are, to some extent irreconcilable, I opt by the following perspective: While the subject's agency is acknowledged, it also must be assumed it depends on a relational dimension. The self-in-relation-to-the-others is central in individual experience in socio-centric cultures. This conception influences cognitive orientations, perceptions, motivations as well as the disposition to relate to others. It also influences individuals' definition of their personal goals.

Some anthropologists have argued as Ewing (1990) points out, that "even the functioning of the 'self (not just the representation of it) as well as an associated structure of emotional experience are culturally organised" (1990:229). The existence of an affective, culturally derived structure is also expressed by Raymond Williams as; "the affective elements of consciousness and relations are not reified as a permanent form of indeterminacy but are treated as structured formations that can 'exert palpable pressures and set effective limits on experience and actions'" (William 1977:132 quoted by McNay 2004:187).

Such conceptions gain strength as they are reinforced within the same individual's social environment. This is explained by Moore (1994) as follows: "…Since all psychic and developmental processes are relational, then the nature of the relationship between [the] self and other(s), and the matrix of social relations and symbolic systems within which that relationship is conducted, must play a role in the development of the self and the subjectivity. It appears pertinent therefore, that in many contexts people do not believe that selves and persons are bounded…" (Moore 1994:34).

In the Andean cultural tradition, human beings are viewed as closely linked to each other, as well as to the natural and supernatural world. Beings and worlds are connected through the same living force that flows through them and linked to one and another in a complex net of interrelationships, structured through premises of reciprocal obligations and duties (Greenway 1998).

In this tradition, individual, family and community are conceived as interrelated. Among Peruvian migrants – as it is among other Latin American cultures – interpersonal obligations and loyalties largely become connected to this socio-centric ideology. In this conception individual experiences of self-worth and self-fulfilment are nested in networks of social relations. Therefore, self expression requires an interpersonal idiom (Lewis-Fernandez 1994).

Concerns may be raised when considering the influence of these cultural conceptions, specifically regarding the extent to which persons who are not thought to be separated from other persons can be conceived as individuals (Moore 1994). Also, whether or not, those persons who are defined in relation to other persons can be said to have "appropriate capacities for agency and intention" (ibid:33).

As Moore asserts, one can be an individual and also bounded to a 'web of kinship'. These are phenomena that occur simultaneously. Indeed, this cultural self conception does not make the individuals concerned incapable of agency or intention as demonstrated in the context of the economic migration of Peruvians to Chile. In this case decisions to leave one's family to look for better economic opportunities is both the result of an individual capacity of agency and – at the same time – a socially accepted move responding to the cultural imperative to fulfil others' needs and goals.

However, the individual degree of response to culturally defined moral duties is variable. Ewing (1990), debates about the multiplicity of self representations operating at the individual level. The author questions aspects of consistency, unity and cohesiveness as permanent attributes of the self and argues that in an individual, self representations can be multiple. For Ewing, self-representations can shift, becoming inconsistent, as they are highly context related. "Self representations are embedded in a particular frame of reference, are culturally shaped, and highly contextual. Contexts themselves rapidly shift, as actors negotiate status and seek to achieve specific goals, implicitly redefining themselves and each other during the course of the interaction" (ibid:310).Thus, as a context-related notion, migration triggers changes in self conceptions.

Nevertheless, as it has been previously stated, intrinsic to the self and beyond each particular culture, there is also a need to experience some degree of continuity of the self across time and space. Such continuity, however, seems not to be a given but achieved, and this accomplishment is fundamental to the definition of personhood. "…Personhood is best understood in terms of people's chronic efforts to acquire and maintain possession of properties that they value: *continuity of the self is not given but achieved;* and ideal personhood involves a lasting form of self-possession or proprietorship in the self" (*my italics*) (Rouse 1995:358).

Ewing further argues that such continuity of the self is illusory. "When we consider the temporal flow of experience, we can observe that individuals are continuously reconstituting themselves into new selves in response to internal and external stimuli. They reconstruct these new selves from their available set of self–representations, which are based on cultural constructs" (Ewing 1990:300).

When people migrate, the context from which their sense of self is constructed becomes shifted. Such migration often affects individuals by *decentring* the attributes of their identity and selves. In relation to this process of decentring, Takeyuki maintains:

> The act of migration frequently disrupts and de-centres the ethnic identities of immigrants, who are thrust into a completely different socio-cultural environment and confronted by new ethnic groups. This can challenge their former identities; causing a profound transformation in ethnic self-consciousness (…) identity and self-formation involve a dynamic balance between centring and de-centring. During a period of de-centring, individuals detach themselves from their previous identities as they confront new experiences and incorporate and reintegrate new forms of identification (1999:147).

This disruption may be experienced even more strongly when the new social milieu is hostile to migrants, as is the case in Chile.

In summary, I have argued here that while the sense of self involves a perception of unity, continuity and separateness of one's own experience, certain cultural constructs of the self, emphasise the connection to others, exerting considerable influence on individuals' subjectivity and affects. Attending to cultural constructs of the self becomes particularly relevant in an understanding of the cultural embeddedness of migrants' experiences of emotional suffering.

Indeed, as I have stated before, Andean conceptions of self and identity emphasise the interconnectedness of individuals with their family and community. This particular migration with its associated social and cultural dislocation, involves a "de-centring of the self and uprootedness". This causes migrants emotional suffering and distress. Such a "taken for granted" state of being gets lost, along with the personal and social displacement produced by migration. Therefore, efforts should be made to maintain continuity in their own sense of self.

The next section highlights those linkages through which a disruption of the identity, resulting from the transformation of the social milieu and the confrontation of adverse social conditions, impact not only the self, but also the body.

2.3.2 Migrants' embodiment of adverse social conditions

From a phenomenological perspective, the sense of self is anchored in bodies; perception and lived experiences. This perspective of the self is described by Scheper-Hughes and Lock (1987) in terms of some intuitive sense people share "of the embodied self as existing apart from other individual bodies" (Lock 1993:135).

From this perspective, the de-centring of the self, triggered by migration is experienced as a disruption in the body. This is described by Jackson in the following terms: "…when our familiar environment is suddenly disrupted, we feel uprooted, we lose our footing, we are thrown, we collapse, we fall" (Jackson 1983:322). This falling, Jackson adds, is not metaphorical, but "it is a shock and disorientation which occurs simultaneously in body and mind and refers to a basic ontological structure of our Being-in-the world" (idem).

Implicit in the above perspective, is the possibility to approach the dimension of lived experiences through the body, which involves an understanding of the culture and self from the standpoint of embodiment. Embodiment can be defined as: "an existential condition in which the body is the subjective source or inter-subjective ground of experience" (Csordas 1999:182).

To conceptualise embodiment, Csordas synthesises two perspectives. Firstly, the author establishes a metaphorical parallel between text and textuality, as well as body and embodiment. The body is seen as "a biological, material entity and embodiment is an indeterminate methodological field defined by perceptual experience and by mode of presence and engagement in the world" (ibid:182). The epistemological standpoint supporting this perspective is one that sees representation "not as denoting experience but as containing it" (idem). Although this perspective allows overcoming the dualism between experience and language, Csordas asserts it does so by "reducing experiences to language, or discourse or representation" (idem).

The second perspective of embodiment is in the phenomenological tradition which asserts the being-in-the-world as the key theoretical term. The work of Merleau-Ponty has been influential in establishing an understanding of experience as embodied immediacy. "… Perception is basic bodily experience, where the body is not an object but a subject, and where embodiment is the condition for us to have any objects – that is to objectify reality – in the first place" (ibid:183). For Csordas the work of Merleau Ponty suggests that culture does not reside only in objects and representations, but also in the bodily processes of perception by which those representations come into being" (idem).

Embodiment is therefore, about experience and subjectivity; an equation stemming from the two perspectives previously outlined and expressed by Csordas in the following terms: "… Semiotics gives us textuality in order to understand representation, phenomenology gives us embodiment in order to understand being-in the-world" (ibid:184). So, in this way, the body can be constructed "*both* as source of representation and as ground of being-in-the-world" (idem).

Within the Andean cultural tradition, the principle of embodiment of the natural and the social world is a fundamental one. This principle becomes clear in the Andean concepts of the body, illness and healing. Within this cultural matrix, body and mind are not conceived as two separated entities. Instead, they are perceived as deeply intertwined realms responding both to the environment and the social order. A central component of the body is an energetic foundation (*ánima*, animating power, breath of life) of the corporeal dimension. (Polia Meconi 1996).

Coexisting etiologies in illness are a distinct feature of Andean beliefs and practices and show how the principle of interrelatedness of the social the natural/supernatural world works. Furthermore, these etiological principles also illustrate the principle of embodiment of these realms in the view of any illness condition. Illnesses are attributed alternatively or simultaneously to: "(1) supernatural causes – devils, spirits, [the] stars, ghosts and dead persons; (2) natural/environmental causes – excessive heat, colds, and winds; (3) interpersonal issues or conflicts with family, community, or spirits (4) biological/biomedical explanations; and (5) socio-political accounts that may underline situations of poverty and lack of financial and material resources and/or social support" (Darghouth 2006:3-4).

These factors may be the cause of a variety of popular Andean illness categories. The popular illness, *susto* – fright illness or loss of soul – common among Andean cultures, exemplifies the functioning of the principle of an 'animating power' among contemporary Peruvians. *Susto* also assembles the Cartesian dichotomy of mind and body and shows the irreducibility of the physical to the mental or the mental to the physical state (Oths 1999). This popular illness also demonstrates how the body in the Andean world is lived as a dynamic and interrelated totality that incorporates without dissecting the psychological and corporeal dimensions. As Kirmayer (1988) observed, cultural variations in metaphors of the mind and the body are a reflection of the influence of social structure, to the extent that it can be stated that the 'intra-psychic world is a social creation' (Kirmayer 1988:78).

The popular Andean illness of *debilidad* (weakness) is in turn, an expression of "embodied exhaustion resulting from a lifelong accumulation of productive and

reproductive stresses" (Oths, 1999:286). *Debilidad* also demonstrates how it collapses "the western boundaries between mind and body" (ibid:287). *Sobreparto,* a chronic women's illness, following giving birth, embodies the hardships of their reproductive work-related roles (Leatherman 2005).

In this section, I have examined some of the continuities observed in the way these contemporary forms of suffering are experienced by Peruvian migrants and how they are linked to cultural representations of the self, body and illness. References made to various Andean popular illnesses aim to show the existence of a non-dichotomist relationship between mind and body, which prevails among the migrant population of my study. This relation is where migrants' conceptions of illness are founded and this relation shapes their bodily experiences. Furthermore, popular illnesses in the Andean tradition are understood as embodied effects of difficult material conditions and social relations. Illness also results from disruptions in the interaction between the body with the natural and supernatural world.

Attending to both cultural continuities and changes, exclusion, discrimination and uprooted-ness represent emergent forms of social suffering, associated with this economic migration. I have also shown that, congruent with Andean conceptions of illness, migrants' current experiences of loss, of personal dislocation and self-decentring have become embodied experiences. As effects of the disruption of the migrant's social world, these embodied experiences must be interpreted in relational terms and regarded in its somatic and socio-moral dimensions. However, before delving into these dimensions and having explored bodies as fields of lived experience, next I discuss how the body-self can be experienced as a means of resistance, and as such, as a source of agency and intentionality.

2.3.3 Agency: recentring the body and self

The concept of agency is placed in my analysis, in the midst of social forces, determining individual experiences of suffering. In this discussion, I draw the concept of agency from McNay's work. As the author rightly asserts, developing mediating concepts such as agency, allows that "the determining force of economic and cultural relations upon daily life can be made visible and, in this way, the issue of identity can be connected to that of social structure" (McNay 2004:175).

Agency refers to an individual capacity for action, which cannot be deduced from abstract structures. Crucial features of agency are intention and reflexivity. Agency can be defined therefore, as an individual capacity for self-reflection and self evaluation. This capacity however, is not only supported by rationality but by experience; an essential notion in an account of agency.

Based upon the notion of agency as generative experiences and situated discourses in lived relations, I specifically explore whether agency can be exerted by and through the body-self. The latter is understood as a unit of experience and support of lived relations. In this exploration, I take an opposite stand to the western dualism between body and mind that emphasises rational agency, individualism and psychologisation of experience. Kirmayer (1988) has rightly addressed the arbitrary nature of the western assumption about rationality and the mind as the locus of agency. He expressed this as:

"the nature of mind, as the interior world or agency of the person, and body, as a medium of sensation and action, [would then] depend on the way in which social structure shapes the development of the sense of self" (Kirmayer 1988:78)

McNay, following Scott (1992) draws from the analysis of historical processes a concept of experience which provides a generative account of agency. Experience as discursively constructed leads to examining "historical processes that, through discourse, position subjects and produce their experiences" (McNay 2004:179). However – as McNay observes – from this historical dimension, the notion of experience has been widely used as a discursive construction mainly in post-structuralism analysis. The problem with this use, McNay adds, is that it suggests a kind of linguistic determinism and as a result, the generative potential of experience in the historical analysis is to a large extent, lost.

Without loosing sight of the potential of discursive representation of experience, the author continues in her search for an approach to keep the generative capacity of experience and at the same time, overcome the dichotomy of material or subjective determination. As McNay proposes, agency must be understood in relational terms and experience, understood in a non reductive or essentialist form but as a notion that can animate other notions such as resistance and subversion.

In this search, McNay further develops a relational analysis of experience by drawing from Bourdieu's work on the phenomenology of social space. This concept introduces the idea of spatial distances as indicative of social distances where social space also functions as symbolic space. The inclusion of social space provides for a relational analysis of experience. At the same time, attending to space, it becomes a strategy to apprehend the effect of structures upon experience. McNay in this regard proposes that "by plotting social positions as spatial positions, the complex interaction between symbolic and material power relations, between immediate experience and invisible structures is elucidated" (ibid:184).

This perspective allows us to understand experience not as ontological but in its relational style, introducing the broader context where experience is situated. The contextualisation is central to agency, and it encompasses "tracing the links between the phenomenal immediacy of experience and abstract systems of power that operate at one remove from everyday activity" (idem). The use of the spatial metaphor to analyse experience completes the discursive analysis of experience previously traced in an historical frame of reference, as the author synthesises: "…discourse is a situated, rather than an abstract, medium where the situation itself is organised by invisible structures" (ibid:185).

In her analysis, McNay focuses on the conflicts inherent to the reproduction of normative forms of gender identity and the negotiations involved in such processes. I introduce this perspective into the examination of the effects of social suffering upon individual migrants in the following way. I take into account migrants' emotional distress as a result of the material determination of the subordinated position they occupy in the host society. Meanings attached to distress, to illness and the body are representations belonging to the cultural and symbolic realm.

Mediating between the two above dimensions is the migrants' agency upon their own body-self, a perspective which I aim to incorporate into the analysis of their emotional distress. Often, as it happens in Chile as well, this perspective has been absent from western healthcare systems, however in Kirmayer's view; this endeavour must be embraced by biomedicine if a change in perspective is to be introduced to better respond to people's emotional needs and distress. "…It is the fundamental experience of agency and accident, and their moral consequences that must be addressed if medical practice is to respond sensitively to the emotional needs of patients and the social implication of distress" (Kirmayer 1988:58).

While living as migrants in Chile, Peruvians experience the decentring of the self and identity – their own bodies are lived in as foreign bodies and their selves as others. Migrants resist this process of decentring as well as the framing of their emotional distress within pathologic medical categories. Agency comes into play in their struggle to regain control over their bodies. This must be done in order to be able to reengage and re-invest their body-self in the productive world, as this dimension is the central focus of their migration endeavours and self-identity. Agency is, therefore, manifest in migrants' attempts to re-centre their own bodies and selves; efforts which are not detached from their material determination.

In other words, the process of pathologisation of a socially produced distress can be understood as the "constraints that operate upon social actions" (ibid:177). Migrant's resistance to pathologisation and their agency – which comes into play in their attempts to maintain control over their bodies and selves – can be interpreted as "the possibility to overcome these constraints" (idem). Through agency over their bodies and self, migrants resist and contest societal attempts to discipline them; a struggle which underlies the competing interpretations of migrant's emotional distress.

An additional element taken from McNay's approach is the centrality of emotions in the analysis of experience. The author states: "by analysing emotions as a form of social interaction it is possible to see how they are both shaped by latent social structures and also the vehicle through which invisible power dynamics are made present within immediate everyday experience" (McNay 2004:187).

An analysis of experience, therefore, should look at emotions in the context where they emerge. The context under analysis is one of structural determination and power struggles over imposed notions of normality and attempts to redefine identities. This clashing of concepts will be discussed when analysing migrants' notions of normality vis-à-vis those held by members of the Chilean society with whom migrants interact on daily bases. Following McNay's argument, if structural forces only reveal themselves in the lived reality of social relations, then attention should be paid to emotions as they speak about these relationships. Conversely, when emotions are suppressed, subjects will speak out through the body about these relationships, demonstrating that such capacity can never be completely silenced.

In the next section I will explore various forms through which people communicate their experiences of suffering and emotional distress.

2.4 Making sense of suffering in alien contexts

This section deals with how to make sense of forms of suffering that emerge from the oppressive structures Peruvian migrants are subjected to in Chile. Idioms of distress are presented as means to communicate and represent personal and collective suffering among migrants.

2.4.1 Cultural idioms of distress

In anthropology the concept of cultural idioms allows an understanding of the role of culture in framing subjective experiences. Crapanzano has provided an approach into the web of interrelations between the person's subjective experience and the inscription of that experience into a field of discourse.

> The act of articulation is more than the passive representation of the event; it is in essence the creation of the event. It separates the event from the flow of experience ... gives the event structure, thus precipitating its context, relates it to other similarly constructed events, and evaluates the event along both idiosyncratic and (culturally) standardised lines. Once the experience is articulated, once it is rendered an event, it is cast within the word of meaning and may then provide a basis for action (Crapanzano 1977:10).

The standardised lines through which an experience is articulated is for Crapazano, a cultural idiom (Vanthuyne 2003:413). An idiom, however, as Crapanzano further observes, should be distinguished from its medium of articulation; which is not necessarily spoken language.

> The act of articulation requires a vehicle for articulation, an idiom, which must be distinguished from a medium of articulation such as spoken language, gesture, a behavioural sequence as in a ritual, or some endopsychic process.[34] (Crapanzano 1977:10-11)

Although the idiom is probably structured in a language it is clearly more than a language in the restricted sense of the term. In each culture, there exist a variety of idioms to express subjective experiences, including distress. Nichter (1981) studied the availability and social implication of the use of coexisting idioms to express distress among Havik women in South India. In Nichter's study, the term distress is used to refer to a wide range of feelings and anxiety states. If they are not expressed in existing and available cultural idioms, they may take the form of an unsustainable social conflict or upheaval (idem). These expressive modes are culturally constituted as "they initiate particular types of interaction and are associated with culturally pervasive values, generative themes, and health concerns" (ibid:379).

Somatisation has been studied as cultural idiom used in response to distress in everyday life. Initial studies in this area asserted that the tendency to somatise was predominant among the less educated and non-western societies whereas the opposite tendency – towards psychologisation of distress – was observed among the more

[34] By this term, Crapanzano describes "dreams, hallucinations, visions and body apperceptions, the shape of the past (and the future), its falling into some, usually chronological order, and the use of the past as explanation or justification of the present , if not as symbolic matrix for the articulation of the present and the future" (ibid:22).

educated and western societies.[35] Contrary to this initial understanding, Parson (1991) found severe and extended forms of somatisation among urban, white middle class, educated Australians they studied. In addition, it was found that somatisation and psychologisation were not two opposite ends in a continuum, but tended to occur simultaneously.

The use of somatic idioms of distress in connection with gender identities and the place individuals occupy in the social structure has been also studied. Somatic idioms can be found among various generations within families and used according to gender. For example, it has been found to be evident among women who occupy similar social positions within their families. Somatisation as an idiom to express distress has been studied in the case of *nervios* suffered among women with excessive social and familial responsibilities in highland Ecuador (Finerman 1989). Having been conducted among similar cultural groups, these studies highlight the embeddedness of individual distress in social contexts.

Headache, a common symptom, has been studied by Darghout (2006) among women in Peru. Headache in this context is a term in the accepted social language of pain which articulates individual and shared notions of suffering (ibid). The authors propose the use of 'psychosomatic families', a concept derived from 'psychosomatic systems' coined by Minuchin and colleagues (Minuchin 1978 quoted by Darghout 2006). They apply this concept to explain the recurrence of headaches among women within a family in the following manner "…If psychosomatic families' form a well-geared system whereby one member of the family (usually one with less power such as a child) expresses discord shared by all members, the groups of women in this study may be analogously represented". The authors draw the parallel. These women occupy a central position relative to other members of the family. Therefore "they are concurrently, perhaps most likely, to exhibit interpersonal tension and communicative difficulties" (ibid:15).

Either in a somatic form or by means of other modes of expression, the way idioms are used to articulate subjective experiences including those of mental illness and emotional distress – are never free from consideration of their political or pragmatic uses (Vanthuyne 2003). The need to locate idioms of distress historically; this is, with respect to changing social conditions, has been stressed by Nichter (1981). For this author it is not enough to describe how a particular idiom is used; "it is also important to study how often this idiom is employed, in what circumstances and with what repercussions" (ibid:399).

The interpretation of idioms should also attend to the power relations involved in social interactions in which these idioms are inscribed. As Morris (1998) observes, idioms can be used as mediums through which individuals can rework their own identity. Certainly, the choice of an idiom is not independent from the interlocutor with whom the idiom is used, nor is it independent from consideration on the effect its use produces.

[35] Psychologisation and somatisation are both idioms of distress. Psychologisation refers to "the Western construal of the mind as being capable of dealing with affect separate from the body … The psychological process includes, therefore, the cognitive response to dissonance, the attempt to interpret the environment and social relations in meaningful narratives, cause-effect associations, and coping strategies" (Parsons 1991:116). Somatisation in turn, is defined as the expression of personal and social distress in an idiom of bodily complaint and medical help seeking. (Kleinman et. al 1985)

> …Different cultural idioms coexist in a society and are hierarchically positioned within a field of power relationships. Hence when people attempt to rework their identity through the use of one or more idioms, they engage in a field of contested truth claims and power struggles. The choice of a language situates them vis-à-vis their symbolic or actual interlocutors and manifests their more or less conscious desire to enter into a dialogue with certain individuals, and/or to signal their intention to distance themselves from others (Morris 1998 quoted by Vanthuye 2003:414).

The use of idioms of distress and its relation with the self and identity has been studied among patients with psychosomatic problems and also among patients with severe mental illness. These studies highlight the relationship between illness and identity and provide a scope to understand such relations in my own problem of study. This is so, since a diagnosis of mental illness often challenges the individuals' perception of their own self. Helman (1985) studied how patients make sense of their physiological experiences, of the diagnostic label of 'psychosomatic,' and of 'stress,' 'tension' or 'emotions' said by clinicians to exacerbate their disorders.

The use of a psychological idiom to explain psychosomatic complaints was negotiated between clinicians and patients in the medical setting, who by means of this idiom, jointly addressed the psychosomatic problem 'out there.' This was done in such a way that dealing with problematic dimensions of the patients' self-perception was avoided.

It was found that, in response to "psychologisation" and socially objectionable parts of the self ("bad emotions"), patients tended to "reify concepts of pathogenic (or "weak") personality, emotion and bodily parts, and separate them from the idealised concept of the self" (ibid:117). This allowed patients – in agreement with physicians – to shift the responsibility to outside forces which exert control over the emotions and body parts identified as problematic. In that way, "parts of the body and the personality are seen as "non-self," either part of other people or of the natural environment" (ibid:118).

Other studies have looked at how the self is reworked in cases of mental illness. Estroff (1991) analyse how illness and self are interdependent processes and domains, present in discursive accounts of patients with severe mental illness. The authors developed the concepts of 'illness-identity work' and 'illness-identity talks.'

"Illness-identity work," according to the authors, "produces the words, ideas, images, actions, and sentiments with which persons with disabling conditions reconstrue and get on with their lives. Elicited illness accounts and self-labelling discourse are a type of illness-identity work we call "illness-identity talk" (ibid:336).

Estroff and colleagues' study revealed that illness-identity work produced two main types of talks about the self and illness: "*normalising statements* and *illness-identity statements"* (ibid:337, cursives in the original). '*Normalising statements'* may focus on the condition or diagnosis, on the individual, or both. The authors see the main aims of these types of statements are "to dispute the assignation of illness and to recategorise either the condition as commonly occurring or the person as non-pathological" (idem). '*Illness identity statements,*' in turn, the authors add, consist of "self representation that encompass symptoms or illness, descriptions of symptoms as objects and separate from

self, labelling statements made by self and others, and “I am” or “I have” statements about illness” (idem).

I claim these concepts can be applied to the analysis of other – less severe but everyday hindering forms of emotional distress. Such an analogy is indeed plausible, considering the severity of the experiences accounted for through illness-identity talks are not sourced in individual’s mental illness but in the disruption of a social world. As such, illness-identity talks provide a means to speak about an equally destabilised self.

In summary, I have discussed here how often psychic or emotional distress expressed in the body or somatisation, is seen by western biomedicine as an incapacity to symbolise the affective experience. Never is somatisation seen as a non-dichotomist relationship between mind and body. I argue that if cultural traditions are to be taken into account, somatisation – as well as other bodily experiences of emotional distress – should be seen as comprising an idiom of distress where the body is experienced as a metaphor of the social world as well as their interrelations existing in this realm. Alternatively, idioms of distress can also comprise forms of illness-identity-talk through which identity and the self are constructed.

Chapter III

Methodology

3.1 Introduction

This chapter discusses the ethnographical research approach used in this study of illness and healthcare practices among a community of Peruvian migrants living in Santiago. This, I carried out by sharing their living space in a collective migrant housing unit, in a building located on Bandera Street, in downtown Santiago.

The holistic perspective of ethnography is consistent with my research goals since it allowed me to reach an understanding of the socio-economic and cultural aspects characterising this specific migrant community. I learned about Peruvian migrants' living and working conditions and achieved an understanding of their migration in its local and transnational dimensions.

This knowledge enabled me to better relate to the migrants' issues of health and well-being. More specifically and consistently with my research goals, ethnography enabled me to identify the existent relationship between illness and various life circumstances associated with migration. I also learned about the resources migrants put into motion to maintain their health and face illness, as they are confronted with barriers to accessing Chilean healthcare services. Moreover, the knowledge obtained through ethnography permitted the formulation of culturally sensitive questions and supported the use of complementary research techniques which I employed in subsequent phases of my fieldwork.

Finally, the information gathered through ethnography provides for a contextual and non-judgmental view of migrants' lives, based on a view from inside the community. In highlighting their socio-economic and cultural contexts, their endeavours and daily struggles, I hope to contest essentialist and stereotypical views that Chilean society generally holds towards Peruvians – often seeing them as uncivilised, ignorant, dirty, promiscuous and violent.

The chapter begins by explaining the phases of the implementation of my ethnographic work and how my personal engagement with the migrant community developed throughout the research process. I explain how trust was built and complicity developed with the migrants through various aspects of our interaction and explore how my perceptions evolved during the development of the fieldwork. I also discuss how I had to deal with issues such as my own subjectivity and positionality while conducting participant observation.

A second section in this chapter refers to the complementary methods used to gather specific information, and the rationality that links them. Firstly, I discuss methods used to gather information about mental health. Secondly, I introduce those used to gather information on reproductive health. Among the various methods applied, the use of illness narratives is a prominent one and is discussed in depth.

3.2 Ethnography

As Malinowsky asserted, the central aim of ethnography is to understand the way of life from the native point of view. Fieldwork, in Spradley's terms "involves the disciplined study of what the world is like to people who have learned to see, hear, speak, think and act in ways that are different. Rather than *studying people*, ethnography means *learning from people*" (Spradley 1980:3) (italics original).

Critical reflections on ethnography particularly those departing from the interpretative turn ethnography took in the 1980's have provided a fertile theoretical field as well as solid grounds for the development of new and more democratic forms of doing ethnography. These critiques have assisted me in addressing some of the questions which emerged while conducting my fieldwork. I will briefly refer to them in order to highlight areas that will be addressed in reference to my own fieldwork, further on in this chapter.

Critics have scrutinised the various dimensions at play in ethnography, focusing on the position of the ethnographer in the field and how that influences accessing knowledge. The multiple ways in which the ethnographer's position in the field mediates the access to knowledge must be examined in each particular case as it informs my case study. Positionality involves issues of gender, race and class among other dimensions of the ethnographer's identity and refers to how they play out in various forms of the field. Skeggs synthesises the issues encompassed in the idea of positionality as she asserts: "When we enter ethnography, we enter it with all our economic and cultural baggage, our discursive access and traces of positioning and history that we embody" (Skeggs 2001:434).

Many of the interactions we engage in, in the field may be informed by factors beyond our control. Therefore, instead of trying to control them, Skeggs proposes "to try to work out how interactions are framed by as many factors as possible … and then try to work through these in terms of power" (idem). For Skeggs, the recognition of the positioning and channels of power is one way of not engaging in normalising power relationships, thus she makes it possible to take responsibility for the reproduction of power. This dimension is particularly relevant as issues of power and my own position emerged while doing my fieldwork.

The focus of the critical reflection on ethnography is also on how 'subjects' under study are affected by issues of power along the ethnographic process. A stream of this critique has focused upon the consequences of the understanding that ethnography is ultimately about written text. The latter is linked to issues of representation of the 'other' in the text, power and authority of ethnography. Issues of representation and my own authority in representing migrants also emerged while doing my fieldwork.

In addition to the issues referred to above, there are two streams of ethnographic work I found inspirational. The first is ethnographies conducted in the field of medical anthropology. The second is more of a methodological exploration, based on the need to reformulate ethnography towards a multi-sited ethnography. This last discussion is in tune with the study of transnational migrant communities. I will first refer to ethnography in the field of medical anthropology.

3.2.1 Ethnography in medical anthropology

Since the early pioneer work of W.H.R. Rivers, contemporary ethnographies in medical anthropology have proliferated and have contributed to challenge the dominant physician's discourse on health and illness as exemplified in the case of Farmer (1990), Nancy Sheper-Hughes (1992) and Ong (1995) among others.

These ethnographies have been an inspiration for my own work. Their compelling capacity to address the effects of everyday forms of violence as well as uncovering the disciplining project of biomedicine, in tune with the critical medical anthropology and social suffering approach, has been particularly useful. As expressed by Kleinman, ethnographies within this last approach are dealing with "an amalgam of historical, political, economic, and cultural sources and consequences of affliction …" All these factors can be portrayed as "overlapping circles that can arrest one at a specific point but need to be visualised as an intersecting whole" (Kleinman 1995:211).

My ethnography has "a systematic focus on the health-relevant aspects of social life" (ibid:205). I pay special attention to illness experiences and interpretations, more specifically; I look at how these convey historical, economic, and political dimensions in the individual's personal experience. This last focus is congruent with the critical medical anthropology approach.

In doing ethnography, I take the double stance of realist and modernist ethnography, a distinction initially proposed by Marcus (1998) and referred to by Skeggs (2001). As a realist ethnographer, I look for "coherence, community, historical determination and structure" (ibid:431). This, particularly as I pay attention to issues of segregation and the subordinate place migrants have in the host society As a modernist ethnographer, I do not concentrate on communities but upon the extent in which communities transcend to "the complex formation of identity across a range of sites in relation [to] wider global issues" (idem). This second stance adequately addresses the study of migration and responds to new processes captured by concepts such as transnationalism.

3.2.2 Multi-sited ethnography

Transnationalism requires multi-sited ethnography. The multi-sited ethnography proposed by Marcus, deals in conceptual and methodological terms with the loss of the firm sense of a world system and its replacement. This is described as: "various accounts of dissolution and fragmentation, as well as new processes (…) the end of organised capitalism, and most recently globalisation and transnationalism," (Marcus 1998:81). The aim of multi-situated ethnography is to give more accurate accounts of localities without losing perspective of its connection with the global. This has involved reformulating the aspiration for holism, characteristic of the classic ethnographic project.

A multi-sited ethnography serves the purpose of studying mobile and contingently settled populations across borders, in exile and Diasporas. Along with the purposes of a multi-sited ethnography, there is a challenge to rethink phenomena occurring within the frame of transnational social spaces. These spaces are constituted by constant flow and movement of people, information, the exchange of goods, as well as monetary

remittances across two or more national frontiers. Relevant questions are therefore, how social spaces are inhabited in reference to a multiplicity of other spaces and specifically; how identity is produced and situated in reference to these transnational social spaces

In this regard, a modernist perspective is aligned with the dissolution of a specific world order, with the ending of coherent articulated meta-narratives and its replacement by processes of fragmentation. It involves the understanding that "…the situated production of identity – of a person, of a group or even of a whole society – does not depend alone, or even always primarily, on the observable, concentrated activities within a particular locale or Diaspora. The identity of anyone or any group is produced simultaneously in many different locales of activity by many different agents for many different purposes" (ibid:62).

Multi-sited ethnography must be designed following the significant linkages which the same phenomenon studied offers. This can be along "chains, paths, threads, conjunctions or juxtaposition of locations in which the ethnographer establishes some form of literal, physical presence, with an explicit, posited logic of association or connection among sites that in fact defines the argument of the ethnography" (ibid:90).

As I explain next, I still define 'the unit of my study' in classical research terms. However, I also call it a point of departure for a multi-sited ethnography, as along the implementation of my fieldwork, I tried to follow the people and their paths.

3.2.3 Fieldwork location as a point of departure for a multi-sited ethnography

My research questions shaped the selection of the place and the people to study. The area chosen was in the vicinity of Plaza de Armas in downtown Santiago.[36] Plaza de Armas is known for being the main gathering point of the Peruvian community in the capital city. Deteriorated buildings surrounding Plaza de Armas have been over previous years increasingly used as residences by the Peruvian community. The shared housing unit which I chose for my fieldwork setting was located on the second floor of a building situated on Bandera Street, just a few blocks away from Plaza de Armas.

While I initially conducted my ethnography in the compound on Bandera Street, later on, I established contact with occupants of eight other buildings located in the vicinity. I extended my participant observations to these buildings and conducted a household survey among their inhabitants. This extension happened 'naturally' as the same migrants I was already studying put me in contact with the residents of the other buildings, people with whom they were connected through friendship and kinship relations. While the compound on Bandera Street had approximately 50 people living permanently there, the total number of adult migrants living in the eight buildings later selected summed up to 373 people. This information came out of the census I took among the migrants living in these buildings.

[36] As it will be demonstrated further on, this area has the highest concentration of Peruvian nationals of all districts in the Metropolitan Region.

*The buildings selected are included within few blocks from Plaza the Arm*as *to the north, specifically from Santo Doming Street up to Mapocho River. To the east from Teatinos Street to the west including Puente Street*

The chosen setting proved to be representative of the larger migrant Peruvian community since people living on Bandera Street shared similar socio-economic and cultural characteristics with the migrant population living in other buildings in that area. As it became clear during the course of my fieldwork, the majority of these inhabitants originated from similar cities in Peru. Like their neighbours, residents of the compound on Bandera Street were part of the impoverished urban population living in coastal areas in northern Peru. They found migration to be the only way out of poverty. In Chile, they all live in similar conditions and occupy similar niches in the labour market. These migrants move through migratory networks, connecting people in their places of origin and destination.[37] So when they arrive in Santiago, they often live in the same residential areas and the buildings inhabited by Peruvian migrants in various areas of Santiago are often in bad condition. Furthermore, similarities in terms of migrant's patterns of collectively inhabiting run-down buildings in Santiago were further confirmed among a second group of migrants living in the district of Estación Central among whom I also conducted interviews. Other areas with high concentrations of migrants living in similar conditions, which I also had the opportunity to visit, are the districts of Independencia and Recoleta in Santiago.

The following table offers an overview of the areas in the city with higher concentrations of Peruvian nationals.

People born in Peru according to sex and palce of residence in selected districts of Santiago

Distric of residence	Men	Women	Men and women
Santiago	2933	2917	5850
Las Condes	535	2561	3096

[37] As Paerregaard (2003) contends the networks Peruvian have created when migrating transnationally are embedded in pre-existent social relations of three different kinds i) Patron client-relations used to recruit rural labour to Peru's haciendas, mines and domestic servant industry, ii) Migration networks that grow out of the massive rural-urban migration experienced in the 20th century in Peru and iii) Ties of kinship and marriage between members of the same household or extended family.

Recoleta	736	730	1466
Vitacura	150	1275	1425
Estacion Central	679	675	1354
Independencia	646	642	1288
Providencia	387	857	1244
Lo Barnechea	147	1031	1178
La Florida	498	614	1112
Penalolen	426	683	1109
Other districts	3650	4967	8617
Total	10787	16952	27739

Source: Martinez, J. (2003) *El encanto de los datos. Sociodemografia segun el censo de 2002, CELADE/ CEPAL,* Santiago.

This table shows the concentration of Peruvian migrants living in specific districts in Santiago. The figures show two clearly differentiated residential patterns. A higher concentration of women is observed in the wealthier districts of the city (Las Condes, Vitacura, Barnechea and Providencia). This pattern is explained by the work most Peruvian women do, as live-in nannies in well-off households. The district of Santiago in turn – where Plaza de Armas is located – absorbs the higher number of Peruvians from both sexes. This district as well as Independecia, Recoleta and Estacion Central are proper residential areas for Peruvian migrants.

The sites of my ethnography

There were various locations chosen to conduct my ethnography. I define location, following Gans as "a relational concept. It refers to the social spaces that make connections between users and uses" (2002:329). This is consistent with the mobile and transnational nature of the phenomenon under study. The first site chosen was a migrant housing collective, located in the compound on Bandera Street where I initially spent most of my time in the field. This was the physical residence and socio cultural space of the migrant community where most of their time outside work was spent.

A second location was Plaza de Armas and its surroundings. This area represents an ethno-territory of the Peruvian migrant community as it contains a collection of locations where migrants gather and reside. This included corners, streets used as gathering points, residences, restaurants, call centres, and a Catholic Church. In this social space, the larger community met to exchange resources and information, produce and reproduce their identity as well as create a sense of purpose. Here, too, they would define their limits as a community, acquire visibility and differentiate themselves from the Chilean society.

A third location was the district of Estación Central where I moved to in the second part of my fieldwork and as it was shown is also one area of high concentration of migrants. There I met migrants living in various communal houses situated in a defined perimeter of the district. This residential area began to be inhabited by migrants more recently than Plaza de Armas and migrants live there following the same pattern of sharing rooms in run down houses. In the area there is a Catholic institution 'El Hogar de Cristo' and associated to it, the Parish "Pedro Arrupe" which runs a special program to assist migrants. Over the last years the area of Estación Central has been increasingly

attracting Peruvian migrants.[38] Initially, I established contact with the migrants through the Catholic volunteer team of the Parish who knew the community and facilitated my access to them.[39] Once I got to know the first group of migrants they introduced me to other migrants living in the vicinity.

As I discovered soon after, some of the migrants living in Estación Central I interacted with either knew or were related to the migrants living in the area surrounding Plaza de Armas, some of them had even lived in the Plaza de Armas area before.[40] Most of the migrants I interviewed in Estación Central came from the same cities in Peru, similar to the group of migrants living in the vicinity of Plaza de Armas. However unlike with the migrants in the vicinity of Plaza de Armas, I mostly visited them over weekends when I conducted in-depth interviews.[41]

In several of these locations I met with migrants, held conversations and simply spent time with them. I visited restaurants serving Peruvian food and I spent time with migrants who were both street sellers and buyers of food. I also accompanied migrants when they called home from formal as well as informal call centres, and when they sent cash remittances home. In addition, I joined migrants when they attended their gatherings in ballrooms as well as events held at migrants' collective houses located in the area.

Other sites of my ethnography were located in Peru in the cities of Lima, and in the mid-north, Chimbote, Trujillo as well as the Huaringas Lakes in the district of Piura in the far north of Peru. These places were visited at the end of my fieldwork, in July and August, 2004 when I met with some migrants who had returned to Peru and to their families. During my visits, I delivered packages and pictures on request of migrants. I shared news and impressions of their lives in Chile. I shared meals and conducted interviews with the returned migrants and their relatives. I also visited traditional healers or *curanderos* in the Huaringa's Lakes, in northern Peru. Migrants visit such healers when they are seriously ill or when their well-being is too compromised. Many non-migrant Peruvians also visit these shamans for health reasons and cleansing. I took part in one such healing session.

Having described the multiple sites selected to do ethnography, it is necessary to briefly reflect on the implication of the chosen areas –and its inhabitants – for the study and its findings. The areas selected inform the specificities of the population selected and its differences with other migrants that were not incorporated in this study. Plaza de Armas and Estación Central (likewise other Peruvian neighbourhoods in the districts of

[38] The closeness of that service together with the general depreciation of houses in the area, and its relative good location (in close distance to the subway and the Bus Terminus) may all be factors attracting migrants to live in the area.

[39] The *Parish Church Pedro Arrupe* is a Catholic Church which offers assistance to migrants, particularly to those with an illegal status. Volunteers from the church regularly visit migrants' collective houses on Sundays. The long-term relationship established by these volunteers with this particular community of migrants has created a bridge of trust. This was absolutely necessary in order to obtain the migrants' consent to take part in this study.

[40] I often heard these migrants expressing their preference for the residential area of Estación Central which according to them is quieter than living near Plaza de Armas where the close proximity of discos makes people more prompt to partying and to the associated imbibing of alcohol.

[41] The selection of this other area was based on the shared similarities with the group of Palza de Armas and allowed me to compare with this group, the findings I had obtained so far.

Independecia and Recoleta) have similar characteristics. In both areas migrants live in ethnically highly concentrated spaces, sharing rooms and being members of social networks consisting almost exclusively of Peruvian citizens. In choosing these sites I did not reach migrants who may have never contemplated living in these areas because their resources allowed them to live in better off neighbourhoods. Nor did I reach those who may have decided or financially managed to move out of the close community and are now dispersed in various neighbourhoods throughout the city. Those other migrants whom I did not reach are probably part of other social networks, may have other experiences of migration as well as may establish other relationships with Chile and the Chileans with whom they probably interact more closely.

The residential areas here selected however, are representative of a significant group of Peruvian migrants living in Santiago–city where the largest community of Peruvian nationals reside in Chile. Having arrived relatively recently into the country as migrant workers, they do not have enough resources to settle down independently. They may be found for example in La Florida, a predominantely middle class district. This factor links to other elements which characterize the group of migrants selected; the majority of the migrants living in the districts selected are blue collar workers, earning an income close to the minimal wage. Would I have selected more integrated and better off Peruvian migrants living in Chile, it would have probably led to different findings.

3.2.4 Participant observation

Participant observation is central to the effectiveness of any ethnographic fieldwork as it was in my own work. The roles conducted in the field allowed me, in various degrees, to combine my participating in the lives of the Peruvian migrants' communities while maintaining a professional distance to adequately conduct my observations and record the data. I refer to these roles and their emphasis here.

In total, I spent seven months in the community of migrants in downtown Santiago. Afterwards, I moved to other geographic areas in Santiago, where migrants lived, and developed focused research activities in the areas of mental and reproductive health as discussed in the second part of this chapter. During the three initial months of my ethnography, I established and developed a relationship of cooperation[42] with the community through my role of volunteer of APILA (Association of Peruvians for the integration of Latin America), whose members are mainly professional Peruvians, whose motive was to contribute to the integration of Peruvians into Chilean society. In the four subsequent months, I shared living space with this migrant community at the compound of Bandera Street.

The group living in Bandera Street had been recently asked to leave the compound by the owner. As I gathered, despite the deteriorated infrastructural conditions of the

[42] The critique of anthropological representation and authority occurred during the 1980s reconceived the classical figure of rapport in terms of collaboration. Collaboration ("co-operation" in dialogue) (Marcus 1998) opens the possibility of a plurality and dialogue in the construction of knowledge. Rapport, instead, is a "relationship" or "connection" as a means of instrumentality for fulfilling the ends; primarily of meeting the ends of one of the partners – the initiating one – of the relationship" (ibid). In my ethnography I established a relation of cooperation in terms of my involvement in migrants' problems and concerns, however not so in the construction of knowledge.

place, these migrants did not want to leave. Landlords have come to see the renting of flats to migrants as a lucrative business as they charge high rates for run down buildings. As tenants, migrants do not have any power to demand improvements of their living conditions. If they choose to leave, the landlords know there will always be somebody else willing to rent an available place. Migrants often face multiple barriers in accessing housing and their demand for housing is far higher than there are existent accommodations on offer. The area is, otherwise, a convenient location for migrants as it is near their gathering point, from where they can easily access various destinations in the city.

Not only was the access to proper housing limited for this group, they also did not have access to proper legal representation or interlocution with local entities. In my view, these circumstances were an indication of a more general situation of exclusion. This led me to decide to follow up on the matter. My decision to assist this migrant group on behalf of APILA, was also due to the fact that the organisation did not have the professional resources to attend to this request.

The emphasis I gave to participation and to observation varied according to the roles I assumed during the time I spent in the field. The volunteer role I initially assumed had more emphasis on participation. Later, as more people became involved in assisting with the housing problem, I was able to revert from that role and place more emphasis upon observation. This shift happened during the third month of having been in contact with the Bandera Street community. By then, I felt that trust had been built and complicity with various members of the community was well established. It was then that I requested to be allowed to rent a room in the shared housing unit.

Over the following months, I stayed overnight a few days in a week as well as on the weekends. There, I engaged with the community in daily activities as well as in celebrations and events. I conducted interviews as well as a household survey. As I shared the living space with the migrants, the time I spent with them was their time outside their work activities. The days that I did not spend in the field, I devoted to desk work, data recording and processing. The table below describes the roles I took and the relationship I established with the community through the various phases of my participant observation.

Table II-1 Phases of my participant observation and the roles conducted

August	**September**	**October**	**November**	**December**	**January**	**February**
First contact with the community through a Peruvian Organisation. ▪Establishing complicity ▪Role as a volunteer **▪Emphasis on Participation**	I get involved in migrants' housing problem and deal with the problem of an imminent eviction. The community gets organised ▫*Construction of complicity;* ▪Role as a Volunteer **Emphasis on participation**	Other professionals became involved[43]. *Confronting Resistances* Combined roles **Transition from participation to observation**	The community negotiates with the owner and are allowed to stay free of charge for three months Increasing acceptance ▪Role of researcher **Emphasis on observation**		▫*Relation of complicity*	The community moves out of the compound into various buildings in the area **My exit**
	Periodical visits to the site.	I request to be allowed to rent a room and to live in the compound	I live in the shared housing unit	I live in the shared housing unit.	I live in the shared housing unit.	I continue visiting them in their new rooms-homes.
	.	My request is decided collectively. One member opposes, but the majority of the inhabitants agree and decide positively.	I am referred to as *la señorita antropologa*	I became a *vecina* (*neighbour)*	I became a *friend.* I am introduced as: *a Chilean, but a friend*	

In the next section I discuss how my relationship with the community and my perceptions of migrants and their circumstances evolved. I start by introducing the circumstances and the people I entered into contact with.

Entering into the field

Graciela and Eligio were my two contacts at the collective housing compound. Liaising with them was crucial in gaining access to the entire community. The fact that Graciela was one of the longest-staying inhabitants of the building gave her legitimacy within the community. Eligio, although new to the building, had a good relationship with most of the members of the community. He had the time and disposition to collaborate with me as he was member of APILA. With his support, my presence was not distrusted. In the context of my study, Eligio was central and indispensable for my fieldwork. He became a key actor in my research and played a pivotal role in linking me with the community.

[43] A Lawyer, a Sociologist and an Architect

> Once the door opened, I saw a youngish man, Eligio, and later I would learn his nickname was *Ñato*. I cannot recall what initial impression I had of him. I was nervous and worried about saying the right thing. *Buenas noches* ('good evening'), the man greeted me. I introduced myself and asked for Graciela. I explained that I had come on behalf of APILA. I did not have the chance to explain much more when he invited me in, leading me to a room next to the doorway.
>
> *Fieldwork notes, end of August 2002*

Following Schutz's description of the immigrant stranger, Manso asserts that the way to orient oneself in a new culture can be achieved by acquiring a position within the culture of the group. The stranger has to gain insights of the equivalence existing between both cultural patterns, the stranger's own cultural patterns and those of the other culture studied. Only by accessing to both systems of knowledge it would be possible "to convert coordinates within one schema of orientation into those valid within the other" (Manso 2001:136).

As a stranger entering into the field, I was confronted with myself as an outsider, while simultaneously investing my efforts to orient myself into a new environment and culture. Initially, my attention was focused upon understanding the cultural equivalences.

> I only walked a few steps inside the building before I reached Graciela's room. In the process of walking, I looked around briefly, trying to observe as much as I could, taking in the building's interior and its atmosphere. Although it was poorly lit, I could make out a row of rooms, one next to the other, along the sides of the building. An empty space in the middle served as an inside corridor. I could not determine how big the living area was, but it looked as if the rows continued to the end of the building. The first impression I had was of a hidden neighbourhood made up of little rooms, separated by thin, flimsy walls. These thin inner walls were in sharp contrast with the solid material of the building's outer walls. It was as if those improvised rooms were built for an emergency shelter, not for permanent residence. In seconds I was inside one of these rooms.
>
> *Fieldwork notes, end of August 2002*

My intention was to gain the necessary knowledge that would lead me to valid interpretations of the group studied. Overcoming the experience of being an outsider is intrinsic to many ethnographic endeavours. As Schutz has pointed out, "only after collecting certain knowledge of the interpretative possibilities of the new culture, can the stranger start to adopt this culture as a scheme of interpretation of its own expression" (idem).

> The man told me to wait for Graciela, who would return from work at any moment. Inside, I met Graciela´s younger son and daughter who were sitting together on one bed, watching television. I sat on the other bed and talked a little with the youngsters. The room seemed to be no bigger than 12 square meters and, as I later learned, it was home for Graciela's entire family. This consisted of Graciela herself, her husband and their four children. Since I counted only three beds, it meant the beds were being shared. In addition, the room contained a big TV, a stereo and a small table which served as a 'kitchen'. Plates, pots, etc. were piled up. Clothes were hanging from the walls and inside of plastic bags. Photographs, pictures and a big clock were hanging from one of the thin walls. I knew there were many other objects stored in that room as well, but I refrained from scrutinising the room too openly.
>
> *Field notes, end of August 2002*

When recalling my attempts to orientate myself into this new culture, I find that there are similarities with Schutz' phenomenological approach which advises that the starting point of this epistemological stand is to approach "*every* phenomenon, including the known ones, as if they are presenting themselves for the very first time in the consciousness" (ibid:138).

The epistemological stand of the phenomenological approach however, does not seem feasible at the empirical level. Indeed, experiencing a phenomenon without any preconception is, in reality, not possible as perception and interpretation are simultaneous processes. Thus, a feasible route for a phenomenologist to take is – rather than completely 'bracketing' all presuppositions and prejudices about a phenomenon – to try to refrain from using frames of references which would contaminate their pure experience of the studied phenomena.

> Soon thereafter, Graciela entered the room. She was a short, middle aged, rather heavy-set woman who looked weary. However, she managed to smile at me with kindness. Shortly after Graciela had sat down, four or five other Peruvians, brought by Eligio, entered the room. I was first introduced to Don Luciano, a man of about 50 years, who works as mechanic. Then, Luis entered; a short, heavy-set man in his mid 30s. He worked as a gardener.
> I was also introduced to Doña Chame. She seemed to know more about their housing situation than the others. They all went on talking to me, giving me all sorts of details about their housing problems and the names of people involved in the housing conflict. They were about to be kicked out of the building, but they did not know why or when, and whether there was a lawsuit filed against them or not. There were a number of confusing stories being presented which made their descriptions even harder to follow.
> I sat there, listening to them, alert to what was happening around me. I remember wondering whether I would later be able to remember all of what I was seeing, hearing and experiencing. I reflected briefly on my own limitations to carry on this dual attempt of trying to naturally interact in the discussion while at the same time trying to record all of what was taking place.
> I was overwhelmed by the amount of information being presented all at once. But I was happily surprised by the fact that nobody seemed to be reacting against my presence there. Again, I strove to keep this dual focus: observing the room and the Peruvians as well as participating in the discussion.
> I could see indications that the family ate, cooked, slept, relaxed, watched TV, etc in that room. I could hardly imagine how a whole family's life could be shrunk down in such a way as to fit into12 square meters!
> The open window brought in all the noises of the busy street outside, into the room. Of course, this further hampered my best efforts to follow what, I felt, were many and quite confusing explanations.
>
> *Field notes, end of August 2002*

My research questions

The purpose of my ethnography was to systematically address the research questions posed in my study. My initial and overwhelming experience of being confronted with reality led to the search of a strategy to deal with these questions.

> Bombarded with so much information as I was, I felt helpless and I gave up in my attempt to retain it all. I decided to ask a few questions in order to get a better grasp of the situation. I asked about the size and number of rooms on the floor and about the number

> of people living there. Were they all families living together or not? Were they all Peruvians? How long had they been living there? How much rent did they pay for each room? How many toilets and showers were there? Where did they cook? What other problems did they have? Did they want to leave or stay? What choices did they have?
> I felt then as I feel now, that my initial research question was too loosely posed for this very lively and many-sided frame. For example, how do migrants' living conditions affect their health?
>
> *Field notes, end of August 2002*

One main challenge was addressing the linkages of migrants' health problems to their living conditions. Ethnography would show the concerns and rewards of their life as migrants. In particular, it would reveal their deteriorated living conditions and unstable housing situation. I wondered how their bodies and minds were being affected. Were they shattered, protected or cared for? And how did they cope with the many challenges and problems while being so far from home?

I was fully aware how difficult it was to answer these questions once I was empirically confronted with them. The migrants' health problems did not come immediately into view. And, they did not become evident during the first phase of my participatory observation, either. Only after some time was spent with the migrants did the language of illness and distress begin to appear. Then, the questions listed above began to find a way to be answered. It was in the subsequent phases of my fieldwork where I could specifically address the questions of illness.

Of this, I give a detailed account in the second part of this chapter. What I would like to discuss next is how my own engagement with the community changed and how my perception of them and their circumstances was also changing.

Evolving perceptions

An initial moment of adjustment was my perception as an *outsider;* eminently an *etic* view in the beginning of my fieldwork. In that beginning, I saw migrants in general terms as a broad category of people characterised by lack of rights, by being discriminated against, by living in overcrowded conditions, and by being ill and exploited. The following text is a recount of those impressions I had after my first contact with the community on Bandera Street.

> A collection of images revolve in my mind now that I am about to start writing my fieldwork experiences of living among the Peruvian migrant community. I clearly remember the first time I stood outside and knocked at that anonymous door on the second floor of a rundown building on Bandera Street in downtown Santiago. I can perfectly recall the feeling and thoughts that crossed my mind during the minutes I waited outside. Or was it just a few seconds?
> Yet, it was time enough to experience all the anxiety and nervousness of a first encounter with an unknown world. The only information I had was that twenty families lived on one floor of this building. Next, I wondered, how it was that only one door could lead to twenty families? How could only one doorbell reach so many people? This thought intensified the sense of in-hospitability surrounding this building. Taking a second glance, I could read *Te amo Chimbote* (I love Chimbote, a city in Northern Peru). It was written on one of the walls, which gave to the otherwise anonymous place a tiny indication of the identity of its inhabitants. This reassured me that I was at the right place.
>
> *Field notes, October 2003*

My initial approach to the fieldwork site was very much as if I was entering into 'foreign territory'. This belied the fact that it was situated in the very heart of the same city where I lived and was born. It was a territory that seemed to me then to be ruled by foreigners, there was a frontier around them, separating them from my nation.

As I see it now, the frontier I imagined they had built was in reality mine; distanced by my own fearful gaze. Yet, this imagined frontier was not entirely or exclusively mine but rather one that responded to public messages and images in circulation which describe Peruvian houses as crowded, dirty, violent and promiscuous. As I had no other previous knowledge with which to contradict these common prejudices and preconceptions, my only recourse was to attempt to work against such a frontier. As I pondered it then:

> There was also the feeling that this first encounter would be important to me both personally and professionally. My personal conviction of my legitimate right to be there prevented me from leaving that evening. Four months have passed since that initial encounter and I feel I have just begun to come closer to the names, faces, and the many lives and stories which I found behind that anonymous door. I also discovered, inadvertently, that the door was never closed to me. Nor was it closed to the people who came after me; the ones who made an effort to get to know this migrant community.
>
> *Field notes, end of August, 2002*

My involvement with the community

Aware that my own perceptions of these people and their circumstances were evolving, I was able to gain an inside view of this migrant community. I soon took the decision to live among the migrants by renting a room in their building. I was aware though, that moving there would not lead me to 'experience' their experiences. However, it would allow me to get closer to them and to their lives. This would give me the insights to more properly interpret the information I was gathering.

The distance was however mutual. I was regarded and treated by the migrants in reference to my most formal role. From the beginning, until I moved into the compound I was addressed as *la señorita antropologa.*[44] One strategy I used to bridge the gap between me and the migrants and to grasp a deeper understanding of life in the community was to work with my own culturally learned habits and routines.

I was actually surprised to find myself wanting to be closer to the community and share as much time as possible with them. At the same time, I resisted entering into their space. A message sent to my supervisor a few days before I moved into the migrant housing compound shows my own resistance to give up my comfort and habits.

> I am intending to start spending one or two nights this weekend, and then come back to my own place... Again, in the middle of the week, I will go back. I will see how it works and how I feel. I cannot express what I feel exactly... There are so many things that are

[44] In general, Peruvians tend to be more formal than Chileans in the way they address each other. Migrants typically used the pronoun *usted* ('formal you') instead of *tu* ('informal you'), when addressing each other. While a degree of formality in the way each treated the other was always kept, the way in which they addressed me changed over time, connoting less social distance.

> culturally determined, such as the sense of privacy. I am struggling with my own feelings of being exposed.... It is a feeling I get once I picture myself moving my life there even though it is just for a short time...
> It is funny that in reality, it is the other way around. It is me who is entering into their private life... I have to make a more systematic observation. So far, it all gets entangled with my own feelings... Yesterday, when I went there to check out my room, it was daylight and the sun was getting through the many holes in these badly put together walls... I felt my public and private life would be filtering through in the same way the sunlight was filtering through the walls of the place... All the small intimate bodily routines may be changed, accommodated, eliminated, exposed... Today I am going to be with my mother. I really need it! Lorena
>
> *E-mail to my supervisor, October 2002*

Gradually I became more comfortable there, even though I was, for the most part, the only Chilean present at any of the social activities. I always remained conscious I was in my hometown, not in a foreign city as the migrants were. I had this ever-present consciousness of my rooted condition as opposed to their uprooted status. Though this was in the back of my mind, I also felt I was in a foreign land and they were living in a closed Peruvian enclave. To manage myself in this paradoxical situation, I made a constant and conscious effort to bridge the fundamental differences of our "being in the world" experiences.

One of the strategies I used to bridge this incommensurability was to try to de-centre myself. I would temporarily retreat from my own rooted social word. This 'estrangement' or 'defamiliarisation' remains the distinctive trigger of ethnographic work. While in classical anthropological work, this is often achieved by dramatically crossing cultural boundaries, in my case, it was achieved by a temporary suspension of my normal daily concerns and social relations.

This would, on the one hand, free my attention to be able to immerse myself in the new environment, and it would at times, suspend the certainties of my own world. This self-inflicted void helped me to hear more; to see more of their own tribulations and concerns. It also afforded me time enough to share equally in their joy, and mutual companionship.

One of the challenges of sharing living space with migrants was for me to manage the mutual rivalry, the tension, and the dynamics of an unstable state of the internal social relations. There was an internal rivalry and hostility expressed through gossip and other forms of indirect communication. As I did not want to take sides, I often stood in the middle of a conflict.

On these occasions I was assisted by Ñato, as he was an expert in keeping on good terms with everybody. He would often say to me: *Lorena, tienes que tener mucha psicologia"* (*you have to apply a lot of psychology).* The conflictive and unstable space, in which everybody was submerged, by living in such a tight social and physical environment, was always a constant. And, I was not exempt from these circumstances, from the moment I entered into the community.

> We meet Doña Chamé, the person who is in charge of the place. She is one of the inhabitants who have lived there the longest. She is an energetic woman, a healer, and, I think, a new friend. She tells us: *we have to see if that room can be rented or not*... This

is news to me as we had already requested the community's permission, and we had talked to the owner. We had, I thought, taken all the necessary steps.
We go into the room. I start to think what new obstacle could come up now? I feel the agreement we had come to couldn't be so fleeting. Marta and pregnant Jenny are very busy hanging decorations and balloons from the ceiling for the baby shower to be held later that night. It looks like they have a lot of work to do for the whole day.
Doña Chamé begins to talk, to get them involved, by referring to the discussion which took place the night before. However, they do not engage. Chamé then says to me: "B*ecause they* (the community members) *said that you could share the room but not rent it on your own*, (as it had been put to me once*). The group had already decided that no one else could rent here".* Therefore, I should not be the one to break the agreement and that I could not make my own rules.
At this, Ñato gets angry. He begins to argue with her. Ché and Luis also intervene and then discussion turns a little ugly. Ñato is very angry. The only certainty I have is that both Chamé and I spoke to the owner and she had agreed to rent a room to me for one month. I'm nervous, I feel uncomfortable. To not be accepted would be a failure… I think it's not going to work out, that this is all happening at the last moment.
Ñato puts forward all his arguments to bring down Chamé's opposition. Of course, her position isn't really her own. She represents the people, who the night before, had been against my renting the room. The opposition, as far as I can gather, seems to be due to the fact that I will be having a room all to myself rather than my actual presence there. This makes me feel a little more relieved. After a few minutes, the situation clears up and Chamé opens the lock to the room. I can go in to take a look. I am much relieved.

From the community's view, opening up to my presence meant running the risk of me exposing the details of their lives to public scrutiny. Such a thing could reinforce negative stereotypes and even possibly create new ones. There were situations happening within the community –violent fights and arguments between neighbours – which, although I often heard about, I tried not to personally witness them, as I knew migrants did not want me to actually see them. This I discovered on the first night I spent in the compound as I witnessed one incident of violence at a party.

The evening had passed in a succession of more or less established steps – toasts, speeches, gifts and *ají de gallina* (chicken chilli). They had made food for about 40 people but not all of the residents of Bandera have been invited. There is dancing and joking around. A glass of beer circulates in camaraderie among the men. The mood around 3:00 or 4:00 a.m. has become quite critical, and the beer has taken effect. Finally, a fight breaks out between two young men who had lived there previously. These men – according to the comments made by everyone – were known for being problematic and prone to fighting.
The fight begins in the middle of all the dancing. There are screams, shoves, someone shouts to turn the music down. No one knows how the fight will end. After hearing all the screams, I head for the end of the room. For all I know, someone could be armed, although it seems this is not the case. They push each other, and the fight makes them fall against the wall of the room where the *bebita* (baby) sleeps. The walls bend slightly and they look as if they are going to come crashing down. The cheap wood bends. They open the door of the baby's room, she appears in her mother's arms. The guests separate the men and the problem is solved.
A young woman, one of the men's partners, intervenes to defend her man with an impressive fury. A little later, everyone has calmed down. The host of the party kicked out the problem guests, and everyone recriminates each other for having invited those people. Don Luciano and Don Carlos call me to one side and apologise for what has happened. They say they hope I don't write about this in my thesis. I tell them not to

> worry, that I won't say anything that could harm them. I tell them that what happened in no way stains the nice evening we have spent together.
> Doña Angela also tells me: *"Hey, please don't put that in your thesis"*.
> "*No, don't worry"* I tell her. In any case, I know this happens everywhere. I'm really scared when Chileans fight. There were only a few punches here, and one of the boys was really drunk.
> I don't know if I have convinced them that they can trust me. I'm afraid they may really feel their lives have been exposed. And, although many said they had nothing to hide when I said was going to come here, they may really feel they have put their lives on show having me around.

I understood that the demand posed to me by migrants was all about representation. This emerged as a concern particularly in the context of how they had been represented by the media and generally by Chileans. As I describe the event here, I believe I exerted discretion and responsibility. While I had not been authorised by the migrants to give the previous account, I assume the research product is ultimately mine. I don't believe I am betraying them or that I am not keeping my word.

It is my contention that, by giving an exhaustive account of their lives as migrants as well as their circumstances; and, by representing them in their complexity, I hope the reader will understand the context in which such violence arises. As I see it, this is very much an expression of a deeper form of violence; one that is chiefly economic, and at times, has racial and gender components. I believe that if I am successful in providing enough background, the risk of the reader stereotyping these migrants is minimised.

Nevertheless this touches upon the issue of authority in writing ethnography, which has been extensively debated in the literature. I run the risk of being seen as exercising my power of representing the other, which I do in my terms in spite of their will; if that is the case, I have chosen to disclose the power I exercise. I am fully aware of the fact that my choice may be at odds with ethical concerns regarding the right of the participant to disclose or not disclose personal information and the responsibility of the researcher to respect such a decision. To face this ethical concern in the field (as I was not sure then whether I would or not write about the issue of violence) as I have explained before, I decided to avoid witnessing episodes which I knew they would not like me to see or to later disclose, in that sense I accepted the limits of their own sense of privacy. I also assumed that entering into their space was not only to document their lives in all their complexity (including episodes of violence), but also to embrace the responsibility of being involved in their everyday struggle (by promoting and assisting them in getting organised, negotiating their rights to housing, among other aspects of their concern). This involvement not only required the building of complicity,[45] but it also involved assuming the role of the circumstantial activist.

> ….that is not the activism claimed in relation to affiliation with a particular social movement outside academia or domain of research (…) rather it is an activism quite specific and circumstantial to the conditions of doing multi-sited research itself (…) in conducting multi-sited research, one finds oneself with all sorts of cross-cutting and contradictory commitments (Marcus 1998:98).

[45] (Complicity) inevitably pushed the entire research program of the single ethnographic project into the challenges and promises of a multi-sited space and trajectory – a trajectory that encourages the ethnographer literally to move to other sites that are powerfully registered in the local knowledge of an originating locus of fieldwork (Marcus 1998:120).

The conflict may not be completely resolved, however a way to address this, as proposed by Marcus, is by being a sort of ethnographer activist renegotiating identities in different sites. My involvement and circumstantial activism in turn, provided a space to negotiate my own identity as Chilean. It helped to bridge the frontiers of my own national identity and allowed me to be seen as somebody who did not perpetuate differences as other Chileans do. I was seen as somebody empathetic as well as 'humble', able to share with them the precariousness of their living conditions.[46]

The responsibility of my circumstantial activism extends to this moment, as I write about them, and that is to address the deeper causes of violence. It is my hope that my work will enable an understanding of the events of violence within the broader social and economic contexts where they originate.

Several other negotiations continued in the field.

As I spent time in the community, I became less of an outsider. As I shared the living space with the migrants, I began to be referred to as *vecina* (neighbour) by all those with whom I established contact.[47] I am not implying however, that I was seen as a neighbour just like anybody else. Rather, while my difference did not disappear, they decided to give me this label which, for me, was a confirmation of their acceptance of my being in their physical space. I also read it as them being more comfortable with my presence.

Sharing living space with the migrants provided me with the opportunity to learn about their social practices. My initial conceptions of migrants were challenged by a closer observation of their practices. If I initially had a biased view of migrants as victims of their circumstances, I had to reflect upon my own perceptions when I observed their opportunistic and individualistic approach to what I understood to be collective matters.

I later realised that most of this individualistic behaviour is rooted in their transitory status of being migrants. This state of being defines them structurally. Indeed, migrants often call themselves *aves de paso* (passing birds). I realised their being migrants often goes against the possibility of them becoming possessors of rights, or of emancipating themselves by collective actions. As I later determined, their difficulties in becoming collective subjects are rooted in the fact that, among migrants, there is not a permanent 'us.'

The 'us' is produced through fragmented spaces, articulated not in a discursive form, but rather in social practices with shared cultural meanings. These entail music, dancing, food traditions, and the need to stick together in order to survive. Yet, their social nets are embedded in a deep economic logic, in which by providing support, the individual is also investing in his/her future where favours can be asked reciprocally.

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[46] This involvement did not erase my Chilean identity though, of which was I always reminded by migrants apologising to me whenever criticism towards the Chilean society was expressed.

[47] I am not including the woman who was opposed to me moving into the compound. My interaction with her was minimal as I could never manage to break the ice. There were also other migrants who I hardly saw therefore I did not establish the relationship I am referring to.

This was when I realised my work had become one of a modernist ethnography, as described by Marcus: "The referent of contextualisation for the modernist ethnography, which denies itself any conventional concept of totality, are fragments that are arranged and ordered textually by the design of the ethnographer" (1998:72-73). I was studying processes which were crosscutting time frames and spatial zones in an uncontrolled way (from a conventional comparative perspective). I realised their identities had other, stronger referents and that the people, places and area of interest I had judged collective were merely circumstantial.

Gender relations in the field

As stated before, Ñato was my key informant. Later he became my fieldwork assistant and my friend. The role he played in my work was crucial in a way I could not have anticipated. He assisted me in conducting a census as well as the household survey. He provided me with knowledge about how to conduct myself in the field. He also taught me about interpersonal relations – including conflicts – and provided rich information about the nuances of everyday life. He introduced me to the people living in the various buildings of the area and answered the questions of those who inquired about my presence there. In addition, he often escorted and protected me from possible risks, especially when I participated in activities occurring late at night. As can be anticipated, there were issues of gender playing out in this relationship.

My own gender and single status played a role in the field and was synthesised into one issue brought up again and again by the migrants. They were curious to know exactly, what was my relationship with Ñato. This was exacerbated by the fact that I was deemed a suitable partner for Ñato. There was a general consensus that Ñato needed to 'get serious'. In short, they meant he should get married. For quite some time, I thought it was simply enough for me to discard that possibility whenever it was suggested to me and to both of us. It must be said however, that Ñato's willingness to assist me was congruent with his general attitude towards the migrant community. The following description is a brief biography and portrays the way he related to the general community which informed the relationship I established with him in the field.

> Ñato studied Civil Engineering at the University in Peru, but he interrupted his studies to devote himself to his political activities. At that time, he engaged in a variety of small odd jobs, railing against the ideals of his middle class family, who valued a professional career.
>
> He worked as security guard, a shop attendant, and before leaving for Chile, he had a small business selling eggs in his hometown, Chimbote. It was one of his youngest brothers who bought the ticket enabling him to relocate to Chile, as a way to help him find better economic prospects. As it was, Ñato's oldest brother and his family were already settled in Chile. Not very convinced, he accepted the ticket to come for a short visit of two weeks. That was his first excursion outside Peru. Seven years have passed since then.
>
> He smiles easily and he is often in a good mood. He enjoys dancing as well as talking. He can spend hours in a conversation, and often prefers to speak rather than to listen. He is a kind person who shows respect for everybody. He is a paragon of correct behaviour and politeness. He never swears or insults anybody. However, when he is upset or gets into an argument, he would raise his voice, which comes out tight and loud. And, as few Peruvian men of his age remain single, he is an anomaly. This single status holds in spite of constant pressure from his friends and acquaintances to give it up. However at this

point, he does not seem to be too concerned with starting his own family. He would rather put the needs of other people ahead of his own well-being.
He is ready to listen to people's problems and promptly gives advice, and is always trying to help the people of his community. He will lend money, even if he has very little himself. He will go out and do the shopping for his neighbour, Sra. Angelica, when she is busy taking care of her little baby. And, he would spend a whole day looking for Yajaira, the stepdaughter of Demetrio, his cousin. The girl often runs away from her parents' room with the neighbour, Chapita.
With the same dedication, he would go to the police station, *Interpol* as they call it, risking his own personal security to learn the reason why the police had come to the building looking for Lucho. Ñato would accept if a friend invited him out for a beer to share his love pains. Often, after having drunk a few bottles, the friend would tell him that he has no money to pay for the drinks. He would also mediate in many of the conflicts in the migrant community of Bandera Street.
Ñato knows almost everybody within the migrant community, as well as the migrants who gather in the point of Catedral Street. With everybody, he has time to chat. *Amigo* is a word that comes out of his mouth easily. And, he is considered as someone who can be trusted, though he keeps his own problems to himself. He never discusses what he considers a personal matter; including his political involvements
It has been difficult for me to gather Ñato's own health narrative. He often cuts out half of the story, minimising the severity or concern that any past health problem or accident may have had upon him.

Fieldwork notes January, 2003

Ñato understood what my research goals were all about, and while he got involved in assisting me in my work, he also put his own agenda forward. He was interested in promoting a migrants' organisation, with a collective voice to claim their rights. Although without entering into details about which political party he belonged to, he often mentioned his political involvement in Peru which motivated him to work towards strengthening the organisation of his fellow country people in Chile.

While I felt lucky to meet somebody like Ñato – with such strong social commitments and a generous nature, it gradually became clear that there was an additional reason which motivated him to assist me in my work. In time, he developed a special interest in me. While my motivation was to place myself in reciprocal and collaborative relationship with Ñato, this expected balance shifted as I suspected he was more committed to collaborate with me as he had become emotionally involved. Although this was never explicit from his side, it was always expressed by everybody else.

Ñato's silence was comfortable for me, as I never had to deal with this issue directly and, I much preferred to ignore it. However, I often tried to dissuade Ñato as well as everybody else from holding any expectations of a romantic liaison between us. I did this by referring to an imaginary partner, and a fabricated engagement. I felt I had to lie about this as the migrants would not otherwise understand why I would not engage in a relationship with Ñato. It was obvious that we got along very well.

Field notes October 2002

I am aware there are ethical issues at stake in how I did not deal with Ñato's and the community's romantic expectations. However, in my defence I admit that I simply did not know how to do it better.

3.2.5 Household survey

The participant observation I had carried out set the stage for the use of other research techniques, in my aim of producing an in-depth and accurate description of the community. As previously explained, it was while conducting my participant observation that I decided to conduct a household survey, based on a structured questionnaire. This would allow me to gather information from a larger number of migrants as well as establish more clearly, patterns of behaviour.

Combining questionnaires and ethnographic interviews are certainly not new to anthropology, as it has been previously used in western and non-western settings. Indeed, the information obtained with the household survey complemented the data obtained through the ethnography. It allowed me to quantify the information obtained. It also allowed me to test the level of generalisation of my ethnographic findings. While ethnography provided a wider, in-depth knowledge of the community living in the building on Bandera Street, the survey allowed the achievement of a higher level of generalisation of the world of those migrants living in the downtown Santiago area.

An additional reason for conducting the survey was, at the time, that secondary quantitative information on migrants was not existent. The last national census had been conducted nine years earlier and as migration was not such a significant phenomenon then, the census did not capture specific information on the issue of migration. The household survey produced, therefore, the first quantitative information based upon a representative sample of migrants.[48]

The questionnaire contained 61 questions. Most of the interrogatives were close-ended with alternatives. Questions covered topics such as demographic characteristics and social networks, their family situation, and queries about their remittances sent to Peru, as well as their living and working conditions. In addition there was a section focused on the migrants' self perception of their health status and their health-seeking behaviour.

The household survey also gathered information on the trajectory and migratory movements of this group. These included length of stay in the host country, home return, and migration to a third country and so-on. In addition, it provided information about the linkages migrants maintained with their families in Peru. This in turn, allowed me to identify the transnational character of this migration. This is further explained in chapter IV (Annex 1).

Sample

The universe of my study is comprised of a foreign population of Peruvian origin, living in the area adjacent to Plaza de Armas (see map above). This sample was selected from that universe. The kind of sampling was stratified random and biphasic. Initially, 8 buildings inhabited by Peruvian migrants were identified in the perimeter. Each

[48] The survey was conducted by a team of three people; myself; my assistant Ñato, who I trained to be familiar with the questionnaire, and Carolina Stefoni, a sociologist at the time affiliated with FLACSO (Latin American Faculty of Social Science, institution which hosted me during my fieldwork in Santiago). Carolina was also involved in designing the questionnaire as well as in the analysis and later, co-authorship, in the publication of the survey's results.

building, flat and room was visited and the total population was recorded. Information on gender, age and nationality of the people in each building was gathered. As mentioned before, a total population of 373 adult Peruvians was counted living in these buildings.

The survey sample of 149 migrants comprised 40% of the total population in the area. The composition of the sample was random, keeping a participant quota of building inhabitants proportional to the total population living in each one of the selected buildings. The sample maintained a 60:40 proportion between women and men, which follows the same ratio as the total Peruvian population in Chile. The sample was, therefore, made up of Peruvian citizens older than 18 years; 93 women and 56 men. Processing and analysing the quantitative data was done using the statistical software package, SPSS.

Based on migrants' self reports, the household survey confirmed what was already known by the ethnography. Mental health was one of the most recurrent health problems affecting migrants in Chile. That information supported my decision to focus on this area of health problems in a subsequent phase of my study.

3.2.6 Leaving the community of Bandera Street

By the time my household survey was completed, the community living in Bandera Street had been gradually moving out of the building. In the process, several conflicts developed among migrants. Some accused the others of deserting the collective agreements, seeking their own self-interests by negotiating with the landlady for an extension of their residence there.

Most of the migrants left as soon as they found alternative accommodations. Others, such as Graciela and family returned to Peru, although later Graciela and her husband did come back. Still others, such as my neighbours Hugo and Angelica and her toddler, tried to stay in the place and resist eviction until the very last. In the end, only a couple of rooms were occupied.

Over that period, I continued visiting the building even though I had moved out, spending some time with them in an atmosphere which resembled a post-war situation. The owner had cut off the electricity and also the water. Finally, the place was bulldozed. Only then did the last inhabitants vacate. They had to bear an uncomfortable situation but had saved as much money as was possible by not having to pay rent.

I had already started to spend more time outside the compound, surveying the neighbouring buildings. I had also begun to establish relationships with various migrants living in the various other buildings. These relationships were of a different kind than the ones I established with the community of Bandera Street. With these other migrants I was merely a visitor popping by to conduct an interview and subsequently, just for visits. With them, I felt freer to ask questions than I did with the people at the building of Bandera Street. With the Bandera Street residents, I actually had not conducted any formal structured interviews during the time I was sharing their living space. This was because I did not want to make them feel they were 'being studied' all the time. At the same time, with the migrants in Bandera Street, setting up a recorded

interview exacerbated my feeling that I was breaking the natural flow of interaction, which I wanted to preserve.

Somehow, being again an outsider, and at the same time, having gained so much insight, it made me feel free to ask more questions of the latter group. The fact that I did not live among these migrants also led them to more easily disclose personal information. My relationship with the migrants from Bandera Street, with whom I had become friends, however, continued. Most of them moved into the neighbouring buildings so I continued meeting them and visiting them, but just as a friend. So, my exit from my ethnographic site happened 'naturally,' or maybe more accurate is to say 'the site disappeared.'

3.3 Methods used for gathering information on migrants' mental health

Information obtained by the household survey assisted me in deciding that the subsequent focus of my study would be mental health. The ethnography had already revealed some of the difficulties involved in conducting research in this area of health among my study group. For example their negative perceptions of mental health issues often prevented these migrants from seeking help. In addition, they resisted labelling their conditions as mental health problems and a separate category of health issues. To refer to their ailments they often used more fluid categories, involving the mental and the physical as a unit.

The approach to mental health which I used dealt with these issues through a combination of methods and instruments of data gathering. This included the use of culturally sensitive questions. Among the various methods used, illness narratives were most prominent and proved to be a useful approach in my attempts in making sense of migrants' emotional suffering. In addition, it assisted me in avoiding framing the migrants' experiences into a pathologising approach to mental health. Given its relevance, I discuss this approach in detail in the next section.

3.3.1 Illness narratives

The analytical value of narratives lies in their potential in allowing me to grasp the core of most human experiences. Narratives can be seen as a "central form of understanding, organising and communicating human experience in its psychological and social subtleties" (Goodman 2001:169). For Plummer, narratives are "…the most basic ways humans have of apprehending the world" (Plummer 2001:185). Narratives are present in every documented life and life story, providing a means to make human experiences transmittable, providing a sense of intelligibility and coherence to a life.

Illness narratives, briefly defined, are stories in which the main topics emerge from and centre about illness. According to Good, narratives are "a form in which experience is represented and recounted; in which events are presented as having a meaningful and coherent order; in which activities and events are described along with the experiences associated with them and the significance that lends them their sense of the person involved…" (Good1994:131). Kleinman (2000) describes the illness narrative approach

as an open-ended approach to the stories surrounding episodes of illness and healing for those who have lived through them. Narratives contain the experience of illness and may relate broadly to the interpersonal context and effects of illness. They may also extend to whatever the narrator considers to be of relevance in a particular illness episode. Through its narration, illness experiences bring to the centre the physical, social, cultural and psychological domains as well as the most transcendental questions regarding life and death.

An early use of illness narratives in medical anthropology intended to challenge the biomedical model of dealing with and explaining illness. Narratives provided a vehicle for "empowering patients". Through narratives, individual patients were given a voice and legitimated patient's right to speak about their own illness experiences. Attending to the potential of narratives, medical anthropologists have intended to capture, by its means, the subjective, psychological and socio-cultural dimensions involved in illness experiences. Yet, the use of narratives in the field of health has not been restricted to academic purposes. They have also extended into the field of therapy were its use for empowering patients has been retained. It is due to this conjunction of interests that healing and suffering became central themes in the analytical as well as the applied uses of illness narratives (Kleinman 1988; Good 1994; Mattingly 1995). My own approach to illness narratives retains this double purpose.

My approach to illness narratives emphasises the dialectical and complex relation between individuals and collectives, as well as between realities and its representations. For Goodman, this approach is an attempt to reach a middle ground between collective cultural themes, and personal experiences and biographies. This approach attempts to understand "how narratives are a link between bodily (and individuals') experiences and social relationships and conditions" (2001:171). Narratives are used in this approach as a way to connect micro and macro levels of analysis, so that an understanding of individuals and their circumstances may be achieved. I will next explain my own approach to illness narratives.

My approach to illness narratives

In my approach to narratives, I pay attention to how cultural meanings are embedded in illness and convey collective experiences. At this level, individual stories are seen as actively participating in the construction of collective understandings. My approach also pays attention to the extent in which illness stories became interwoven with pre-existing models culturally available, creating consensus and culturally framed references to understand and interpret new illnesses. In this cultural contextualisation I attempt to understand the perception and the meaning given to illness experiences.

The social dimension in narratives is also relevant as it attends to my research goals and is present in my analysis. I recognise the need of retaining the broader socio-economic dimension when analysing narratives, to allow an understanding of "concrete events that require relating the inner world of desire and motive to an outer world of observable actions and state of affaires" (1994:771).

However, as Campbell points out critically, often analyses relying upon narratives tend to refer to background social structure and action in favour of culture and rhetoric[49] and there is a need to counterbalance this risk. The relevant question in my approach is how this broader social, economic and political context is affecting individuals' lives, their health and illnesses. The 'social contextualisation therefore explores to the socio-economic embeddedness and conditions to which these narratives may be, in a causal way, connected.

As Campbell suggests narratives should not be used in isolation. Instead they must be situated in relation to the wider political economy, and must be able to engage with the problem of measurement and verification with biomedicine and psychiatry. In this author's view anthropological studies in illness should "set out the rationale of a holistic study of illness/disease allowing one to contextualise interview data, verify the nature and composition of the wider population from which specific information is drawn, and if necessary verify by direct observation account of practitioner-patients interaction" (Campbell 2000:118).

With Campbell, I share the perception of the need to use different measurement methods to ensure that the dialogue with biomedical sciences continues. My own approach to narratives has not only attended to cultural dimensions and the socio-economic context but also has used narratives in combination with other forms of measurements. I am referring specifically to the household survey as well as the screening of symptoms of anxiety and depression through the use of mental health tests.

3.3.2 Gathering migrants' narratives of emotional distress

A screening for symptoms of anxiety and depression was conducted in order to identify those migrants experiencing emotional distress. Two mental health tests were used with this purpose. The measurement based on these tests provided a point of departure to identify migrants who, according to medical criteria, exhibited the most severe symptoms of depression and anxiety. The ultimate purpose of the use of mental health tests was, therefore, to assist me in identifying and gathering illness narratives among emotionally distressed migrants. Next, I explain how the screening was conducted.

The use of mental health tests to screen for symptoms of anxiety and depression

The instruments used were the Goldberg General Health Questionnaire (GHQ12) and the John Hopkins Check List-25. These tests have been used in international studies and have already been applied to various cultural groups including the population in Peru as well as numerous migrant groups in different parts of the world.[50] Although this study

[49] Campbell's critical account backs this up by referring to Kleinman's pioneering and influential book "The Illness Narratives". The problematic use of narratives here is Kleinman's uncritical treatment of patients' narratives, in which other communicative modes are left unexamined. The cultural understanding of the self and the body is not examined; nor is the influence exerted by the context in which these narratives have been elicited (Campbell 2000).

[50] These questionnaires were used in the study of Violence in The Andes, carried out by Duncan Pedersen from McGill University Hospital, Montreal Canada. The instrument was translated into the *quechua* language and validated among the Peruvian *quechua*-speaking population. Dr. Pedersen, stressed the convenience of using this same instrument to compare different population groups. In my study, I use the Spanish version, since that is the language of the Peruvian migrants in Chile.

does not conduct a comparison between these populations, the use of these instruments leaves the possibility open for future comparisons.

The mental health test was applied to the second group of migrants, living in Estacion Central. Reasons for selecting a second group were linked to the need to compare the findings I obtained in the first phase of my study. It had also to do with the lengthy gap of time between information obtained through the household survey and the time when the mental health test was to be applied. This duration was however, inherent to the research process. Nevertheless any length of time may be a too long period when dealing with migrants and highly mobile populations.

When the mental health tests were ready to be taken, about 50% of the people initially polled had moved out of their rooms. Reaching them again was not feasible as typically, migrants very often move houses, change work and even leave the country. In other instances, while people still lived in the same rooms, the symptoms of their problems were no longer evident. Nevertheless, when some experiences of emotional distress were detected among this group, a few cases were selected for further in-depth interviews in order to obtain a retrospective perspective. In view of these various circumstances, I decided to apply the mental health tests to a second group of migrants living and working under similar conditions as the first polled group.

Tests were applied to a representative sample of 58 migrants living in the district of Estacion Central in Santiago. The sample is statistically proportional in sex and age to the population of migrants – filtered by the variable 'born in a foreign country' – living in a geographical area consisting of a few blocks within this district. The information used to select the sample was obtained from the national census of 2002, as its results were already accessible to the public.

The criteria for selecting the sample were migrants older than 18 years, and residing in Chile for longer than 6 months. Tests were applied in the months of January and February 2004, with the assistance of a final-year psychology student. This person volunteered at the Parish and had contacts with some migrants in each of the collective houses we selected in the area. In addition to the test, information was gathered on the socio-demographic characteristics, family situation, as well as the migrant's legal status and working conditions. The rationale was to compare test scores with the socio-economic variables of the migrants.

This screening led to identifying a smaller group from the selected sample based on their relatively high test scores. Among this group, in-depth interviews were conducted to gather their illness narratives. Through illness narratives, it was possible to learn about migrants' experiences of emotional distress and their own interpretations of these experiences. In the next section I will explain how these narratives were gathered.

Eliciting narratives of emotional distress

Unlike the first group, in-depth interviews among this second group were conducted shortly after the mental health tests were applied. This procedure, however, involved a risk. This was the possibility of imposing medical criteria into migrants' narratives of their experiences, as the tests would eventually frame the narrative into medical conceptions of depression and anxiety. The need to separate the test from migrant's

illness narratives was also important because, in general, migrants did not identify their emotional distress as a mental health problem. Also, the use of the term "mental health" often triggered negative perceptions among migrants, as they tended to associate mental health problems with madness.

Several precautions were taken in order to avoid contaminating the migrant's narratives in application of the tests. There was indeed a risk the test would provide migrants with medical criteria and terms that were alien to their original way of talking about themselves. There was also a risk the test would make them feel they were 'crazy' or that there was something wrong with them. Tests were presented as a set of questions helping the researcher – as well as the Parish Church – to gain insights to some of the health problems migrants may have been facing in Chile. The test was not presented as a diagnostic instrument. Indeed, as further explained in Chapter 7, the test's score was not given to migrants unless it was requested. With the exception of just one migrant, none asked their test score. The way the test was conducted, rather than pointing at a final diagnosis, prompted an illness narrative which in turn, took its own course later on, during the in–depth interview. As illness narratives were elicited, the focus of the interview was placed upon migrant's emotional distress and the various circumstances which triggered it.[51] I approached this area of experiences with open questions (Annex 2). In this way, I avoided framing migrant's distress in the specific category of a mental health problem. As mentioned, the use of the term 'mental health problem' to refer to migrants' illness experiences was found to be problematic.

In the initial testing phase of the household survey, migrants were asked about their health problems, and none of them mentioned any "mental health problem". An additional question was then employed in the household survey to elicit answers in this area of health problems. "Have you been worried by your moods in the last few weeks?" This proved to be a culturally appropriate question to ask. This allowed space for an *emic* category of emotional distress to emerge as well as allowed unanticipated categories of distress. In this way I was able to prevent the contamination of the interview with the researcher's perspectives and categories.

Only when the term emerged in the interviewed migrant's own voice, did I refer to their distress using that label. However, often more than one category emerged.[52] Migrants' usage of a term to describe or explain their emotional distress led me to explore where that particular label was learned from and what uses they made of this label, where they used with members of their own community, with members of Chilean society?

In this way, during an in-depth interview, care was taken to not introduce any particular category of distress which might influence the interviewees' perspective of their own distress. To explain, the in-depth interviews normally took place a week or two after the test was applied, but in some cases, after several months. In cases where the interview was conducted when the experience of distress had already elapsed, the

[51] Emotional distress was defined by those interviewed as it was experienced by them. The term "emotional distress" is used here to refer to a variety of forms of emotional suffering experienced by migrants, as it will become clear in the chapter devoted to mental health.

[52] Alternatively, I used the term "symptoms", when the description of their emotional distress was vague or not completely defined.

extended time-frame provided for a more distanced perspective of the illness experience. The gathering of the narratives at two points in time proved to be beneficial for the purposes of my analysis. It provided for a better understanding of how illness experiences evolve over time (first group); as well as how emotional distress was experienced in its acute form (second group). The framing of a time perspective also allowed for examination in retrospective of the migrants' culturally specific ways to deal with their illness and distress. This approach also provided the same benefit for studying their health-seeking behaviour and mechanisms to manage and cope with their illness and distress.

In cases when the interview was conducted while migrants were going through experiences of emotional distress, this involved my own emotional engagement with the affected person. In those instances I offered my support and gave advice as well as assistance in practical matters when they were required. After the interview I would typically pay a few more visits in order to accompany migrants in dealing with their emotions. I believe all of this helped – perhaps to a very limited extent – to ameliorate the person's distress. Many times, migrants expressed relief after having confided their problems to me. I was seen as a sympathetic and neutral listener as I did not belong to the community. Keeping the confidentiality of the information was, in this regard, crucial.

Analysing narratives of emotional distress

A twofold approach was used in the analysis of the illness narratives. Firstly, I paid close attention to the perceptions migrants had of different circumstances in which their symptoms of distress emerged. Also, I asked how distress symptoms were experienced and what the causes they attributed to their suffering were. Secondly, I looked at conflictive interpersonal relationships, frustrated goals and sense of loss experienced by migrants in their social interactions. In addition, I examined the broader socio-economic structures and the relationships underlying the particular causes and circumstances in which their distress had emerged. In other words I aimed to produce a cultural and social contextualisation of their narratives, as addressed above.

The analysis of these illness experiences focused upon identification of life events, particularly those events which were migration-related and resulted in suffering, uprootedness and increased emotional distress. Each illness experience and the micro-circumstances surrounding these experiences were seen as embedded into the broader societal and economic dynamics. Such mechanisms create and perpetuate the subordinated position migrant workers occupy in Chile. Emotional suffering and illness experiences of the participating migrants in Chile were carefully recorded in each individual biography. Some of the questions leading the analysis dealt with the extent that illness and suffering emerged in their displaced lives. How did they deal with being so far from their homes and family in Peru? How did their precarious economic and legal status in Chile affect them?

In terms of processing the information, interviews were recorded and transcribed verbatim. Interviews were then coded using ATLAS.ti software. Supported by this software program, a relationship was established among the various codes and the analysis was conducted accordingly. In addition, each narrative was analysed separately and compared on the basis of gender and age of the migrants.

3.4 Methods for gathering information on migrant's reproductive health

Information obtained through the household survey also showed that the main reason why migrants consulted the healthcare system was for reproductive health consultation. In all cases, it was the women who did the consulting. This area of health problems was therefore chosen to address my research goal to study the interactions between migrant patients and healthcare providers. The study of migrants' demands for healthcare outside the healthcare system was important as it would lead to exploring the nature of barriers to access and the extent in which they deterred access to the medical system.

The methodological approach to reproductive health aimed at characterising the services in reproductive healthcare available to migrants, and to research activities inside the healthcare system. Identifying the existence of barriers for accessing healthcare for migrants was another aim of my study. I also wanted to characterise the demand for contraception among female Peruvian migrants as well as their behaviour in response to family planning services offered by the Chilean public healthcare system. Topics to consider were adaptation to the offer, unmet needs and seeking alternative care. This exploration, in particular, required studying women's demands, needs and behaviour outside the healthcare system. Only in that way, was it possible to reach women who were not making use of the public healthcare system as well as to identify existing barriers preventing access to the Chilean public healthcare system.

3.4.1 Research activities conducted outside the healthcare system

In this section, I discuss the method used to study migrant women's demands, perceptions, behaviour and access to healthcare in reproductive health outside the Chilean healthcare system.

Household survey conducted among migrant women

A second and smaller household survey was conducted among a sample of 60 migrant women. This survey was conducted under the research supervision of two students in their last year of under-graduate obstetrics, who took on the project as part of their under-graduate thesis. The survey focused upon the use of contraception among migrant women, outside the healthcare system.

Women were selected from a larger group of migrants living in the vicinity of Plaza de Armas. They were randomly selected from the same eight buildings where the initial and larger household survey had been conducted. Criteria for the sample selection were that women should be older than 18 years and should be using a contraceptive method at the time of the study – traditional or modern methods – and had given their consent to participate. Besides being users of contraceptives, the women selected needed to have resided in Chile for longer than 6 months. Women were contacted and interviewed in their rooms at times when they were free. Appointments were always made in advance and interviews held in privacy.

The questionnaire focused on the women's use and knowledge of the contraceptive method(s). It also queried the women's regularity for medical check ups and also explored the existent barriers for these women to access healthcare.

After the questionnaire was delivered, the students conducting the interviews took on the task of answering the women's own queries regarding reproductive health, contraceptives and how to access healthcare. In addition, they provided information to clarify misconceptions which had emerged during the interviews. This educational activity proved to be very beneficial. Women who had not been interviewed also approached the students to get answers to their own questions.

Interviews with migrant women

After the survey was conducted a group of 10 women were selected for in-depth interviews with open-ended questions based on a guide. These cases were selected among women who were using a variety of contraceptive methods and were not having regular medical check ups. Interviews were also held in women's rooms, at a convenient time for them. All interviews were recorded, transcribed and analysed using a matrix of various entries. The women's decisions, in terms of contraception and about having children, were traced. Also noted was the extent to which reproductive decisions where related to their life conditions as migrants. The analysis was conducted by using a list of codes related to the various categories of analysis.

Table III-2 Research activities conducted among migrant women outside the healthcare system

Research techniques	**Participants**	**Total numbers**
Household survey	Migrant women living in downtown Santiago, users of contraceptives, living in the country for more than 6 months	60 women
Semi-structured interviews	A sub-sample of women who were not attending healthcare services	10 women

3.4.2 Research activities conducted inside the healthcare system

The research activities were conducted in two primary health clinics: *Consultorio* N° 1 and N° 5. Both clinics were dependent on the Central District of the Ministry of Health, where migrants holding various legal statuses were receiving healthcare. They were also healthcare clinics that provided family planning and pregnancy control programs to migrant women.

The study's goals were known and authorised by the director of the Primary Care Department of the Ministry of Health. The directors of the clinics and the head of the women's units of each of the clinics were contacted to attend a meeting where I introduced my study, its goals and the activities I intended to conduct. I submitted my objectives and methodology as well as the questionnaires used in the various methods.

While conducting research activities with the healthcare providers as well as with migrant patients, I was confronted with the possibility of being seen as someone who

could expose their critical perceptions to a higher level in the healthcare chain. This could result in negative repercussions for them as individuals. Midwives feared being exposed to clinic directors or with authorities at the Ministry of Health. Administrative personnel did not want to expose themselves to the clinics' directors. And, the migrant women feared the entire group of healthcare providers.

Aware of this limitation, I tried to offer a 'safe' space of expression for all the participants. First I assured them of their anonymity and reiterated that their opinions would be protected. I explained to the participants of this study that I would not identify individual opinions but I would most often seek out collective ones. In cases where individual interviews were conducted and, the interviewee's opinion referred to, I did not identify the person by name but would use generic descriptions as 'patient' or 'midwife'. In general, while the names of the healthcare professionals were accessible to me at all times, it was not the case with women patients. Here, the women were selected randomly, from the group of foreign patients attending care on any particular day at either of the two clinics. During the interviews and focus group, I asked people to identify themselves by their first name only.

I then explained in detail the purpose of my study to all participants in the focus group as follows: I needed information to complete my thesis and, in terms of its implications for development, I needed them to provide insights to improve the quality of care to migrants in the Chilean public healthcare system. I invited the various groups of participants to take this conversation as an opportunity to express their views, which as they declared were often not heard in the healthcare institution. To a great extent, I believe, I managed to overcome the risk of self-censoring by producing conditions favourable to gathering the collective discourse of these various groups. Furthermore I believe I may have incited them to be critical, since they knew the outcomes of the research were to be input for improvement measures in the healthcare system.

Semi-structured interviews with healthcare providers and migrant patients

Semi-structured interviews are recommended in situations where there is not more than one chance to interview someone, as in the case of migrant patients. These types of interviews also proved to be efficient "among managers, bureaucrats and elite members of the community – people accustomed to efficient use of their time" (Bernard 1994:210), such as healthcare providers. This mainly demonstrated that the researcher was fully in control of what was wanted from an interview, while at the same time, it did not exert excessive control over the informant (idem). Semi-structured interviews to healthcare providers were based on an interview guide, which included a list of questions in a particular order (Annex 6).

Using a structured questionnaire (Annex 7), twenty female migrant patients attending family planning as well as antenatal care were interviewed after their consultations. The interviews were conducted in the clinics in a separate room provided to me by the healthcare staff. These interviews generally lasted 30 minutes to one hour.

Recruiting participants and obtaining consent

Women were contacted by paramedics who asked them first about their availability to participate in a study on the quality of healthcare. In addition, women were informed the study was anonymous and told the approximate length of time the interview would take.

Those who agreed were brought to meet me in the private room. Once the women were settled, I introduced myself, explaining again the objectives of the study.

I assured both, the anonymity of the information they would provide, as well as my position external to the clinics. The goal of the interviews conducted with women patients was explained to them as 'learning about their perception on the services provided to them as well as about their healthcare needs.' After this, I asked again if they would agree to participate and assured them that if they were not willing, there would be no repercussions for them in anyway. The interview began by gathering information on each woman's past reproductive history – birth, use of contraceptives, etc). Later it focused on the characteristics of the healthcare received as well as the identification of women's reproductive health needs and the extent in which these needs were met by the healthcare received.

Interviews with key informants of the healthcare system

Key informant interviewing is an integral part of any ethnographic research. "Good informants are people you can talk to easily, who understand the information you need, and who are glad to give it to you or get it for you" (Bernard 1994:166). Key informants inside the healthcare system were defined on the basis of their experience on the job as well as by their position as members of the various levels in the system. Very little was based upon their willingness to participate or share information. A certain initial reluctance to disclose information was observed particularly in the first interviews conducted. However, in subsequent interviews, key informants were more open to participating and less cautious when sharing information. This probably coincided with their realisation of what the aims of my study were.

Eight interviews were conducted with key healthcare providers and members of management including directors, midwifes, technicians and personnel at the registration desks of the two clinics.

Focus groups with healthcare providers and migrant patients

Four focus groups were conducted among healthcare providers in numbers of 6 to 8. Healthcare providers were divided into two different groups: the professionals and technical and administrative personnel. This division responded to the pre-existent hierarchy of the health system and aimed at reinforcing the collective voice of each stratum within the structure of the system. It also facilitated those groups' conversations, which usually were not shared with the other stratums in the healthcare structure. Focus groups were used to gather healthcare perceptions, opinions and attitudes towards migrants in general, and of migrant women in particular.

Focus groups were also conducted with the study group patients in each clinic. The groups were integrated by women in family planning as well as in antenatal care, in numbers of 8 to 10 participants. With them I discussed, their opinions and perceptions of care relief as well as how the service addressed their needs in healthcare.

Analysis of the information

In the analysis conducted, I looked at the degree of correspondence or discrepancy between the demand and offer of services in relation to reproductive health for migrant

women. Also, I explored the consequences that these characteristics had upon migrant women in the areas of sexual and reproductive health.

When analysing the doctor-patient interaction, I looked for those aspects of migrants' illness experiences where they were neglected in their medical consultation (culturally specific elements). In the doctor-patient interaction, I also tried to identify some of the assumptions and presumptions made by healthcare practitioners on the subject of migrants. In addition, I explored the existence and examined the nature of the experiences of discrimination Peruvian migrants are exposed to when interacting with the Chilean healthcare system.

Table III-3 Research activities conducted in two primary healthcare clinics in Santiago

Research Techniques	**Participants**	**Number**	**Total number of activities**
Focal groups with healthcare providers	Midwifes, Personnel at the registration desk, paramedics	2 groups in each clinic	4 focal groups in total
Semi-structured interviews with key informants	Directors of the Clinics, Heads of the Programs, Staff members: midwifes and paramedics	4 key informants in each clinic	8 interviews in total
Semi-structured interviews with migrant women patients	Female Peruvian patients in family planning programs and pregnancy controls	10 interviews in each clinic.	20 interviews in total
Focal Groups with migrant women patients	Female Peruvian patients in family planning programs and pregnancy controls	2 focal groups in each clinic	4 focal groups in total
Observations of the attention provided	Series of observations inside the attention boxes and in the waiting rooms.	Series of observations in each clinic.	Series of observations

Part II

Migration and its Discontents

Part two opens a window into migrants' cultural, social and material world, through the experiences and life of a community of Peruvian migrants residing in a derelict building in Santiago downtown.

The ethnographic account of this community is presented in three chapters. The description moves from giving an account of some of the dimensions of the collective lives of this community to some specific aspects of their lives as economic migrants.

Part two portrays both the inner world of this community as well as its relation with Peru, visualising the transnational character of this migration. With this perspective the description moves from the centre of the community towards migrant relationships with the host society as well as with their families in Peru.

The aims of this ethnographic account are several. Firstly, it is to provide information on the living and working conditions of migrants. This in turn is expected to enable an understanding of the contexts where illness and distress emerge. Secondly, it also aims to provide the necessary information to place the analysis of illness experiences into the cultural and social context where these experiences find their meanings. Thirdly the account aims at providing insights on migrants' lives as members of families and as partners in conjugal relationships. This dimension provides information on gender values and patterns as well as on the logic of migrants' reproductive behaviour and of their decisions in that sphere as well as how these are embedded in gender and family relations.

Chapter four provides an overview of the larger community of migrants living in the surroundings of Plaza de Armas. This information is based on a household survey conducted in the context of the ethnographic work. Socio-demographic characteristics of this community are here presented as well as some dimensions of their relationship with the host society. An initial assessment of their health status based on migrants' self-reports is also contained in this chapter.

Chapter five delves into the life of this community, by firstly paying attention to the material housing conditions and tries to convey how migrants inhabit, build a home and construct privacy in this deteriorated physical environment. It also presents some of the elements which articulate migrants' collective lives in the creation of a shared identity. Their social encounters, celebrations, music and cooking as well as the remembrance of their lives in

Peru form part of the social fabric that keeps this community together. However some conflictive dimensions of life in the community are also presented here. Conflict in the community is witnessed in acts of violence among members of the community as well as among couples; alcohol consumption is described here as an element exacerbating these aggressive interactions.

Chapter six delves into migrants' lives as members of families as well as partners in conjugal relations. These dimensions are examined in the context of migration and cultural contact with the host society. These dimensions on the one hand provide the support for the creation of a shared identity in this community as well as of transformation and differentiation among their members. This chapter also examines the distance and ruptures which exist between migrants and the host society. This is done by presenting the perceptions that migrants have of Chileans. These perceptions are influenced by the material dimension of migrants' identities in Chile, which are a result of the limited labour options that are available to migrants, thus contributing to a downward social mobility and a lowering in their social status. An expression of the conflictive relations with the host society discussed here is related to migrant's experiences of discrimination. Everyday forms of violence against members of the community are described through an event in which the researcher was a first hand witness.

Chapter IV

Socio-Demographic Characteristics and Health Profile of a Peruvian Migrant Community Living in Downtown Santiago

4.1 Introduction

During the 1990s, Chile's economic prosperity and the recently installed democracy attracted a first wave of migrants. The majority of this first group were professionals from Ecuador, Peru and Cuba. They entered the Chilean labour market through very specific sectors including the health sector.[53] During the second half of the 1990's Chile experienced the arrival of a second wave of migrants, among whom Peruvians predominated, mostly blue-collar workers whose job opportunities were more restricted than earlier migrants.

During the 1980s and 90s, sustained unemployment and terrorism in Peru forced many Peruvian citizens to look across the borders for better job opportunities and a safer environment.[54] According to the Peruvian Consult in Santiago, Peruvian migration to Chile in the early 1990s was politically motivated, and primarily comprised professional and skilled workers fleeing political turmoil. During the second half of the decade, migrants from Peru expanded and tended to be more economically motivated. On the whole statistics state that over 2.500.000 Peruvians have moved abroad as a result of the prolonged economic and political crisis in the past quarter century (Altamirano 2000).

Several factors contributed to Chile becoming the destination of choice for Peruvian migrant workers. Other attractive migration destinations, such as the United States, had become very difficult to access because of ever-tightening US immigration reforms. In the case of Argentina, migrants were no longer willing to seek work there because of that country's severe economic crisis which had begun in 2001. Chile, therefore, became an important new destination for Peruvian migrants seeking employment. Shared language, geographical and cultural proximity as well as relatively low cost made a migratory move to Chile a very possible and achievable target for a number of sectors of the Peruvian population. Furthermore, the geographic proximity offers the possibility of traveling frequently between the home and the host country, a factor which has contributed to the consolidation of a transnational migration.

[53] The recognition of these migrants' professional documentation in Chile was possible due to existing bilateral agreements subscribed to by governments during the past century. According to recent statistics from the Ministry of Health, more than 50 % of the professional personnel working in the Public Primary Healthcare Sector (medical doctors, nurses and midwifes) are of foreign stock from other Latin American countries.

[54] For a detailed account of the political and economic factors that have consistently pushed Peruvians to migrate abroad as well as internally throughout various successive governments see Araujo (2002:17-25).

According to the 2002 Chilean Census, Argentineans formed the largest foreign group in the country, numbering 50,448, while Peruvians represented the second largest immigrant community, numbering 39,084.[55] While the Peruvian are the second largest group in Chile, overall this group has grown at the fastest pace; between 1992 and 2002 it increased by 400% while the Argentinian community increased by 40% in the same period (Martinez 2003).[56] Many of these migrants, regardless of their educational level, found jobs only in the lowest economic strata of the labour market. The segregation in low skilled jobs is true for both women and men, however the occupational segregation of women is particularly striking; according to the census of 2002, 71% of the Peruvian women work in domestic service. In the case of men, 26% work in the service sector, 22% in commerce and 18% in the industry (Martinez 2003:43-44). Another pronounced trend is the visible presence of women in this migration. In 2002, 60% of the Peruvian migrant population in Chile was female; among the various migrant community the Peruvian is the most feminised migrant flow into the country (Martinez 2003:28).

Even today, in 2008, most Peruvian migrants live in Santiago, Chile's capital, as documented by the 2002 census almost 80% of Peruvian migrants living in the Santiago metropolitan area (Martinez 2003). The majority of these migrants come from impoverished regions of Peru. However, a small number are refugees who suffered political persecution under the Alberto Fujimori government. The larger group of migrants comes from the coastal areas of northern Peru, including the cities of Chimbote and Trujillo. This region, since the 1980s, has experienced economic hardship and large unemployment rates brought on by a depressed fishing industry, a stagnant steel manufacturing industry, the collapse of the local sugar industry and the privatisation of state-run enterprises.

The speed of migration from Peru has been very noticeable, Peruvians being often at the centre of the public debate whenever migration issues are discussed. The problem of illegality among the Peruvian community has been of particular concern. Peruvians represented the absolute majority of illegal immigrants in the country which led the Chilean government during two occasions over the last 10 years to apply amnesty. The last Amnesty in 2007 was agreed between the two countries' governments and as estimated, it has benefited around 15,000 Peruvian nationals.[57]

This chapter provides of empirical information on the characteristics of a group of Peruvians living as migrants in Santiago centre, the district in Chile with the highest concentration of Peruvian nationals. As we discuss this data, some of the changes in health and social conditions which have occurred among this group, while living as migrants in Chile will be discussed.

[55] The total foreign-born population in Chile adds up to 195.320 people, about 2 % of the total Chilean population (Census 2002).

[56] The 2002 census also states that about 80 % of the Peruvian women and 73 % of the Peruvian men residing in Chile had arrived since 1996 (Martinez 2003).

[57] This figure has appeared in the media as an estimate; however exact figures of the number of beneficiaries of the last amnesty are not yet available. According to information provided by the Departmento de Extranjeria of the Ministery of the Interior, during the first amnesty 16.794 beneficieries were of Peruvian nationality. In second place beneficiaries were 2.116 Bolivians (Araujo 2002:41).

The information presented here has been gathered through a household survey conducted with the Peruvian migrant community in the residential area surrounding Plaza de Armas, in the heart of downtown Santiago, where migrants concentrate.[58]

The first section of this chapter gives an overview of the socio-demographic characteristics of this migrant group. This information allows establishing the degree in which these migrants are confronted with the problem of labour segmentation in Chile.

A subsequent section of this chapter explores the nature of Peruvians' migratory movements to Chile. Specifically, we document the extent in which these migratory moves tend to be of a transnational nature. Understanding the transnational character of this migration – I will argue – is relevant for the purposes of this study. Indeed, this particular migratory dynamic, and the multiplicities of migrant's belongings to a large extent frames the lives, the minds and subjectivity of those whose lives and struggles I am interested in studying.

The character of linkages of this migrant community with the broader Chilean society is discussed in the third section of this chapter. This information allows us to have an initial insight of the most apparent acculturation strategy adopted by these migrants.

Finally, this chapter provides an overview of their most recurrent health problems for which they may or may not seek medical care. This information is based upon migrants' self-reports of their own health problems. Finally, it is discussed how variables such as gender, family situation, legal and employment status are associated with migrant's general health status.

4.2 Socio-demographic profile

4.2.1 Place of origin in Peru

According to our[59] survey, 96% of polled migrants came from urban areas of Peru. The main cities of origin are Chimbote (26,2%), Trujillo (25,5%), and in a lesser number, from the cities of Lima and Barranca (8,7 % and 7,4%).[60]

[58] Characteristics of the survey and a sample have been given in the chapter on methodology.
[59] I will use the pronoun 'we' as I present the results of the survey given that, its conduction was a joint endeavour with Carolina, Stefoni and Eligio Campos *(Ñato*)
[60] The same places of origin are found by Silke and Maher (2006) in their study of Peruvian women working as domestics in Santiago.

Main cities in Peru where migrants originate

As said before, the majority of migrants come from coastal areas in the centre and north of Peru. Specifically, from areas which have sustained economic depression since the 1980s. The affordability of incurring a trip to Chile acts as selection mechanism. Indeed, the people who undertake migration to Chile are mostly from the lower income groups. They choose to relocate to Chile as they lack the resources to afford a trip to other and more attractive destinations such as Europe or the USA (Berg 2005, Paerregaard 2002).

4.2.2 Year of arrival

Official statistics show an increase in Peruvian migration to Chile began in 1995. In our survey showed migrants actually began arriving in the country two years later, in 1997, with 1998 and 2000 as peak years of entry. This discrepancy between our findings and official statistics can be explained by the physical place where our study was conducted – the shared housing located in downtown Santiago. It is possible to assert that over time, migrants tend to move out of these collective housings and into individual family households, or to houses shared with a fewer number of people in other areas of Santiago.

4.2.3 Age, employment, gender and legal status

In general terms, migrants from Peru are a young population seeking jobs and wanting to send money home to Peru. The majority of them see their stay in Chile as a transitory one. Of the people polled, 84% are older than 20 and younger than 45 years, confirming the economic character of this migration[61]. In fact, 85, 9% of the total sample at the time of the survey was working; 9, 4% was unemployed and 4,7% was inactive. This last percentage is composed of women whom, mostly for the reason of pregnancy, were not working when the survey was conducted.

[61] As explained in the methodology chapter, the survey sample was composed of migrants older than 18 years, therefore children were excluded.

There is a clear tendency observed globally and confirmed in this particular case, that international migration around the world is becoming predominantly female. Among Peruvian migrants in Chile, women are the majority.[62] Furthermore, our survey showed that women arrived earlier than men. 1998 was a peak year for the arrival of women, while 2000 was the peak year for men. These figures indicate the existence of a pattern consisting on women taking the first step in the migration endeavour. Once they are settled down in the new country, the men join them. This pattern was confirmed by interviews conducted afterwards.

Regarding migrants' legal status, we found the majority of polled migrants (54%) held temporary visas and only 24% had acquired permanent residence. Those whose visas were irregular accounted for 19% of the total polled group.

Table IV-1 Visa status

Visa	**Percentage**
Resident	24%
Temporal	54%
Tourist	3%
Irregular	19%

These percentages indicate the majority of migrants in the sample were in a rather precarious legal situation – with temporary, irregular or tourist visas. Temporary visas are issued for one year. These visas are attached to the possession of a work contract. After their valid period has expired, migrants may not be able to renew their documentation and thus fall into an irregular status. Those migrant workers holding a tourist visa in turn are clearly breaking the law, as they are not entitled to work. In a similar situation are those having an irregular visa status; meaning they have no legal status at all.

4.2.4 Education, training and job opportunities

Generally, migrants' level of education is fairly high. Such high levels of education challenges the common perceptions generally held by Chileans regarding migrants being uneducated. These findings in turn, allows inferring to this group as merely poor is incorrect. They are people who have become impoverished due to a variety of reasons. This can be deduced by the fact they had access to education previously in Peru.

Of the total sampled, 24% had completed tertiary education (Technical and University level). Another 14% had reached the tertiary level of education but had not completed it. Of the remainder, 59% had secondary education and only 3% a primary education. Those migrants who finished their tertiary education studied most frequently to be technical nurses, mechanics, teachers and electricians.

[62] As explained in the methodology chapter, the sample of the survey was defined on the basis of existing proportions – 60% women and 40% men – observed among the general population of Peruvian migrants in the country.

Table IV-2: Educational level

Level of education	Percentages
Completed tertiary education (Univ. and Tech.)	24%
Incomplete tertiary education (Univ. and Tech.)	14%
Secondary education	59%
Primary education	3%
Total	100%

To some extent, obstacles to validate foreign professional titles in Chile – other than health related professions – limits job opportunities for those migrants who have tertiary education. However, beyond this factor, opportunities are very restricted for Peruvian migrants in general. Labour segmentation which affects them as workers becomes evident when comparing migrant's educational levels and the kinds of employment they have access to in Chile. They often carry out jobs for which no formal qualifications are required, and their training and work experience is not utilised.

In fact, when asked about the last occupation they held in Peru, migrants declared 39 different occupations. Most often, they worked in commerce (12, 8 %), as sales people (11,2%), as labourers (11,2%), as public employees (6,4%), as fisherpersons (6,4%) and nurses (5,6%). When asked about their current occupations in Chile, the diversity of occupations became clearly reduced. 51,7% of polled migrants working in Chile is engaged in domestic service and 11,3 % in construction. The rest were scattered among many different professions.

Labour segmentation among women is more accentuated than for men. 85% of polled women were working in the domestic service sector, whereas 26,8 % of men worked in construction. 10,7% of men worked in gardening and 8,9 % in commerce. The average income for men and women was $150,000 Chilean pesos a month (240 USD). This amount is slightly higher than the minimum wage in Chile, which is 120.000 Chilean pesos (192 USD). Women in general, receive higher incomes than men. This fact helps to explain why migration to Chile is largely female. Finally, 32 % of the working population does not have a work contract, while 68 % do have such a contract.

4.3 Transnational characteristics of migrants' families

The concept of transnationalism, as discussed previously, is used to differentiate what seems to be a global trend in current international migration – the fluidity of migratory moves. Unlike other migratory movements, this type of migration involves constant transfer of people, money, goods and information across national frontiers. Faist (2000) refers to transnational migrants as often having their homes in two or more countries and carrying on dual lives. Faist's typology is useful to define and differentiate this type of transnationalism**.** This is a transnational kinship group, whose primary resources in ties are based upon reciprocity, as it is typical of many first-generation labour migrants and refugees (Faist 2000:195).

Thus, the transnational character of this migration was established based upon the fact that migrants maintain a bi-national kinship, as members of their nuclear families,

which remain in Peru. This relationship is further strengthened as they provide economic support to their families in Peru, through monthly cash remittances.

Three items measured in our survey – marital status, partner and children's residence – are indicators of migrants' family structure and living patterns.

4.3.1 Marital status and partner's place of residence

Table IV-3 Marital Status

Marital status	**Percentage**
Single	30%
Living together	37,6%
Married, spouse in Chile	14, 1%
Married spouse in Peru	14,1%
Does not respond	4,2 %
Total	100%

30% of the surveyed people declare to be single, only a 14,1% is married and their spouses live in Chile, 37,6% lives together in free union and 14,1% are legally married with their spouses living in Peru.

4.3.2 Place of residence of children

Regarding children, the survey showed that 33,6% of polled migrants have no children, while 28,2% have two children and 20% have 3 children or more.

Table IV-4 Number of Children

Children	**Percentage**
Have no children	33,6%
Has one child	18,2%
Have 2 children	28,2%
Have 3 children or more	20%

The majority of polled migrants who have children (66%) had their children either in Peru or scattered between Chile and Peru (80% of parents). Only 20% of migrant parents had all their children living with them in Chile.

Table IV-5 Place of residence of children

Place of residence of children	**Total percentage of migrant parents**
All their children in Chile	20%
Children in Peru or scattered between Chile and Peru (or a third country)	80%

The family situation just described portrays the increasing number of family arrangements where children are left in the care of a third person in the country of origin. This allows parents (or at least the mother) to cross frontiers in search of better

job opportunities. As it was gathered in the household survey, most migrants have either their entire family or more than one close family member living in Peru. This situation gives migrants the incentive to maintain in permanent contact with their places of origin and demands us to think of migration as a reality in movement; one in which people keep strong and permanent linkages with Peru but also merge with their host society.

Migration to Chile seems to start as a temporary move as only 14% of respondents wished to stay permanently in Chile. The remainder of the surveyed group declared they wanted to either migrate to another country or go back to Peru. The wide spread perception of living in Chile for a short period makes it difficult for migrants to engage in long term projects. Most migrants are hesitant to save with the goal of buying a house[63] or purchase goods that cannot be sent back to Peru. This 'short time-line' perception persists in spite of the fact that they may have spent several years living in the same transient situation.

On the basis of the information provided by the three indicators used (marital status, partner and children's residence), it is possible to assert that Peruvian migration to Chile is transnational in character, confirmed by the regularity of remittances.

4.3.3 Remittance money

A remittance is the money sent regularly by migrants to their relatives in Peru. In our survey, we found 81% of those polled had sent money home at least once during the last six months. The regularity with which the money is sent home and the amounts sent allows us to verify the degree of economic responsibility migrants have with their families in Peru. Furthermore, it confirms the bi-national kin linkages of this group, and therefore the transnational character of their migration.

Those who have children in Peru tend to send more money – and with more regularity – than those who did not. The survey results indicated that 60% of those who have sent remittances 6 times over the last six months had all their children living in Peru. Another 35% of this group had some of their children there. An additional influencing factor is the age of the children. Younger children in Peru are supported with greater regularity by their migrant parent(s).

We also learned that remittance money is seen as the main goal of migration, particularly for those migrants who had left their children behind in Peru. They need to save and they do so – for example, in housing, health or entertainment. Thus, they live under even more precarious conditions, so the money saved can be sent to the children, to assure their subsistence and education. When there are no children to maintain or the children do not live in Peru, the regularity and amount of their remittances decreases, often drastically. Regarding the use of the remittance money in Peru, we found it is mainly used for family consumption – food, clothing, school materials and educational fees.

In summary, the constant flow of remittance money reveals the existence of strong linkages migrants maintain with their places of origin. These connections tend to endure

[63] Available state housing subsidies for low-income families could also be a possibility for migrants.

in spite of distance and time. The fact this is a rather new migration makes it difficult to predict the future trends concerning remittance money. A longitudinal study will have to determine the variation of remittances over time. However, beyond individual variations, there is a month-to-month flow of capital that is generated in Santiago and goes to Chimbote, Trujillo or Lima. This is part of the construction of a trans-frontier community.[64]

4.4 Social networks and interactions with the Chilean society

We asked about the type of interaction that exists between Peruvians and Chileans having as an indicator the nationality of migrants' friends. 54% declared that the majority of their friends were Peruvian. 39% said half of their friends were Peruvian and the other half Chileans. Only 7% stated that the majority of their friends were Chileans. Even though these figures show migrants sociability is preferred framed within the same community group, we learned friendly relationships often developed in the workplace and oftentimes with the bosses themselves.

In fact, most of the friendships the polled group declared to maintain in Chile are restricted to the workplace and do not seem to go beyond that space. Questions about the character of these relationships arise, since while restricted to the workplace, they may be marked by vertical relations in particular with migrants' bosses. This has been proved to be true of women working as domestics. Many women can view their Chilean employers as acquaintances and even attach some degree of friendship. Therefore, friendship relations with Chileans in the workplace are not based on horisontal relations. Instead, they are framed within a hierarchical relationship established with their Chilean employers.

To explore migrants' social participation in Chile**,** we looked at their formal linkages with Chilean society. Results revealed little achievement had occurred. Our survey showed the level of participation in social organisations diminished among Peruvians residing in Chile. Only 23% of the surveyed group was currently a member of an organisation in the country. However, 72% of this same group previously took part in organisations in Peru. Also, in Chile, the number and variety of organisations diminished and were reduced to grassroots welfare committees and sport clubs. Unlike in Peru, the spectrum of organisations in which these groups participated was much larger and covered a wider spectrum – labour, religious, age, gender, culture, volunteering and community work.[65]

As it is possible to assert the degree and kind of interaction with the host society depends, to some extent, on the characteristics of the migrants themselves. However, the kin of interaction migrants establish with the host society also involves the structure

[64] This same flow of money has opened up an economic niche for transnational micro-enterprises in Santiago and in the main cities where migrants come from in Peru. These include Chimbote and Trujillo. These are services such as couriers and money transference.

[65] The following organisations were mentioned: Centro de Padres, Catholic Church, Mormon Church, Evangelical Church, "Vaso de Leche", Fishing Trade Union, Iron & Steel Trade Union, Trading Trade Union, Neighborhood Association, Chess Club, Sport Club, Volunteering Group, Housing Association, Mother's Club, Youth Club, Agricultural Association.

of opportunities available to them. From the data gathered, it appears the structure of opportunities available to migrants in Chile is very limited. This becomes evident, as it is possible to observe in decreasing levels of social participation of the polled group. Also, as discussed before, this migrant group does not have access to a more diversified range of employments; in accordance with their training and labour experience previously gained in Peru.

In the survey, we also tried to establish the degree in which migrants were exposed to stressful events of different orders in their last year of residence in Chile. This information also gave us an indication of the kind of relationships migrants have established with the major society. We learned that their family situation affects them the most, since the majority (61%) said they worried about their children, followed by experiencing discrimination (46%). Even though migrants were not asked to specify what kind of discrimination they experienced these answers are indicative of a particular psychological climate as well as an adverse social milieu in which migrants' lives are immersed.

A third point of importance was given to elements linked to their precarious living conditions. 29% of the surveyed group said they were bothered by housing problems and 28% had been the victim of a robbery.

The kind of relationships migrants establish with the dominant society has an impact on their subjectivity and mental health. This will be further discussed later on in this study. However, this is not a fixed state of affairs; rather it is subject to change, strongly linked to the intensity and character of the contact between the migrant group and the host society (Levitt 2001:56). Closer interaction with Chileans often goes hand-in-hand with changes in people's perceptions, prejudices, and stereotypes, many of which are formed due to a lack of knowledge about each other.

4.5 Migrants' health profile

We learned that 12.8% of the surveyed group had suffered from physical health problems and 20.8% had suffered from emotional distress over the last six months.[66]

Table IV-6: Have you had any health problems over the past six months?

Health Problem	**Percentage**
Only physical problems	12,8%
Only emotional problems	20.8%
Both physical and emotional problems	38,9%
No health problems	27,5%
Total	100%

Those who suffered from both kinds of health problems (physical and emotional) comprised 38, 9% of the total surveyed group.[67] One third – 27% – declared not having experienced health problems of any kind during the previous 6-month period.

[66] The question asked was: have you been worried about your state of mind during the last six months? The answers given were: having experienced nerves, worries, and tension, depression and stress problems. These results will be discussed in the mental health chapters.

Migrants were asked about their most prevalent physical problems. In some cases, the information migrants provided concerning their health problems was based upon a medical diagnosis. However, in the majority of these cases, information included some discomfort or indisposition for which they did not have a medical diagnosis. These percentages comprised migrants who had experienced physical problems only as well as those who experienced both physical and emotional problems.[68]

Table IV-8 Migrant's self-assessment of physical health problem

System	Percentage	Specific problems
Neurology – nerves	10, 2 %	Headaches, migraines
Muscular – skeletal system	8, 1%	Spinal, neck & leg aches
Genital – urinary	7,4%	Pain and inflammation in the kidneys
Digestive	6,8%	Stomach-aches, gastritis, irritable colon, gall stones
Cardiovascular	4,0%	High blood pressure, heart pain and discomfort
Respiratory system	4,0%	Bronchial problems, asthma
Accidents	1,4%	Burns and cuts

To begin neurological afflictions – problems with the nervous system – were the most prevalent. Headaches and migraines accounted for 10,2%. 8,1% had problems with their muscular–skeletal system; with prevalence of spinal, neck and leg aches. In third place came the genital-urinary system at 7,4% with a predominance for pain and inflammation of the kidneys.[69] Next, were digestive problems (6,8%) with a higher frequency of stomachaches, followed by gastritis, irritable colon, and gallstones.

Less frequent were problems associated to the cardiovascular system – only 4% – with problems such as high blood pressure, heart pains and discomfort. Respiratory system problems accounted for 4%, with illnesses such as bronchitis and asthma. Finally, health problems caused by accidents (1,4%) included burns, cuts, etc.

4.5.1 Health problems and seeking medical aid

Only half of the surveyed group who had suffered physical health problems had actually sought medical aid. Migrants more often consulted a doctor when health problems resulted from an accident, or when cardiovascular, respiratory and reproductive problems arose. Less frequently, they consulted medical experts for problems with the muscular-skeletal, digestive and genital-urinary systems.

Regarding where they seek help, we found most migrants go to the public health system when medical care is needed.

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[67] More specific information regarding mental health is presented in chapter 6, dealing with this area of health.

[68] An individual migrant may experience more than one form of ailment. Therefore, these percentages do not coincide with the percentage (51,8%) of individual migrants that comprise the group experiencing physical health problems.

[69] What individuals in the surveyed group referred to as 'kidney pain' or 'kidney inflammation', we have classified as corresponding to the genital-urinary system, but may well correspond to muscular discomfort placed in the kidney area.

Table IV-9: Where did you seek help?

Seek medical aid	Percentage
In a public primary health clinic	32.1 %
In a private primary health clinic	14,6%
In a pharmacy	14,6%
Did not seek help	24,2%

The majority of those who consulted doctors went to a public clinic, while an identical percentage (14,6%) consulted advice at a pharmacy or went to a private clinic.

Of the surveyed group having physical health problems, 24,2% did not seek medical assistance. Their reasons for not consulting were:

Table IV-10 Reasons for not consulting

Reasons	Percentages
Lacked time	36%
Unconcerned[70]	15%
Health problem solved	10%
Did not consider it necessary to consult	10%
They will consult in the future	10%
Other/ did not answer	19%

The most common reasons for not consulting a doctor were lack of time (36%). Second was not being particularly concerned (15%). Coming in at 10% were: their health problem was solved outside the medical system; they did not consider it necessary to consult for that health problem; lastly, they would look for healthcare sometime in the future.

Interestingly enough, migrants do not declare their lack of money or health insurance as reasons for not consulting. This is particularly noticeable in regard to having heath insurance. We learned 41% of the group did not have healthcare coverage of any kind, while 58% of the group was affiliated with FONASA, the state-owned health insurance. Only 1% was covered by ISAPRE, the privately owned health insurance plan.

Table IV-7 Do you have health Insurance?

Health Insurance	Percentage
Not covered by health insurance	41 %
Covered by Fonasa (public health insurance	58%
Covered by Isapre (private health insurance)	1%
Total	100%

A possible explanation is that lack of insurance and/or money, are both factors dissuading migrants from pursuing further medical consultations once original consultations have been already made. The figures presented above indicate that half of those who suffered from physical health problems did not seek medical aid at all.

[70] The terms *'unconcerned'* and further on, '*negligence'* have been referred to by the surveyed people themselves in answer to open questions.

Instead, they endured their ailments without medical diagnosis and without treatment. However, even in the 50% of cases where medical consultation did take place, it did not guarantee migrant patients followed prescribed treatments, or purchased medicines, or eventually took the required tests.[71]

These facts lead us to consider that, to the extent health problems affecting migrants are not diagnosed and properly treated, they could become chronic with a more serious impact on their long-term health. Asked whether they suffered these health problems in Peru, 84% of migrants replied they had not experienced it before.

This clear answer seems to indicate the cause of migrants' health problems lies in the experience of migration itself. Uprooting their lives, moving to another country, poor working conditions, as well as their altered family situation are all contributing factors which generate health problems. This will be discussed further in this study.

4.5.2 Health status and social status

In this section, health situation in relation to social variables is discussed. Specifically, I examine the influence of gender, family structure, legal status, and the migrant's quality of life, in relation to their physical and mental health.

Women have more health problems than men, accounting for 67% of those experiencing health problems. Men represent only 33% of migrants with health problems. Women also tend to have both physical and emotional health problems, comprising 63% of the combined group. Men suffer mostly from mental or emotionally related problems, representing 45.7% of the total.

Health profiles of male and female migrants confirm the impact of the gender variable in health problems. It can be said the economic, social, labour and power inequality related to gender status are reproduced in the new country at a great cost and harm to women's health status. The likelihood of women to experience health deterioration after migrating has been confirmed in previous studies (Findley 1988).

Health problems are clearly concentrated among those who have trans-national families. Those who have all or some of their children remaining in Peru are among the 82% of those who suffer from health problems. The group having all their children still in Peru is the one with the poorest health situation. 55% of this group suffers from both physical and emotional health problems.

Migrants, whose children are living in Chile with them, show fewer symptoms of both types of health problems. In general, their physical and emotional health is superior as they made up only 18% of the total group having health problems.

[71] In the interviews carried out following the survey, answers showed that often treatments are not followed up, either for lack of time or money, or because the medicine prescribed causes them side effects. Therefore, prescribed medical treatment is interrupted or postponed, thus interfering with the resolution of their health problems.

The percentages show a clear association between family structure and health. This is expressed in more vulnerability of those who been away from their families, and affecting equally men and women whose families are away. To be close to the family seems to be an important health-protecting factor for migrants. This has been found to be true for different groups in other studies. Those not living with their relatives are more likely to experience post-migration health declines (Findley 1988).

Examining the relationship between the legal situation and health problems of the group surveyed, we found health problems were higher (51%) among those who held temporary visas. Within this group, 71% declared they suffered from some form of emotional distress. Those who held a permanent residence permit and those who had 'irregular' visa status made up the remaining 18,5 % of the total. These results seem to indicate the instability and uncertainty associated with temporary visa status most directly affect migrants' health.

The reason to assert a possible connection between legal status and health problems may be found in the requirement imposed upon migrants applying for a permanent residence permit. For this, they must prove they have had a consecutive three-year contract with the same employer. This situation often leads to abuse on the part of the employers over migrant workers. Migrants see themselves forced to remain in bad working conditions with low salaries, in order to meet the requirements to obtain a permanent resident permit. This situation certainly undermines their mental health.

Regarding quality of life in Chile we found there is a direct correlation between quality of life indicators[72] and health profile. Indeed, an improvement in quality of life often is associated with better health indicators. Those who considered their quality of life had decreased – 44% of that group – exhibited a more deteriorated health profile.

In the survey group, health problems were less acute among those whose quality of life remained the same as in Peru (26%). Less health problems were found among those who had achieved a balance between positive and negative aspects in their quality of life in Chile – 15,4% of this group. Finally, those whose quality of life in Chile had improved made up only 14,4% of the total group experiencing health problems.

4.6 Summary and Conclusions

As often stated in the literature on migration, people who cross frontiers in search for better job opportunities tend to be young and enjoy good health (Findley 1988; Junghanss 1998). Findings indicate the infirmed would be less likely to relocate. Factors include avoidance of the burden of moving, having fewer resources to migrate, or simply, being discouraged by the knowledge of the difficulties to obtain healthcare in the new country when needed.

The majority of the Peruvian migrants moving to Chile are not an exception to the above pattern. They are at the peak of their economically productive work-lives and

[72] The quality of life indicator was built from individual assessments dealing with a variety of aspects such as quality of sleep, food, physical exercise, recreation, weight, general appearance, as well as their smoking and drinking habits.

they count on physical fitness as their main asset. It is thus reasonable to assume that, at least at the time of their departure, these migrants enjoyed good health. However, as it has been also widely discussed in the literature already reviewed, changes in migrant's social status, quality of life and health status may occur after migration. This change results from difficulties in becoming integrated into a new residential, social and economic milieu within the host society.

This chapter has tested the above findings as described in the literature by providing empirical information on the characteristics of Peruvians living as migrants in Chile. Also, it has shown some of the changes in health and social conditions which have occurred among this group, while living as migrants in Chile.

Through the survey, it was possible to draw a socio-demographic profile of the migrant population. The majority of migrants come from the northern coast of Peru and is a rather young and educated population. Women came earlier than men and are mostly engaged in domestic service, whereas men work mostly in construction.

The information obtained through the survey conducted indicates existent segmentation of the local labour marked which affect migrants. Indeed, in spite of the fact migrants may have tertiary education; they only have access to unskilled jobs in the lowest strata of the Chilean labour market. In addition, the diversity of occupations migrants have access to in Chile becomes drastically reduced when compared to opportunities in Peru.

Indicators of marital status and residence of partner and children, together with regularity of remittances demonstrate bi-national linkages of these migrants and confirm the transnational character of this migration. The greater majority (80%) of those who have children don't live with them, or at least, not with all of them. This information confirms this migration is mainly economic in character. It also suggests this may be a transitory migration. This is because the possibilities for migrants to reunite with their family in Chile often appear to be minimal. This is proven to be so, given the Peruvians' lack of opportunities to move upwards in the labour market.

To some extent, migrants' vulnerability and precarious living conditions in Chile are linked to their transnational condition. On one hand, being apart from their families causes great emotional attrition. On the other hand, being the only economic support for their families in Peru often leads migrants to endure precarious living and working conditions while working in Chile. The survey showed these migrants earn low salaries, as their average pay is only slightly higher than the minimum salary in Chile. Information gathered about remittances show that out of their meagre salaries, most migrants sent money to Peru regularly. Doing so obviously placed additional constrains upon their already precarious situation.

The visa situation revealed approximately 20% of the group was in "irregular" status. This percentage coincides with the percentage estimated at the national level. Movement from irregular legal status to regular status has proved to be difficult. It involves being in possession of a work contract and to be able to pay fines, which were relatively high, considering a migrant's income.

In order to provide a general, although transitory, solution to this problem, current irregular migrants were given amnesty in 2007. This was an agreement signed by the governments of Chile and Peru. This allowed Peruvian migrants in Chile the possibility of regularise their situation. Therefore, “irregulars” became “regulars” and were given temporary visas, issued for one year.

However, this regular status does not prevent migrants from re-entering into an irregular status once their visas have expired. This may again happen, as it is often the case, in the event migrants are not in possession of a work contract entitling them to extend their visas and to live and work in Chile for another year.

Even though the majority of migrants have the intention to leave Chile as the survey shows, their stay tends to become permanent as the economic situation and job opportunities in Peru do not ever seem to improve. Adding to this situation, the money migrants send home has become crucial to the family’s survival.

In terms of migrants' linkages with the Chilean society, the survey reveals the incipient development of bi-national friendships between Peruvian migrants and Chilean nationals. This can be read as positive sign of integration. However, another fact counterbalances such appreciation; these bi-national friendships are mainly circumscribed to the labour space and therefore framed within hierarchical relationships.

The quality of relationship with Chilean nationals shows a very negative side in the fact that nearly half of the migrants declared having been affected by experiences of discriminations in Chile. An additional indicator of lack of integration into the Chilean society can be found in the decrease in the level and variety of organisations migrants belong to, as compared with their membership experiences in Peru. As showed in the survey in Chile, their social participation decreases.

The survey conducted also provided an overview of the health problems Peruvian migrants experience while living in Chile. In most of the cases, migrants reported their own perception and not an accurate medical diagnosis. In other instances, migrants did receive a medical diagnosis for their ailments.

The majority of polled migrants said they had suffered from a variety of physical and emotional problems over the last past six months of they stay in Chile. Furthermore, most of them (84%) declared they had experienced these problems for the first time since relocating to Chile. However, these problems did not immobilise them as most migrants continued to carry on their daily lives and labour activities.

The severity of these health problems cannot be established, as the majority of migrants who were ill did not seek healthcare, nor did they receive medical diagnosis. Reasons for not consulting a doctor are the many obstacles migrants face in accessing healthcare. These issues will be further discussed in the chapters covering mental and reproductive health.

The next two chapters first provide an account of daily life within the migrant community. It was only due to the ethnographic approach to the community that it was possible to conduct the household survey. As explained in the methodology chapter, the

survey to be conducted needed to create a trustful relationship and, in this way, gain access the community. Knowledge of this community was achieved through ethnographic fieldwork and participant observation conducted over a seven-month period.

Chapter V

Migrants' Living Conditions and Community Life

5.1 Introduction

On the basis of participant observation, this chapter presents an ethnographic account which takes an inside look at the collective life of a migrant community living on the margins of Plaza de Armas, at the main civic point of Santiago centre. The aim of this chapter is to provide a systematic approach to local contexts in which illness emerges. This perspective, central to anthropological analysis, has been generally absent from epidemiological studies.

Most of the literature on health and migration refers to living in crowded conditions as a significant factor affecting migrants' health. Among the various health problems associated to this, over crowdedness, is seen as a potential vector for the spread of contagious disease (Junghanss 1998). Another dimension of communal living factors is social support which is often regarded as a buffering aspect that moderates stress derived from the process of incorporation into the new society.

However systematic accounts of those environments are often not provided. As Young asserts; "serious stressors and inadequate support are not reified entities but systematic relationships among meanings, legitimacies, and structural arrangements of power in local cultural systems that conduce to distress" (1980:137).

The ethnographic approach used here deals centrally with factors such as social support and stress. In doing so, I give an account of the main features of migrant collective lives. This includes linkages within migrants' own community as well as of migrants with the broader society. Attention is paid here to the way in which distress and illness, as well as therapeutic processes emerge, embedded in this double set of relationships.

The various dimensions involved in collective life and consequences of living in close proximity are explored in this chapter. A double and conflicting dimension of the migrant community's collective life is examined here. A positive dimension is the transformation of an adverse physical space into a space of psychological and physical protection. This chapter examines the various forms in which a migrant community makes use of decaying places for temporary homes. By living together, migrants create a safe environment that protects them from discrimination and a generally hostile societal climate. Furthermore, by living in this kind of community, individual migrants have access to an extended social network which gives them access to various resources including emotional support, money, as well as information about visas and jobs. While all this may be positive, there is also a negative side to be discussed here. Community life exposes migrants to internal conflicts, physical violence, and alcohol abuse as well as to social control through cross border gossiping.

The first section looks at the transformation caused by migrant co-habitation of a run down building. This derelict structure became their temporary home as well as a place of refuge and protection. Migrants' practices of creating privacy and intimacy are here examined. Attention is placed on those values, meanings, norms and social relations which reflect and contribute to the affirmation of these migrants as a community.

A second section looks at events that made up a substantial part of their collective life and describes two conflicting sides of the community life. On the one hand, spaces of encounter and celebration are created; on the other, violence and conflictive interactions among its members also exist. This section also looks at the construction of symbolic kinship among members of the community. This encompasses a collective response to face illness and adversity.

The last section of this chapter gives a glimpse of what life is like in the community this time *outside* the compound. Activities taking place in gathering points, such as the Plaza de Armas in Santiago, are described as well as the importance of social networks for migrants.

Overall, what this chapter aims to accomplish is: to weigh the rewards of communal life and to assess whether or not life in the community is effective in providing migrants with sufficient social and psychological support. Linked to this is the dilemma that by living in the community migrants obtain support, but at the same time, they are excluded from the mainstream society. Thus, they live on the margins of the Chilean society.

5.2 Fieldwork setting

5.2.1 N° 823, 2nd floor, Bandera Street, downtown Santiago

The shared housing unit was located on the second floor of the building in Bandera Street in downtown Santiago, only four blocks away from the Plaza de Armas. The pattern of collectively inhabiting rooms in rundown buildings is common among economic migrants in various host countries. Peruvian migrant workers living in Santiago are no exception. The main reason explaining Peruvians' extended housing pattern of sharing rooms is their lack of resources. However there are also structural reasons at play, as this pattern results from the segmentation in housing made available to them in Chile.

The shared housing unit can be considered a home base for this migrant group. In the physical and social space of the housing unit, cultural codes were shared. Here migrants used to live, meet, talk, rest, sleep, eat, and exchange information about jobs, bargains, and strategies for dealing with the foreign system. It functioned as a place where illegal migrants could hide from the police and feel secure. It was a place to listen to favourite traditional music, usually played loudly, and whenever possible, to eat traditional food and reminisce about home. The community in this place held its members in a social and emotional web. It was a place to love and fight, to celebrate and mourn, to share worries and concerns, to complain about hardships, to share joys and pains, to get and

give advice, to tell stories from home and to gossip, to sell and buy, to borrow and lend, to share resources and treatments, to face illness and to restore health.

In short, the unit was a constructed trans-national social space. Inhabitants here had the experience of being both here and there – in Chile and yet still at home with their families and friends in Peru. As Vertovec puts it: "trans-migrant communities are, 'neither here nor there', but, in both places simultaneously" (2003:2). It was in such compounds where migrants' cultural identity was produced and celebrated. In addition, the migrants' well-being was maintained through meaningful interactions with other migrants and by culturally distinctive practices. Before delving into those dimensions, I will first introduce the group living at the compound.[73]

5.2.2 The residents of the housing compound

There were 50 to 60 people living in the housing compound.[74] This number increased on the weekends with the arrival of temporary residents – friends and acquaintances who dropped by to visit. By improvising beds and squeezing into the existing ones, residents hosted many other migrants who needed temporary shelter. These residents came from the cities of Chimbote, Trujillo, Barranca and Lima, as did the majority of Peruvian migrants who settled in Santiago. A rather young population, the majority was at the peak of their productivity. The exceptions were the few youngsters who were living in the compound with their parents - newborns and school-age children.

Most of these migrants had completed secondary school and a few of them had completed technical studies. Conversely, only three migrants had attended the University in Peru – medicine, engineering and administration. However, the economic crises in Peru obliged them to interrupt their studies so only one had actually graduated. This person was my neighbour, Don Hugo.

Almost all the women in the compound were domestic workers. Those who had live-in contracts came only to their rooms on weekends, but the majority of women returned to the housing everyday in the evening as did the men, following work. Men worked primarily in construction but also as guards and gardeners.

At the compound, a high tenant turnover had occurred since the building had been opened for use as migrant housing. This I gathered from the many weekend visitors I met at the building. Most of them had previously lived in this building on Bandera Street. It was only in the last months before the final eviction that the residents remained static. No one moved out because they didn't have to pay rent. No new permanent residents (except me, the researcher) were allowed to move into the compound following the initial eviction notice. This was a condition imposed upon the

[73] Detailed account of each one of the migrants is given in Annex 3.

[74] Even though I got to meet all of the people there, I can only recount the lives and concerns of those I spent the most time with – about 30 people. Others I knew very little of, either because they did not spend much time in the housing compound or because they did not socially interact with other people in general, as well as with me.

remaining residents by the owner, in order to reach an agreement regarding the housing situation. This condition forced the group to become more permanently, a community.[75]

5.2.3 Living conditions

The shared housing unit contained 20 rooms in total. In a space the size of a gymnasium, flimsy dividers, made of pressboard, were used to create these small and ceiling-less cubicles. Initially, only two cubicles were pulled together on the floor. However shortly after, the entire 2nd floor was filled with rooms built one after the other to create more space to rent. This proved to be a very good business for the subletting landlord.

The rooms next to the entrance had windows facing the noisy street. These were more independent from the rest since they had direct and closer access to the entrance. They were considered better rooms and preferred by the tenants in spite of being exposed to the strident traffic. Here is where the older residents of the compound lived. Going through the narrow corridor formed by two rows of rooms, one reached the less convenient and less independent rooms. These cubicles were without windows and natural light and home for the more recent inhabitants.

Two open and slightly wider spaces formed between the rows of rooms were used as common areas. Here gatherings and celebrations were held. One common area was at the entrance and the other at the back of the compound, marking two different social areas in the housing unit. Two toilets, two showers providing only cold water and two makeshift kitchen areas made up the two shared facilities. An open terrace served as common space to place trash and unused items, to wash and hang clothes, which often disappeared if the owner did not keep an eye on them. When good weather allowed, this space was used for barbecuing or holding dinner parties. These events normally ended when the police stopped by in response to complaints issued by their Chilean neighbours. This migrant housing unit resembled a small-scale shantytown, a kind of precarious neighbourhood hidden behind an anonymous door of a run down building in downtown Santiago.

In general, the housing area lacked security. Robberies were frequent and drug addicts used the entrance to smoke crack. Electricity shortages were frequent and resulting from an overloaded electrical system. This threatened lives and damaged appliances, but, as I gathered, the residents seemed to resent more their electrical devices being broken than the possibility of a fire. As a result of continuously leaking water pipes, the walls were damp and grew moss. The space in between the wooden pressboards, in turn, proved to be a good nesting space for the cockroaches the inhabitants fruitlessly combated. Cubicle walls were usually covered with colourful gift-wrapping paper, in an attempt to decorate them and to disguise their deteriorated state.

[75] For Cohen community is defined by members of a group of people who have something in common with each other, which distinguishes them in a significant way from the members of other putative groups: "that entity to which one belongs, greater than kinship but more immediately than the abstraction we call 'society.' It is the arena in which people acquire their most fundamental and most substantial experience of social life outside the confines of the home" (Cohen 1985:93).

The building was in extremely poor condition, insecure and the rent was high. It served as a temporary home for migrants and, from observations, there were always migrants wanting to move in there. Yet, one of its residents expressed a contradictory view about the place:

> We are living in this mousetrap. This is not fair. We are charged more than 50,000 pesos[76] for a room of 12m^2. With this money, one can rent a full house somewhere else. …I am only staying because I have got used to this place. But I can leave at any moment without paying the rent, and I think I will not pay. *(Demetrio)*

It seems the building's strategic location in the city centre compensated to some extent for its poor condition. From there, migrants spent the least amount of money in transportation to and from their workplaces. This proved to be crucial for these migrants' tight budgets, as paying for one extra bus ticket would consume an additional and substantial part of their monthly income. Furthermore, the building was located near Plaza de Armas. This made the old building an especially convenient one.

In addition, several reasons made it difficult for migrants to find other places to live. I witnessed many failed attempts to find alternative accommodation. An immediate obstacle they faced had to deal with landlords who were increasingly reluctant to let their properties to Peruvian citizens. In interviews with Chilean landlords they expressed the fear that Peruvians would damage their properties and they suspected many more people than the homes were designed to accommodate would occupy houses. In addition, they held perceptions of Peruvians as noisy, unclean people. In short, renting a property to a Peruvian would lower the commercial value of the property and instigate neighbours' complaints.

Arbitrary restrictions on migrants' citizenship also limit their housing opportunities. Migrants did not fulfil the formal requirements that would entitle them to be "regular" house tenants.[77] All these concomitant factors made it difficult for migrants to find alternative housing. In numerous instances, many of the Peruvians genuinely looked for accommodations other than in rooms in rundown buildings in downtown Santiago. But, prospective landlords rejected them straight away on the basis of their national identity – by their accent, facial features, and so on. In short, the migrants had no other choice but to resist the eviction request issued by the building administration.

5.2.4 Health resources: hygiene and the spread of contagious diseases

Concern about the relation between living conditions and the spread of diseases were often expressed at community meetings or when complaining about living conditions in

[76] This was approximately US 80 dollars, the price for a small room of 12 m^2. A monthly rent for the bigger rooms, about 18 m^2, was approximately US 100 dollars. Electricity and water were paid separately. Monthly electrical and water charges were divided by the number of rooms in the building to determine each room's portion of the cost.

[77] These requirements are: a work contract, steady and sufficient income, a bank account & financial guarantor. The objections of landowners to rent to their houses to Peruvian migrants were: they only hold temporary job contracts and temporary work visas. Even in cases when migrants were in possession of permanent legal status and work contracts, they often found it difficult to fulfil the additional requirements.

front of the owner. But most of the time, the urgency of the issue would subside. However, the serious illness of a baby triggered her parents' concern over this issue.

> Leslie, the 10-month-old baby of Don Hugo and *Señora* Angélica fell ill and had to be taken to the hospital. Initially the diagnosis was meningitis. Alarmed by this possibility and having gathered information regarding the living conditions of the parents, the doctor was about to prescribe medicines for everybody in the compound. This diagnosis was fortunately discarded, and the baby was found to have a milder disease so soon would be released from the hospital.
> However, after this episode the communal buildings became unhealthy and dangerous for the parents. In a conversation, they told me there were cockroaches and mice in the place. At this point, they had been living in these rooms for three months. It was first Don Hugo who fell ill and then his wife. She said her bones ached and blamed it on the dampness of the place. Then, the little girl fell sick as well. They complained about these poor conditions to the owner, who is a medical doctor. However, she had not yet called the Municipality to ask them to exterminate the mice.
> But now, after having had their baby in hospital, they think they will have to leave the place, in spite of the fact they had become used to living there. The couple also complained about the many people (non-residents) who came into the compound. They fear the rooms may be infected with viruses. "There are so many people coming over the weekends. They get in an out. They drink and the bathrooms cannot be kept clean".
> As they said: "even though there is somebody in charge of the cleaning (that person is Chamé) and she cleans the bathrooms every day, in the evening, especially on Saturdays, they are always dirty. Tomorrow, there is going to be a meeting among the residents and, besides the collective bills, Don Hugo said he will raise the issue of how unhealthy the place has become".
>
> *Field notes, September 2002*

Leslie was back and the family remained in the compound until the very time of the eviction. Leslie recovered quickly, becoming a 12 kg toddler who, close to a year old, did not yet walk. In fact, she was used to being held in her parents' arms, probably because they did not want her to crawl on the dirty floors. The issue of insalubrious conditions of the building was not raised again. However, efforts were always made among the residents to keep the place clean. When I moved in, Ñato suggested I washed the floors of my room with chlorinated water. He did that all the time in his own room.

Besides the baby episode, there were no major illnesses in the compound. In cases of health emergencies, migrants rushed to the emergency ward of the nearest hospital to get primary care. Dental problems were solved with a trained Peruvian dental mechanic, who came to the compound to give the residents basic dental care.

In general, one important health resource migrants have is food. Various criteria define a good healthy meal. For example, a good meal should be one that is warm and recently cooked. It should never be eaten the day after it was cooked, not only due to the loss of its nutritional qualities but also because it might harm one's health. Additionally, reheating food may cause it to ferment, a process that continues in people's stomachs, resulting in illness.[78] They also believe foods of varying temperatures during a meal may alter its quality. For example, according to popular perceptions, eating something very cold after having eaten something hot will produce a negative effect on either the stomach or the throat.

[78] As I observed, no matter how little money migrants had or how uncertain they were about their next meal they never kept leftovers to be eaten the next day. Leftovers were always thrown away.

The qualities of being hot and cold are extended to physical processes such as pregnancy or menstruation as well as to emotional states. For example, in the case of a nervous breakdown, the body is considered to be in a hot state. During such an episode, the body of the person affected accumulates heat – heat that should be expelled. This person needs to "*desfogar*" (literally "*let off steam"* meaning 'to vent') by throwing things around, breaking things, screaming or crying. Then, after having calmed down, drinking cold water with lemon juice is advisable.

> Olgüita usually called home to Peru from a nearby call centre at Plaza de Armas. She did this one Saturday when I was there. Having received bad news that her mother was seriously sick in Peru, she began to tremble. Her sister and niece, who were there with her, brought her back to the room where she had a nervous attack. Olgüita was allowed to cry and then given lemon juice in cold water to drink to regain emotional balance.
>
> *Field notes, November 2002*

Treatment and emotional support from her relatives helped her to feel better. The choice of food given to Olgüita, in this case a cold liquid did not come arbitrarily. It is ruled by the temperature principles present in physical process and emotional states. The importance of this is stressed in order to highlight the underlying logic, which may lead to revealing the relationship between health and illness. Certainly migrant's food choices are indicative of a knowledge transmitted through generations. These choices are applied on each occasion they recognise the signs of sickness in each other. If eaten in the traditional way, food has a healing effect when ill.

As it is possible to observe in the account above, temperature seems to be an important criterion applied to food and health by migrants. Along with it there underlies a coherent conception of what is healthy. It is actually a vestige of Hippocratic Medicine brought by the Spaniards to Latin America, where some of its principles, such as temperature, are still prevalent among the population.

5.2.5 A whole world in a room

I clearly recall the impressions I got when I first entered into one of the migrants' rooms at the housing unit. Stepping inside one of these rooms was like entering into a migrant's private life. Each one of these rooms was a world unto itself; a space intensively used, as the second room I visited showed:

> Chamé's room is nicely decorated. There is one bed positioned along one of the side of the room occupying the full length of the wall. The space underneath the bed is used for storage. The wallpaper is a colourful wrapping paper. Several decorations hang from the walls. There is one powerful stereo set placed on a shelf fixed to the only solid wall in the room. From the other wall hangs a big portrait of the Chilean Virgin del Carmen, lighted by a lamp. This is his Tony's devotion, as Chamé said to me.
> Chamé has her own small picture of the Peruvian saint el Señor de los Milagros. This image is also lighted but with a small red light and hangs from the opposite wall. Electric plugs are all connected to the same outsource in one wall, which feeds the lights, the music equipment, the TV set and the fan, making the chances of an electric overload and fire an everyday possibility.
> There is a wardrobe were they keep their clothing, and in the other corner, next to the door, is the kitchen area with a small stove on a table and a gas container placed

underneath it. Plates, pots and pans hang from nails to make better use of space. A mirror is also placed in that corner.
There is a sofa placed in front of the wardrobe and this can be unfolded to become a double bed. Next to it is a small table with a picture of Chamé's son kissing his grandmother who looks after him in Peru. In the centre of the room, a small stool is used as a centre table as well as a seat. Besides the four people who live in the room, Chamé's sister arrives every Sunday to spend the day in the room with them, after attending morning services at the Catholic Cathedral.

Field notes, October 2002

Through our household survey, we found that, on average, migrants shared their rooms with 3.2 permanent residents. However, as a pattern of these shared housing units, there were always an undetermined number of occasional visitors, who would come to spend the night, after a party. Newcomer migrants often moved in temporarily until they found a job or other means to rent a room of their own.[79] The survey also showed, with few exceptions, permanent and occasional inhabitants were all of Peruvian nationality. On average, they lived in $12m^2$ and 12% of these rooms do not have windows. In the housing unit on Bandera Street, as in almost all the buildings included in the survey conducted, the bathroom had to be shared with a variable number of residents. Their rooms were the spaces where these migrants slept, cooked, ate, and rested. Their rooms were also the preponderant locale for sociability. Of the migrants surveyed, 93% said it was either in their own room or in a friend's room where they spent most of their free time.

Regarding migrants' possessions; we found within the small space of the room-house-home, there were numerous electro-domestic items. The majority owned a cooking stove, but only a few had appliances such as refrigerators and washing machines. The survey also showed the majority of people had a television set, stereo and a mobile telephone. A less often owned item was a video/DVD system. These items are essential equipment for migrants. They substitute linkages with the Chilean society and also, allow migrants to keep in touch with their country, with their families and homes.

These various items perform as technologic devices, making possible the flow, production and exchange of what has been called "*social remittances"*. These are "*ideas, behaviours, identities, and social capital that flows from host-to-sending-country community"* (Levitt 2001:54) that circulate in the transnational space triggering transformations *here and there*. At the core, triggering changes in migrants' frames of reference. These changes are neither visible nor obvious, besides that of being variable, as Levitt has stated it: "the degree to which migrants' interpretative frames are altered is a function of how much they interact with the host society" (ibid:56).

Among those surveyed, it was found that the interaction with Chilean society took place within the micro space of the workplace and at the macro level, through the inter-media space of television. This raises the question of what frames of reference result from such a very restricted and imbalanced space of interaction with the Chilean society?

[79] Payment arrangements were made so that those who came regularly, to sleep over the weekends, had to pay a percentage of the rent to 'the owner' of the room.

5.2.6 Construction of privacy

After some time, I became more comfortable spending time with migrants in their rooms. I no longer felt, as I did initially, that I was trespassing into their private space. I realised the simple fact that when they invited me in; it was because I was welcomed. It was my own physical proximity as well as time spent together which helped us to gain the required trust. It also allowed me to share in their lives as a participant and witness.

Yet, there were situations that triggered in me a sudden awareness of how culturally engrained certain values are, and how much they are embedded within me. As the only Chilean among them, I was the only reference I had to test cultural differences, when they emerged. I would like to refer specifically to their sense of privacy. This is so cultural in nature and, in the case of migrants, so tuned with their collective life.

While living among them, I often thought migrants experience a different sense of privacy, at least different than mine. Privacy may be tentatively understood here as: the sense that there is something in oneself; in one's own body or in areas of one's life that should be protected from open exposure; to the eyes or to the knowledge of others.[80]

The question regarding whether or not migrants' bodies are embedded in a different cultural matrix – and to what extent, while living in Chile, they are subjected to other "disciplines" – will be explored further in various chapter of this thesis[81]. Yet it is important to say here that migrants do not need to draw a rigid "separateness" or boundary between their bodies. This, I will argue, is a feature acting as a precondition of their collective life.

I remember how often I walked into a room during the day and there were people sleeping while others where socialising in the same physical space. It always made me feel uneasy. Falling asleep was something that was not necessarily restricted to evenings, nighttime or *siesta* time. Sleep actually happened whenever the permanent or temporary room's inhabitants or the visitors felt like doing so, no privacy was needed. Nobody seemed to be bothered about it. In fact, all normal activities would go on – conversations, TV watching or listening to loud music. Nobody was concerned about turning down the volume just because a person was sleeping.

Cooking or eating would be carried on as well. As I describe next, this was one of the many occasions I spent time with migrants while somebody was sleeping.

> Yesterday I had dinner in Chamé's room. Her bleach-blonde roommate who was laying down on the bed, fell fast asleep, soon after I arrived. Maybe she was not invited to eat

[80] This sense of privacy is strongly formed by culture and basically conveys a powerful conviction that there is something to be protected or hidden from others. This connects with the "need of privacy" which drives people's acts and routines to protect or to achieve privacy. The sense of privacy, on the other hand, not only relates to bodies and forms part of the disciplines and regimes ruling them, but also to the possibility of protecting from others, some dimensions of one's own life. This includes cultural ways in which societies, generations or groups historically relate to physical bodies and to private life. To exemplify this further, and specifically in the case of the body, I would like to mention the imperative of physical separateness that presupposes modern life and modern subjects. This, I believe, informs my own subjectivity, as well as the differences I perceived in the way migrants defined and lived their own sense of privacy.

[81] See endnote.

> with us, or maybe she was and just did not want to. However, nobody seemed to worry about it when she, wanting to "switch off," laid back and put the magazine she was reading over her face. This was enough to allow her to sleep. Meanwhile, Chamé, Tony, his brother and I ate lentils, scrambled eggs and rice and watched news on TV. The feature story was about starving babies in Tucuman, Argentina, and we commented on the dramatic economic crises Argentina was going through.
>
> *Field notes, November 2002*

I was puzzled by the ability of migrants to live in such small spaces. It seemed to me that the way they coped with overcrowding was to allow each individual to enjoy his or her "space" and to do whatever they wanted. As in the situation described above, the TV was kept on, dinner was served and shared life went on. In order to further explore the issue of how migrants cope with having their entire lives compressed into such a small space and totally surrounded by other people, I asked the question of intimacy among couples. The first person I discussed this matter with was Demetrio. We had been talking about their living conditions and I felt the question would not be out of place.

He said he and his partner went to a couples' motel every two weeks, often on a Saturday afternoon. However, this was always a matter of great relevance because they had to pay approximately 10 US dollars for each visit. This, he considered to be a reasonable price because it gave he and his partner the indispensable privacy they needed. He said: "My daughters are already *señoritas* (young girls). I cannot do anything while they are there in the room. I can not do anything in front of them*"*.

I asked Don Carlos and Doña Luisa the same question. This couple shared a room with their 23-year-old son. For them, the situation was not so acute. They enjoyed some level of privacy whenever their son went out to a party. This usually happened on Friday or Saturday evenings. Still, Doña Luisa confessed: "I always worry that he might come home at any moment. So I can't really relax". Being alone in a room protected couples from the gaze of others but it did not prevent them from being heard when they engaged in sex. In fact at night, I could always hear noises that led me to conclude that couples were having an intimate moment.

A very negative aspects of life in the community is migrants' inability to afford to have a 'private life' or at least, aspects of their lives protected from the community. This is something migrants often complained about. They feared to disclose personal information to other members of the community as this information could quickly circulate. This in turn, affected the involved migrants reputation(s) and credibility in the community as well as their family units, exposing them to criticism.

On various occasions, migrants expressed surprise about how quickly information about their lifestyle, friendships and especially their 'love life', whether true or false, was communicated to their families back in Peru. This is often done through telephone calls by 'anonymous sources' who, as Tony said "can spend 10 dollars on a call, money they can hardly afford, just to gossip and lie". Tony remembers once his mother became extremely concerned as she had been told that Tony was sick and losing so much weight. He could not convince his mother on the phone that he was fine and fit until he sent her a picture to prove what she was told had been a lie.

When privacy was needed – for partners to have intimacy or simply to have a conversation about personal matters – it had to be constructed. One way of doing it was to play loud music, often; the result was a cacophony of competing sounds coming from the various rooms, played simultaneously at competing levels. Many times, with this 'wall of sound', conversations among the rooms' inhabitants could go on without being heard by others in the next room. I learned this once I visited Eligos' room to talk.

He wanted to tell me about an argument between two neighbours that had happened while I was away. So, he turned on the radio and was able to talk freely without fear of being overheard. Yet, the capacity to bear loud noise and still be able to sleep was a skill to be learned, as in the situation I describe next.

> I visited a mother and newborn baby in their room on the top floor of one of the nearby buildings on General MacKenna Street. The baby had been just released from the Hospital where she had spent about 20 days. She was suffering from meningitis and placed in intensive care just hours after she had been born. I got into the small room where only one bed could fit, along with a small table holding a TV.
> I greeted the mother and celebrated the fact the baby was finally home. I held her in my arms, and after chatting and checking on the baby's health condition I asked the mother why she had the TV on so loud. Hard rock music was blaring from the speakers. It seemed, to me, it was totally unsuitable to have such loud music during the sleep-time of such a young child and one just released from hospital.
> When I expressed my concern, she laughed and agreed to change the TV channel to a 'kids' program. However, she did not turn down the volume. She then explained she was trying to make the baby get used to sleeping with loud sounds because living where they did, the baby would be exposed to music, noise, and loud quarrels all the time. Therefore, it was better to start accustoming her right from the start, so she will be able to sleep "just fine" in the future. I suppose this was the right thing to do, after all.
>
> *Field notes, August 2002*

5.3 Community life in the shared housing unit

Community life involved most of the housing unit's residents. It was here where migrants spent their most meaningful time away from Peru. This was because only another migrant could fully understand the sadness and loneliness of being away from home, or being absent on birthdays, deaths and/or sicknesses of their beloved ones. This was especially true during culturally important holidays such as Christmas and Mothers' Day.

At the core, this kind of migrant housing temporarily suspended the oppressive conditions they were subjected to in the broader Chilean society. But certainly, the living situation did not erase other conflictive and sometimes violent relationships among community members. In fact, the housing unit was the scene for many robberies as well as loud and violent quarrels among neighbours and couples. More than once, the police had to be called in to squelch a violent incident.

5.3.1 Weekdays and weekend routines

Slowly, after some time visiting the migrants' homes I got to know their daily routines. Life in the compound during weekdays begins as early as 5:00 in the morning.

> Early in the morning I am awaken by the movements of those who get up to go to work. This starts at around 5:00am, another group gets up at 6:00am and another at 7:00am. I hear the sound of water and the sounds of people getting ready to work.
>
> *Field notes, November 2002*

During the day, only the unemployed and the youngsters were present. The largest group arrived at eight in the evening, after work. Some just cooked and slept, while others got together inside their rooms or in the common areas to chat about home or the events of the day.

During weekends, beginning Saturday afternoons, everybody would be at the house and it would get busy and noisy. Most of the time, Peruvian music was played; *Huainos* and *Chicha* music – the kind everybody knew and used to listen to when they lived in Peru. Music was either brought along by migrants themselves or purchased in the local informal market. Music would always put people in the mood to dance and sing. This happens particularly during weekends and would go on from early morning until late at night.

Weekend mornings were mostly spent cleaning, washing and shopping for groceries. Then lunch was cooked, and the afternoon was the time to go to Cathedral Street. Here, migrants would do a variety of things: make phone calls home, send money, buy presents or clothing in the downtown malls. Most of these purchases would be sent home to their children and relatives in Peru. On Saturday evenings, most migrants get ready to go out to dance, often returning quite late. Sunday afternoons were also suitable for going out to dance, as many live-in domestics had only that one day off. Dancing is a good way to get distracted and forget about the week's bad experiences they said.

> I walk into the bathroom. It is Saturday night and I find Maria Elena there. She has had a bad day. The *Señora* (her boss) has "disburdened herself" with Maria Elena because she made a mistake sewing pieces of clothes (she is a dressmaker). This caused Maria Elena to feel very offended.
> Maria Elena tells me that she came back to the building feeling *cólera* (anger) and she cried in her room. She adds: "I felt like going back to Peru". She is washing her face with soap to get rid of the signs of crying. Her friend is keeping her company and soon they are going to *La Buena Mesa* (a Peruvian dance hall). Maria Elena tells me she wants to get distracted from the annoyance caused by her boss.
>
> *Field notes, January 2003*

5.3.2 Celebrations and alcohol consumption

Music, dancing and engaging in heavy drinking are core activities at any social event among the migrant community. However, it was mostly the men who unsuccessfully fought the sadness and nostalgia of being away from home with alcohol and who gathered in the communal space of the compound to drink for an entire weekend. As a result, they often disrupted the precarious balance of relations with their partners and neighbours. Very frequently, alcohol consumption led to physically violent fights among men. Women, although less often, also participated in such outbursts.

As alcohol drinking is eminently a male social activity, men administrate its distribution. Normally, the group drinking would use one single glass, which would be circulated among the members, followed by a bottle of beer. Beer appears to be migrants' drink of choice. The person who receives the glass fills it up and drinks it. Then, he spills the beer foam onto the floor. This is done to share it with the *pachamama* ('Mother Earth' - Andean Deity). After this, the glass and bottle are passed on to the next person. This procedure goes on until the beer bottle is empty and another bottle is opened. Women drink as well, but not with the frequency and quantity that men do. Moreover, culturally, women do not have the autonomy to drink as men do, as it is regarded not proper behaviour for women to drink on their own. Women should wait to be offered a glass of alcohol by a man. She must be served; only then can she drink.

After few bottles of beer, partiers would get drunk and start arguments or fights with each other.

> The breaking of a beer bottle often signals the moment in which a party becomes a fight. The same 'friendly' bottle that circulated may in a second turn into a dangerous weapon to be used against those who may have insulted a man's honour.
> Spectators encircle the fighters and while some may try to intervene, others try to protect themselves from broken glass or additional bottles been randomly thrown. Women scream and, in desperation, some try to intervene to protect their men from being hurt.
> To use a bottle as a weapon, the thumb should be inserted inside the neck and is held tight from there, using the rest of the fingers. The bottle is then smashed into a hard surface and broken. I have heard that a wound made with a broken glass is often a serious one. This particular weapon originated, according to one informant, in Callao Peru and became part of the harbour culture. From there, it spread through to other northern cities along the coast.
>
> *Field notes, December 2002*

Alcohol consumption and drunkenness is the consequence of many social gatherings in the migrant community. During the time I spent in the collective house there were a number of celebrations and also fights.

Unauthorised parties were most often spontaneous, following an extended Sunday lunch. On these occasions when food sharing was accompanied with music and few beers, more alcohol would be purchased and the drinking would get people dancing well into the evening. Regularly, parties continued late into the night with very loud music - often the reason for the arrival of police and resentment among neighbours who either did not want to participate or were not invited.

The process of community organisation resulted in the formation of a committee who decided on collective matters including issues of authorisation such as holding parties in the collective spaces of the housing. The committee authorised some of the celebrations and the whole community was invited. Authorised social activities were celebrations such as birthdays and *polladas*.[82] For the purpose of gathering financial resources, food was sold, often to help somebody pay for the expenses of a sudden illness, a robbery or unemployment. Since beer was also often sold, and accompanied by loud music, these

[82] The *pollada is a meal* consisting of one quarter of a chicken per person and salad. The *polladas* were implemented during the eighties in the *Pueblos Jóvenes* (shantytowns) of Peru as an activity carried out by the community particularly to generate financial resources.

occasions frequently ended up as wild parties. The more *polladas* were sold, the more beer was bought and brought into the house. Naturally, it was the sale of beer that makes the most money. Sometimes, there would be authorised preparation and selling of food under the condition of not selling beer.

5.3.3 Conflicts in the community

After moving into the house, I witnessed frequent quarrels among neighbours and families. Close interaction among the community made hiding conflicts from the rest of the community almost impossible. However, neighbours would not interfere unless the general climate of the place was altered; that is, if a quarrel got out of hand. But generally, it was expected that people involved would handle their conflicts themselves.

The following episode reflects the intricate way conflict was handled between two neighbouring families, preventing the quarrel from escalating to a point where it would turn the two families, and close neighbours, against each other.

> It is early in the morning and I am abruptly woken up. Demetrio and Tania his oldest daughter are screaming. Their fight must have started inside their room but suddenly moved out to the corridor. It seemed to me, judging by the noise, there were more people involved. They are talking and screaming too. But I cannot distinguish their voices.
> What I hear next room is Ñato getting up quickly. My guess is he is going to intervene in the fight. I remain in my bed, trying to figure out what is going on. The screams stopped after a while and everything returned to normalcy. Later that morning, I asked Ñato about what happened on that side of the house.
> He told me Luciano had told Demetrio that his son in law, Chapita gets into his room while he is away and spends time with Yajaira there. Yajaira is Demetrios' eldest daughter. And furthermore, they were *pololeando.* This is a Chilean term used for an informal love relationship. This state of affairs made Demetrio furious and he decided to beat all his children evenly. He did this because they knew about this situation and kept it secret!
> I asked Ñato: "But why Luciano did do this?" To this, he replied: "…well Demetrio needs to educate his children. What happens is that they are very disobedient and disorderly because they had been left alone for four years in Peru, while their parents were working in Chile". He continued: "So what happens is what Demetrio was saying if they were back home, they could be seated in the lounge and that would be okay. There, the children can have their friends coming over for a visit without problems. …But here in the room, they are sitting in the beds. They are *encamados*! (A deprecating term used to refer to couples engaging in sex). And that looks bad," says Ñato. He quotes Demetrio: "It looks nasty; so they must learn". I asked Ñato again: "But why did Luciano want to make this information known to Demetrio?" Ñato replies: "To avoid a bigger and more serious fight. If by any chance, Demetrio happens to catch them (the boy and girl) together, it can get really serious. …Luciano did it to protect his son-in-law from getting badly beaten by Demetrio".
>
> *Field notes, December 2002*

Living in such a small and crowded place requires careful handling of conflicts. This is particularly true because as I discovered after I spend some time living in the compound, there were always conflicts or arguments set off at any moment. In conversations with migrants, they said they believed this was caused by their living situation. The next account reflects the limit this community would go to in solving individuals' conflicts.

I remember the thoughts I had before falling asleep one of the nights I spent in my room in the house on Bandera Street. I felt I could sleep more easily in the room as the situation was beginning to be more familiar to me. I was still very conscious of how strange it was thinking of me literally 'lying down in the middle of this community'. It seemed to be a quiet night as there hadn't been much movement.

The situation changed at about 5:30 in the morning by a sudden loud noise; the smashing of a door and much activity in the corridor. A quarrel was in progress. I heard the screaming of a woman and I realised it was a couple fighting.

She shouted: "Let me go! Giiiive me my handbag…! I want to leave! Let me go! Leave me, leeeeeeeeave me alone!" I was worried that the fight might escalate. I knew I would not leave my room unless things become more complicated. I heard the woman, but could not hear the voice of the man.

As they were getting closer I realised they would go into a room across the hallway from me. From this, I deduced that it must have been my neighbour 'young Luis'. The woman continued screaming very loudly. A group of neighbours were now up and had congregated outside the room. I heard several of them. People were banging on his door saying: "Okay *'vecino'* Luis (neighbour). Let her go…Come on, let her go at once! We want to sleep!" The group was putting pressure on Luis, the renter of the room.

Slowly, the woman ceased her protestations. Soon there was complete silence in the room. Satisfied, the neighbours went back to sleep. I overheard somebody saying: "We only have to deal with what happens in the corridors but what happens inside the rooms, it is not our business".

There was still a small argument continuing in the room. The woman appeared to be accusing Luis of infidelity, but I could still not quite hear his voice. The dispute slowly shut down and turned into a much softer, lovers' whisper. The fight concluded in a passionate encounter, and the rest of the neighbours, as well as me, went back to sleep.

Field notes, November 2002

On going conflicts between people were often known by the entire community. Accusations were constantly delivered indirectly, never in actual confrontations. The next account is of one community meeting which illustrates the multiplicity of conflicts as they overlap and the indirect way they are addressed.

I attended a community meeting called to deal with the payment of the electricity and water bills. After dealing with that, a new topic arose – robberies in the compound. Some of the neighbours suspected the person responsible was a friend of two of the youngsters who lived in the housing compound.

This accusation triggered an argument between the two mothers of the mentioned youngsters. Marisol and Maria Elena got into an escalated shouting-match, each blaming the other. Both mothers defended the honour of their 20-year-old sons. Maria Elena got angrier with each passing minute. She shouted at Marisol, that she (Maria Elena) supports her son with her own hard work. …"I do not prostitute myself to earn my money*!"*

After this strong but indirect accusation, some men in the group intervened and tried to calm the two women down. Ñato spoke out, trying to conciliate, saying that they are "all part of a happy and noisy culture*",* but this did not mean it should turn into a fight.

His impassioned speech took too long, and people got impatient. They stopped listening to him. Don Luciano interrupted Ñato and acknowledged his own responsibility. He did this because his own nephew, *Chapita,* was also friends with the one youngsters accused of stealing in the compound. Demetrio also acknowledged his own part in generating the loud quarrels that took place there.

To this, Don Hugo responds: "I offer my apology, Don Demetrio, with all my respect... When you get drunk, you cause a lot of problems too*"*. Demetrio defends himself claiming his role as a father, but admitted he also makes mistakes. Luis next intervened to

say: "Nobody from outside can come into the housing to insult one of the ladies, accusing her of being a prostitute. That should not be allowed!" To provide a little history, it seems at an earlier time, somebody from outside the compound came into the building and insulted Marisol. Everybody heard the insult and this was what Maria Elena was referring to in an indirect way.

Somebody in the group pointed out that the person(s) responsible for the robberies should not be allowed into the compound. Don Luciano said the problem is these youngsters are invited to come into the housing. "Some here are friendly (with them) and even flirt with them". Graciela immediately jumped up, demanding Don Luciano clarify whether or not he was referring to her children. Don Luciano, trying to divert his accusation, said: "Children are a reflection of what their parents allow them to do". However, he was indirectly referring to Graciela's daughters.

There was an attempt to create a "House Rules Commission" but the idea did not receive enough support. Don Hugo, who had been leading the meeting, asked everybody to be alert and get involved. When they saw strangers in the housing, they should ask them to leave. He ended the meeting by saying: "Being here is not like being in our own houses. Whatever happens here affects us all". The meeting ended with small agreements reached. But the conflict between the two mothers continued.

Don Hugo, his wife, Doña Angélica, el Ché, and I stay behind to discuss the incident. "Everything is turned into something bigger here (by the people)", Ché commented. "That has to do with the way we live here". To this, Don Hugo added: "I have heard this is the way people live in the *quintas* (also '*conventillos*' or tenement houses)". By saying this, he and the others were distancing themselves from the migrant community. Don Hugo said he was not used to this way of life. Ché and Angélica agreed with him.

Field notes, *December 2001*

As can be observed in the events described, conflicts in the community were ongoing. The balance in the internal social relationships was never stable. Everybody was somehow accustomed to the outbreak of violent fights. However, certain rules were held in place to deal with certain conflicts.

Private fights among family members and couples were to be resolved inside their rooms. However, other conflicts involving two or more neighbours would be dealt with in public. Here, although indirectly, accusations and charges were exposed to public scrutiny. This was primarily done to gain support. Another and more permanent mechanism through which alliances among neighbours were formed was through the establishment of "politic kinship" relationships. Such relationships were referred to as *compadrazgo*.

5.3.4 From neighbours to compadres: the construction of symbolic kinship

The status of godfather and godmother creates a more solid relationship between parents and the child's godparents. Being *compadres* is the relationship linking parents with their child's godparents. As Lewis-Fernandez stated, among Latino American communities: "*confianza* (trust) can be cemented through the incorporation of the other into the status of family members via the fictive kinship of *compadrazgo* (literally co-fathership) arranged by mutual sponsorship of children's baptisms"(Lewis-Fernandez 1994:69).

This particular relationship, so extended in Latin America, plays an important role among migrants. It allows for a wide range of exchange among members in the relation; it entails mutual assistance and support to accomplish their migration endeavours as well as in situations of need in the host country, including care during illness**.**

In the compound on Bandera Street, the status of godparent was given by parents to some of their neighbours, who helped them face adverse situations such as illness. It was also bestowed in order to set up political alliances in a context where conflictive situations could emerge at any moment.

The couple Hugo and Angélica gave godparent status to some of their neighbours. Angélica described to me the various stages in the process of giving a child, godparents. As she explained, a baby's first godmother is often named when the baby's fingernails are due to be cut – usually 25 to 30 days after birth. As with her own baby, a "nails-godparent" does not need to be a close friend. This person can merely be an acquaintance; somebody you like. Generally, a woman is the first, and sometimes the only one, chosen to be a "nails- godparent". This is because the chosen godparent is the one who actually cuts the baby's nails. "Although*,"* Angélica said, "it can also be a man, but often men do not know how to cut a baby's nails*"*. Apparently to be a "nails-godparent" does not involve a great degree of commitment to the parents or the child, as Angélica explained. If that person wants to give a present to the baby she does it. In the case of her baby, the "nails-godmother" was *Señora* Cristina, Angélica's next-door neighbour who had become the couple's friend. They also gave Don Hugo's cousin status as the baby's "nails-godfather".

The next godparents selected are those associated with the baby's earrings – when it is a baby girl, as in this case, that person gives the first pair of earrings to the baby as a present. Marisol, one of the oldest inhabitants of the compound, was chosen to be this godparent. Besides the fact they are friends, she had great influence upon decisions made regarding community issues. Marisol gave the baby her first set of earrings and became the parents' *comadre*.

The next pair of godparents is named when (or if) the baby is given the *Agua de Socorro*. This is a pre-baptismal protection ritual which takes place outside the Church. This is done to protect the baby from harm, such as falling victim to the 'evil eye' as well as from any other serious children's illness. Indeed, the need to take a baby through the ritual of *Agua de Socorro* is often triggered by an episode of illness. This was the case for Angélica's baby. On the occasion of this *Agua de Socorro'*s ritual the godparents named were Luis and Angela, neighbours on both sides of the couple's room. This decision was based on the support Angela and Luis had given Angélica and Hugo during their daughter's sickness. They did not remain indifferent to the child's suffering and had offered their support to the couple by lending money, providing a mobile telephone to use on the days the baby was in hospital. Angélica next described how the ritual was done.

> One goes to the Church and brings from there the Holy Water. A friend brought it for me. We asked them (the godparents) to pour the water onto the baby. They pray for the baby and pour the Holy Water onto her head. It is done in such a way so the baby would not be frightened. This is done so if the baby gets sick, nothing bad will happen to her. When the water is poured onto her, she does not cry anymore. From that day, you (one) shall call *comadre* and *compadre* (to the godparents) …But the (official) Catholic baptism is going

to be in Peru, together with her brother (Angélica's eldest son). It is going to be in Guadalupe, two hours from Trujillo were my parents-in-law live.

The couple was sharing the events of the baby's illness over the telephone with their family in Peru. When the baby's health situation became critical, Angélica's mother-in-law requested they give the baby to the Peruvian saint *el Señor de los Milagros* (Lord of the Miracles). This also was done to help the child recover her health and to protect her from illness and bad influences.

> My mother-in-law called (on the phone from Peru) and she (told me she had) offered her (the baby) to the "Lord of the Miracles". She sent us from Peru the saint's costume. It is an entirely purple dress with its *detente* (a symbolic halt icon)[83] of the "Lord of the Miracles" and a white cord of half a meter length, which has a knot at its ends. Each year, you must make another knot. Next year she is due to have two knots. One has to say: 'Here I put the costume on you'.
> The 1st October (the day of the saint "Lord of the Miracles"), the saints' customs should be worn the whole month of October. …She (the baby) wore it (only) half of the month, because it was then when she arrived home from the hospital. But when we return home, we will take her (the baby) to the saint's temple in Peru. In October next year, we are going to dress her with this costume on top of her normal clothes. (Angelica)

I then asked *Señora* Angélica; why it is her baby has so many godparents? To this, she answered: "The baby has more godfathers and godmothers because she is a girl. And maybe because we are here in these rooms. We were told that *penan* (souls in torment) exist here. It is not like being in one's own house".

It was the baby's illness that triggered a clear expression of solidarity among some of the neighbours in the compound. After this episode, the cooperative character of this relationship was cemented through rituals confirming the neighbours as *compadres.* Lewis-Fernández stated *compadrazgo* creates a network of *confianza* (trust), which "serves as dissipators of certain emotions that are culturally understood to be potentially disruptive of social life because the lay claim to a significant amount of relational capital, such as anger or jealousy" (idem).

The *compadrazgo* relationship helped to moderate the expression of disruptive emotions among the close neighbours. Furthermore, *compadrazgo* relationships at the compound also served political purposes. They played a role in community conflicts, creating alliances among members in this relationship, channelling their mutual support.

However, symbolic kinship relationships established among migrants in Chile tend to be of temporary character. As in the case described above, the baby's parents wanted to wait to be back in Peru to perform the official baptismal ceremony. Similarly, protection ceremonies and rituals performed in Chile are subsidiaries and transitory as they should be confirmed in Peru. In this case, the devotion to the "Lord of the Miracles" should be confirmed by taking the baby to the sanctuary in Peru. Furthermore, protective rituals are implemented with the intervention of relatives from Peru. As in this instance, Angelica's mother-in-law asked them to perform the ritual on the baby for which she sent the necessary customs (the purple dress with the Saint's icon on it).

[83] A *detente* is an icon (this could be a stamp of the saint or a Christian cross) which stops the "devil's forces" from inflecting damage upon the person.

In this section, various aspects of community life have been looked at. Life in the community provides its members with support which moderates stress arising from the process of incorporation into the Chilean society. As seen, the community plays a complex role; on the one hand, it helps to cope with stress but also, it contributes to generate conflicts and exposes its members to violence.

5.4 Community life outside of the building

In this section I look at the use of public places by migrants, as it can help to highlight the role of spatial temporal strategies in the construction of cultural-transnational identities.

5.4.1 The little Lima: Plaza de Armas of Santiago

From the 1990s onwards, the presence of Peruvians in the country became evident to Chileans. Native Chileans saw more and more Peruvians gathering in the main square of Santiago, the Plaza de Armas. Slowly and steadily the Plaza, formerly used by retired people and domestic servants on Sundays, had become increasingly 'inhabited' by Peruvian migrants. Today, the Plaza and its surroundings resemble the centre of Lima rather than Santiago. It is a familiar haunt for the migrant community, a sort of enclosed territory within the big foreign city. It is a place to meet fellow Peruvians and serves as a place of reference.[84]

There is constant movement in the Plaza as migrants come to sit along the walls of the Cathedral. Here, they meet their friends, get to know new people, wait for someone or simply for something to happen. They chat, eat, borrow, lend and trade all sorts of things; share and pass on information about jobs and housing as well as ways to find cheaper goods, medicine, clothing, or to make international calls. Restaurants serving Peruvian food as well as bars and discos have opened up in this area. These are places to go chatting, drinking and dancing on Saturdays and Sunday afternoons. These social gatherings help migrants to cope with nostalgia and loneliness, as well as Santiago's cold weather. Informal vendors use the street at the opposite side of the Cathedral to sell their Peruvian products,[85] as well as homemade traditional Peruvian food.[86] Whenever a new place opens a little further away from the Plaza, special kombi-buses are arranged as a way to encourage Peruvian clients to visit their establishments. People are fetched from and delivered to the Plaza hours later. In some cases, some of these people may spend the rest of the night there.

In the Plaza many types of networks are operating. Some of them are well intentioned and genuinely based on reciprocity. But there are also others, of a mafia

[84] Tamagno (2003) finds similar patterns of production of locality among Peruvian migrants in Milan. The main gathering point of the community of Peruvians in this Italian city is around the Cathedral of the Piazza del Duomo.

[85] Some of the Peruvian products sold are: S*errano* (corn), *Doña Pepa Sublime*, *Donofria* and *Cua-cua* (chocolates), *Kikko* (soy sauce), *Hamilton* (cigarettes), *Ají no Moto* (food flavouring). At Christmas time, the traditional sweet bread *Panetone* is sold.

[86] Such as *Ceviche*, *Ají de Gallina*, *Papa a la Huancaína*, *Arroz Zambito* and *'Tamales.*

type, such as the *marcadores*[87] that trade in smuggled goods and stolen mobile phones used for making international calls. The economic exchange between Chile and Peru takes place here, basically composed by money remittances to support families left behind. Several foreign currency exchange offices have been set up around the Plaza advertising services such as money remittances to Chimbote, Trujillo, and Lima, home cities for the majority of Peruvian migrants. These networks, whether legal or illegal, act as efficient channels through which any manner of goods, information, and people circulate.

The Plaza is often the only point of reference for newly arrived Peruvians. "I only knew I had to go to the Plaza de Armas," said a recently arrived migrant. One can see them there, sitting with their travel bags, waiting to be contacted by somebody who can help them to get a job or housing. It is a place where new arrivals wait for their relatives or friends to pick them up. This marks the last stop for the migrants after a long journey from Peru, after having made their way down through the arid geography of northern Chile. It also marks the beginning of their migrant lives in Chile.

[87] *Marcadores* are migrants involved in a semi-criminal activity, one of the informal jobs created out of the migrants' need to communicate long-distance at cheap rates with Perú. They are sellers of cheap international phone calls to passers-by along the Cathedral side of the street. Calls are made from mobile phones which are connected to land lines. *Marcadores* dial the number for their clients (*marcar* means to dial), after which they control the time of each call.

Chapter VI

Families, Identities and Frontiers

6.1 Introduction

> Graciela, pondering their years in Chile says*: Chile has given us food for four years. It has given us all these things. It has given us money, work, all this that we are taking along*.
> To this I said: *well, yes Graciela, but you have earned it out of your own work.*
> *Yes* (she says), *and they* (the Chilean employers) *exploit us. …Our strength.*

Migrants' identities are like pieces of a broken mirror. Migrants recognise each other's faces in some of its broken parts. In others, new features begin to be reflected. Migration involves changes in migrants' identity as well as the reassertion through its enactment of other and more persistent dimensions of their identities. While some dimensions are constitutive of the condition of being a migrant, others are in the process of being redefined and negotiated, to a large extent, as an effect of the influence of the host society. Yet, most of these dimensions become apparent in the boundaries – or differences – that exist among migrants themselves and the broader Chilean society. Migrants' reflection on what is seen as central to their identity often emerges in comparison with –and contrapostion to– the Chilean society. This chapter explores various dimensions of migrant's identity as well as some of its redefinition.

One of the shared elements of being a migrant is the fact that most, if not all, have left close family members behind in Peru. They are part of transnational families. Maybe it is this circumstance which gives them a sense of similar purpose and compels them to live under similar constrained circumstances in order to provide for those left behind. Being part of a transnational family also implies great emotional burden shared by these migrants. The chapter begins by looking at migrants as members of those transnational families and examines the efforts invested and dynamics involved in keeping their families together across national frontiers.

A following section examines another dimension of migrants' identity – this time their national identity – through food related practices**.** These practices include the preparation, eating and talking about food**.** Two processes are observed here. Firstly, food practices are seen as 'liberating'; they reinforce social linkages among migrants creating a sense of place and of belonging to a common national identity. It is argued that such food practices constitute a critical social domain for the perception of selves among Peruvian migrants in Chile.

Indeed, in this rundown housing unit, migrants cook their own good Peruvian food, far from the gaze of their Chilean employers. In this sense, the compound serves as a social space where Peruvians are free not only to cook their own food, but also to regain a sense of control over their own lives through social interactions with other Peruvians. Through their food practices migrants differentiate themselves from Chileans and assert their own national identity (Núñez 2005). Secondly, while food is a celebration of their

national identity, it also confirms the traditional sexual division of labour since the task of cooking continues to be assigned to women. This issue is discussed next.

Changes in gender identities and gender relations among the migrants are also discussed. These have been triggered by women's involvement in the labour market but also by the influence of living in a more liberal society. Gender identities are examined along with the coexistence of conservative and innovative behaviour. While migrants redefine some aspects of gender identities in more egalitarian terms, some other traditional dimensions are retained in the new context – such as the ideal of the 'decent woman'. Forms of male control are reinstituted in reaction to women's increasing freedom.

The last section explores interfacing with Chilean society. This is done through migrants' perceptions of their differences in relation to Chileans. An issue such as the change of status, which particularly affects educated migrants in Chile, can be seen as a reflection of the imposition of a foreign identity upon migrants. This is very much a reflection of the general exclusion affecting them in the host society. Finally, the issue of discrimination is discussed here as witnessed by me, the researcher.

6.2 Transnational families

Most of the migrants included in this study were part of a transnational family. These families can be defined as "families that live some or most of the time separated from each other, yet, they remain held together. They create something that can best be described as a collective welfare and unity, called 'familyhood'. This exists even across national borders" (Bryceson 2002:3).

Furthermore, important family decisions are taken via long distance communications. Indeed, transnational family life "entails renegotiating communication between spouses, the distribution of work tasks, and who will migrate and who will stay behind..." (Levitt 2004:1016). As Yeoh puts it, "the decision to migrate and the whole migratory existence are not simply based on each individual's experiences but strongly influenced by being part of a family network" (2004:148).

For many migrants, to be part of a long distant family relationship involves great emotional cost and a constant concern about their well-being. The various dimensions involved in being part of such a family are discussed here as well as tensions and conflicts associated with its dynamics. These include: (i) the formation of a transnational family, ii) the logic guiding these family bi-national movements, (iii) conjugal relations in a context where migrants are living away from home and their partners, iv) the importance of remittance money and lastly v) cultural definitions of motherhood and fatherhood, as well as the financial commitments associated to these roles.

6.2.1 Formation of a transnational family

Families, whose members have had a previous trajectory as internal migrants in Peru, seem to be better prepared to take up an international migration endeavour. In these

cases, crossing borders is seen just as 'another step' in their long-term search for better opportunities. For members of these families, migration is expected, moreover it becomes the norm. The experience of *Señora* Angélica, my neighbour, illustrates well this situation. Her case also shows how migration is a collective enterprise, based on an extended social network. Acquaintances may be part of it but their help is not always reliable as the assistance family members can provide.

> One day I asked Angélica about her family and where she came from in Peru. She showed me pictures of her family and her 9-year-old son who is under the care of his grandmother. One of these photos showed a traditional indigenous celebration in which all the participants were dancing in colourful traditional costumes. She took a deep breath expressing the sadness of missing her hometown Huancayo in the *Sierra* highlands. This was a place she left when she was 13 years old, as she migrated to Lima to live with an uncle. In the city, she finished school. Finally, she married Don Hugo and lived with him and his extended family in that same city.
>
> When her older son was 6, the economic difficulties began. Her husband's salary was not enough to support the family. She planned to migrate to Japan with the help of an acquaintance. She borrowed money and bought the ticket, but the plan fell apart at the last minute. Her friend dumped her. The trip was cancelled and she lost the money for the ticket. Now, she needed to find an alternative solution since she was in debt and still stuck in Peru. This was then when she decided to migrate to Chile – a cheaper and more feasible alternative.
>
> She left her husband and child behind. A year after settling down in Santiago, her husband joined her. However, after 4 years in Chile, the couple was not satisfied with their life in Chile but now they had the additional burden of a small daughter. *Señora* Angélica currently takes care of her baby and cannot carry on with paid work. She and her husband have not been able to save any money and the promotion promised to Don Hugo at work has simply not happened.
>
> *Señora* Angélica is now planning to move to Italy. Her sister-in-law lives there and has offered to lend her the money to travel. Again she will go alone. This time, she was assured she would have good job opportunities in Italy as a domestic worker. However, men do not find jobs so easily.
>
> *Señora* Angélica's plan is to leave her daughter with her mother-in-law in Peru. The entire family will return home as she thinks it may take her a year before she is able to migrate to Italy. In that time, her daughter will accustom herself with her grandmother. Once Angélica finds a job in Italy, she plans to send for her husband, and later her children. Then, finally her family will be reunited in Europe. When I asked her about how she felt moving so much, she said: "I only feel at home in my hometown. …Everywhere else is the same for me, it is not my home*"*.
>
> *Field notes, December 2002*

Señora Angélica was ready to take up the adventure of migration again. However, in her case, the presence of family and the fact that she was not engaged in paid work, made her situation much different than the majority of the other women living in the compound. Indeed, for women working as domestics in live-in situations, the distance from their family seems to be almost unbearable. Rosita returned every two weeks to spend the weekend in the compound with her partner Lucho, whom she met in Chile a year earlier. One Saturday morning, we chatted in their room. I noticed she was having problems. I sat with her and she said with great sorrow that they would not go to Peru in December.

They had planned to attend the graduation of Rosita's eldest daughter. Then, she realised she couldn't afford to take a month off work and pay for the trip too. She had

just got back from calling her daughter to tell her the bad news. She was very affected by this, and told me with tears in her eyes: "All what I want is to go back to Peru. I need to be closer to my children. They are growing. My eldest daughter is almost 18 now and I need to be closer to her". Although she made regular telephone calls, she said it is not the same. She was crying. Rosita had been working in an in-live situation for three-and-half years, only getting days off every two weeks.

6.2.2 Family reunions

In general, if resources are available and the legal status in the country is not a problem, migrants may travel back home during Christmas, Mother's day, birthdays or school's graduations. However Rosita's situation was not uncommon as migrants often faced several impediments to travel. Limited mobility is the result of many factors such as a lack of resources, difficulty getting time off at work or having irregular legal status. Indeed, migrants who do not have regular visa status know they would risk not being allowed back into Chile again. This can be especially difficult in situations where migrants cannot be present in times of illness or attend the funeral of a close family member in Peru**.**

Migrants who enjoy more mobility are those who hold permanent visas to reside and work in Chile, or as they call it have *la definitiva* (the definite one). Such visas allow them to come in and out of the country without being questioned by border controls about their intentions. In addition, they are entitled to bring dependent family members into the country, a prerogative not available to those holding temporary visas. However, in order to maintain such visas, migrants should not be away from Chile for more than one year. Stories abounded of relatives that were not allowed to enter into the country.

> Demetrio is worried. He and his family are getting ready to go to the airport to fetch Yajaira, their oldest daughter, who is about to arrive. He tells me he fears she may be sent back. To my disbelief, Don Carlos who has joined the conversation tells me the story the daughter of *Señora* Marisol. This young woman was not allowed into Chile after she had arrived in the country. Upon arrival, customs officers asked those Peruvians who were coming to Chile for the first time to stand in a separate group and all of them were immediately put on a flight back to Peru. The same night, mother and daughter were talking on the phone and were both crying.
>
> *Field notes, September 2002*

Yet, for migrants who have *la definitiva,* returning home to deal with urgent matters may involve quitting their jobs. Typically, in cases of serious illness or a death in the family, employers are only willing to grant leave of one week. Unfortunately, the trip back to Peru takes a minimum of three days and the traveller may not reach home on time the deceased's funeral. Therefore, the only way to be able to remain in there for a more extended period is to resign from their jobs.

In the most fortunate of circumstances, a migrant may negotiate to have another migrant work at their job as a temporary replacement. In circumstances of migrants' own illnesses, decisions may vary from returning home or somebody from home coming to assist them while they are ill.

Migration of other family members is mainly driven by economic criteria. Often members of families reunite in the new country. Predominantly these new arrivals are people who can work and are more likely to find jobs in Chile. Conversely, families separate as parents leave their children behind in the home country, to be able to fully engage in paid work. To a large extent, this is a "forced separation" and causes migrants, great emotional attrition.

As a general rule, migrant workers first come to the host country alone. After the first member of a family has migrated, others may follow. After some time, it is expected the newcomer will become economically independent. This pattern was confirmed by the fact that in most of the rooms at the compound, there were two or more adult family member and almost everybody had some relative living and working in the country.

There is a residential pattern associated with family transitions. This begins when one member of the family comes alone and shares a room with friends. As more family members arrive in Chile to join him/her, an independent room is then rented. This pattern also applies in the case of women but is also dependent on type of work regime they engage in. So typically, women who come to Chile on their own, would work as domestics and enroll themselves into live-in systems. Eventually, partners may follow them, or they find another partner in the new country. In such situations, the woman may then switch to a "living-out" system, where she would rent a room and move with her partner.

In general, migrants can never be sure of the length of their stay in Chile. They may plan to bring more relatives into the country but they, themselves, may leave at any moment if a better opportunity comes along. The decision to remain strongly depends on what the Chilean labour market has to offer them. It also depends on the exchange rate of the dollar as their remittance money is converted into that currency. If the dollar rises, as was happening at the time, then the worth of their money was less. Carlos assessed the situation in this way: "we might leave soon. To find a well-paid job now, it is very difficult. It used to be good but now the dollar is very expensive and there are too many of us" (Peruvians in Chile, competing for the same jobs).

Furthermore, as the trip to Peru is quite affordable, many migrants have moved and settled in Chile more than once. Some have made money and returned home to try operating their own businesses in Peru. If such ventures do not turn out well, such entrepreneurs see themselves obliged to return to work in Chile.

When facing problems sending money to support their families in Peru, parents may decide to bring their younger children to Chile. This is especially true of children old enough to go to school. This is never an ideal situation, as parent workers usually have to leave their children alone in the rooms; in an insecure environment. In addition, migrants also feel the influence of a more liberal society upon their children is not a positive one.

Often, new family members are born in the new country, although most pregnancies among migrant women are unwanted.[88] This is because when a new baby is born, the economic participation of the woman is interrupted for a protracted period, dramatically

[88] This topic will be further discussed in the chapters on reproductive health, chapters X and XI.

affecting the migrant family's finances. Migrants refuse to leave their small children in Chilean crèches, as they don't trust the care given there; to the extent that they would prefer to take their children back to Peru rather than arrange for day care in Chile. So often, a woman will look after her child for two or three years, until the baby can be sent back to Peru. This is done to allow her to again go back to work. Young couples especially resent having to separate from their newborn children. However this is not different to what happens to Chilean live-in domestic workers whom originally come from rural areas to work in big cities.

The case of the Campos family illustrates the efforts made to reunite. However, the precarious stability reached through these family arrangements leads to continuous movements back and forth – in and out of the country. Of the 20 rooms in the building, only Demetrio and Graciela had their four children living with them for an extended period of time. First the two younger children aged 12 and 14 arrived. But only Amparo the girl attended school. The older boy, Demetrio *chico* refused to go to school and helped his father with gardening work. Tania, their 19-year-old daughter came later to do domestic worker. However, after some months, she decided to return to Peru to live with her grandmother who had raised her, and whom she missed very much. At 21 years of age, Yahaira was the eldest child, and the last to arrive in Chile. Although her parents invested in her education – she graduated with a computer sciences diploma – she was only able to find work as a domestic. Soon Yajaira was pregnant and ran away from the family's room to live with her new partner, Chapita.

Graciela often expressed the opinion, especially following a family fight, that she would have preferred not to have had her smaller children with her in Chile. She felt they were a nuisance and a constant concern. But as it was said to me, Demetrio was missing them too much. I later gathered from other neighbours, that when he was alone without his family, he used to drink a lot. Demetrio was unfaithful and violent with Graciela. Even though the presence of his children seemed to have influenced Demetrio in a positive way, Chilean society was not having the same impact upon the children.

I arrived at the building one evening and a group of residents were discussing the rearing of children. Something had happened the night before when I was not there. Demetrio had beaten up three of his children for something they had done. He had also beaten his wife when she tried to intervene. Graciela, I heard, went to the police who came to the building but she did not press charges, so Demetrio remained free.

> But the conversation concerned the question of how to educate the children in Chile, as the neighbours were trying to understand why Demetrio had so violently punished his kids. Everyone had an opinion regarding what should be done.
> Marisol said she could not control her 20-year-old son. She remembered how she, herself, was taught and how strict her parents had been with her. The entire group seemed to agree on the view that Chilean society was "irresponsible and messy".
> They remarked on the excessive freedoms youngsters enjoy and how easily they engage in love relationships corrupted their children. All this was said after having first apologising to me for being so critical. They usually would introduce a criticism towards Chileans in front of me by saying: "…we apologise Señorita Lorena, please don't take it wrong, but Chileans are…"
>
> *Field notes, November 2002*

Demetrio and Graciela's family were a particularly mobile one. Once they packed up, took the younger children and went back to Chimbote. Graciela then returned with Amparo to Santiago to continue working and re-enrolled the girl into school. After some time, Demetrio also returned to Chile but then left again. By the end of my fieldwork, Graciela was living with her daughter Yahaira, her daughters' partner *Chapita* and their newborn baby, in Chile. The rest of the family had gone back to Peru.

6.2.3 Conjugal relations

Most migrants were married and had families in Peru. However to migrate causes great tensions in the stability of partner relationships. Couples often face problems in remaining loyal to each other. This is particularly true when one partner stays away for extended periods – even years. New relationships are often formed in the host country among lonely migrants. Men and women, now living the same migrant life – sharing houses and rooms, combined with the emotional burden of being far from home and family – share a close physical proximity and common experience. They have similar needs of emotional support and can offer each other company. All are circumstances which often lead to the establishment of new love relationships. This section deals with marriages and temporary relationships as well as tensions created around these partner arrangements.

My first commitment

Migrants refer to their permanent and stable relationships in Peru as *mi primer compromiso* (my first commitment). This socially consented union has as much strength and validity as a legal marriage. In fact, legality is seen as not something necessary to assure the couple's mutual obligations.[89]

However, having a socially validated partner commitment as well as one's own family represents an important element of the ideology for this community. It legitimates migrants' endeavors and justifies their sacrifices, although – in practical terms – migrant married men and women live separated from their families in Peru. Moreover, while being away, as it was said, migrants may well engage in other partner relationships. But this ideal situation, Ñato does not fulfill; he is single 'uncommitted' man and has no family to care for. I witnessed how often he was teased assigning him all sort of potential partners – including me. This was an issue, which until the day I left the community, an invariable topic raised by members of the community, in any conversation I had with them.

Ñato was often questioned about being single and whether he had or had not, marriage plans in the future. The conclusion drawn by married women, which explains his single status, is that he is scared of women. Men on the contrary, pointed to him with some measure of envy, that he could live his life carelessly. They felt he was free from burden and the responsibility of having to support a family, Ñato was also

[89]In general, couples may marry in Chile when circumstances oblige them to do so. This would be when this status is a requirement to obtain visas or to access to social benefits such as health insurance. More often, migrants may prefer to postpone marriage until they go back to Peru. Ideally, for a wedding party, they expect to have their relatives and friends present at the celebrations.

criticised that he has not saved any money after his seven years in Chile. Furthermore, his status as a single man was often used as an argument to invalidate Ñato's efforts. He wanted the Peruvians in the compound to organise improvements in the building of Bandera Street or to participate in the meetings held by APILA (the migrants' association). The fact that he did not have a family to support undermined his credibility. However, everybody thought it was fine for him to participate and spend time in such activities.

For most of the migrants in the compound having their own family to support and a commitment in Peru gave their stay in Chile a clearly temporary character. Thus, they were simply not interested in getting involved in any local initiatives if it was not directly related to their individual needs.

My second commitment

In the new context of migration, women and men – already married or committed to other people – live together, setting up temporary relationships. This helps each participant to cope with the distance and unbearable loneliness of being away from their spouses and families. Such living arrangements may well coexist with an intended faithfulness with priority given to each one's 'first commitment', who still lives in Peru.

Migrants refer to the other relationship that has been initiated in the context of temporary relationship as *mi segundo compromiso* (my second commitment). The moral standard of these relationships lays in the commitment of the new couple to continue sending money to their respective *first commitments* and children in Peru. New couples even go together to buy presents for their respective children in Peru.

Señora Esperanza, 66 years old, and Don Luciano 60, was a couple in Chile. However, each of them was married to someone else and had a family in Peru. *Señora* Esperanza affirmed with conviction, the positive aspect of their relationship: "I always tell Luciano to save to send money to his children. I remind him of his obligations". They gave each other company. More than once, Don Luciano expressed to me with sentiment, how lonely Esperanza was before she met him. However, information about their current relationship, although known, should not be publicly acknowledged.

> We are celebrating the birthday of *Señora* Esperanza. The party was organised by Don Luciano, and held in *La Buena Mesa*. The event is being video taped. In a moment, we are all singing Happy Birthday while the couple stands solemnly in front of the camera and an imaginary public. *Señora* Esperanza calls me to stand between them. I go there. I congratulate her and join them in front of camera smiling as she introduces me.
> Esperanza then tells me in my ear "I can't hug Luciano because this video is going to be seen in Peru".
>
> *Field notes November, 2002*

A source of conflict was Dany, Luciano's son who shared the room with his father. He kept the secret of his father's relationship from his family in Peru but did not get along well with *Señora* Esperanza. Here, it can be surmised that Don Luciano did not fail as a provider for his own family in Peru, and this allowed him to be on good terms with his 'first commitment' and children.

Nevertheless, as many other migrant couples engaged in a 'second commitment', the future of Esperanza and Luciano was in question. Both were well aware they would eventually go back to their families and different towns in Peru. Their return was at the same time wanted and feared, especially by Señora Esperanza. She would have to go back to what she considered a bad marriage. There is a general tolerance existing among migrants towards the setting up of 'second commitments' which may often coexist with 'first commitments' in Peru. This is probably due to the fact they are all acutely aware of how important these relations are for maintaining their own emotional survival.

6.2.4 Remittances and transnational parenthood

Remittances – money and goods – are indicative of the emotional ties binding families together. Remittances operate as a language of care and help and maintain relationships among family members. It is as an "expression of profound emotional bonds between relatives separated by geography and borders and, they are the manifestation of profound constant interaction among these relatives regardless of the distances between them" (Suro 2003:4).

The frequency and regularity with which money is sent to Peru signals the affective proximity and migrant's responsibility to other members of their families. No matter of how little economic value, "remittances represent the continued connection between migrants and their origin households or families" (Cohen 2005:91). Remittances are also related with constructions of gender and 'cultural commitments' to family, aspects which increasingly are becoming relevant to the understanding of migration patterns. Cultural commitment to provide family support as well as failure to meet these will be discussed in this section.

Sending money and goods home was often the topic of conversation among migrant men and women. This regularly included their inability to save enough money and was their greatest concern. Migrants' unstable economic engagement in the labour market, led them often to face problems in meeting their commitment of regularly sending support money to their families in Peru. The continuous increase of the dollar's exchange rate at the time seriously impacted migrants' ability to meet required remittances. In addition, financial demands for children's maintenance in Peru often increased, making it even more difficult for migrants to fulfil their economic commitments.

Failing to send support money regularly often caused the caretakers of the children in Peru to complain. This not only put additional economic strain upon their families in Peru but it also affected the relation with them. Other times, migrants talked with enthusiasm about their plans to repair or extend their houses back home,[90] and set goals on what they would save for next.

[90] As I could personally witness, in Chimbote, many houses had been structurally improved as a result of migrants' remittances. It was actually possible to identify those families whose members had been abroad by the use of solid material their houses are built of. Totora roof (vegetable fiber) was replaced by bricks, and dirt floors are covered with cement. Although good weather allows *Chimbotanos* to live in somewhat flimsy houses, they are subject to breaks-in. As soon as remittances allows, they build sturdier homes.

> It is a Sunday morning. Olgüita, smiling, walks into the corridor where we are sitting. She showed us a sketch of her house in Peru. The drawing was sent to her by her son in a letter she just received. The construction has been made with the money she has been sending every month. She explained to us which were the rooms that were made bigger. Satisfied, she comments that she covered the floor with cement and closed the back of the house. It has already been six months that she has been in the country working as live-in domestic.
>
> *Field notes, January 2003*

However, things didn't always operate so smoothly. Sometimes migrants living in Chile experienced difficulties in controlling their investment money from a distance. Many times, this "earmarked" money would not be used for the planned purpose. I often heard stories of houses that were not completed, and of relatives who used the money for themselves. Aurora told me she periodically asked her husband to send her videos of the improvements on the house, to make sure the work was really being done.

Transnational motherhood

Migration alters traditional roles, the division of labour and meaningful categories of gender construction**.** Sustained unemployment in Peru has eroded the role of man as the economic provider for their families. Women, as a consequence, cannot rely entirely – or often at all – on men for the family economic support. Therefore, they have taken on a full productive role. However women's migration endeavours, in this context, does not seem to clash with their moral commitments as mothers. On the contrary, it is in response to this commitment that women have migrated, leaving their children behind.

The value of motherhood among migrant women seems to have been transferred from their physical presence of raising their children at home. Similar to what Hondagneu-Sotelo and Avila found among Latino women in Los Angeles, transnational motherhood for Peruvian women is not based on physical circuits of migration, but rather on "circuits of affection, caring and financial support that transcend national borders" (1997:550). Motherhood for Peruvian migrant women now extends to providing for the economic support of their children – even when this responsibility involves leaving them behind, left in the charge of other family members. The redefinition of motherhood among transnational migrant women as Pareñas found among Philipino women and Hondagneu-Sotelo and Avila among Latino women in the U.S. is so that "rather than replacing caregiving with breadwinning definitions of motherhood, they [migrant women] appear to be expanding their definitions of motherhood to encompass breadwinning that may require long term physical separations" (1997:562). Existing cultural patterns of collective motherhood prevalent among Peruvians are well established in Latin American cultures. Reliance on grandmothers and compadres for shared mothering comprises an emotional and practical resource for Peruvian as well as other Latino women, one that "facilitates the emergence of transnational motherhood" (Hondagneau-Sotelo & Avila 1997:559). Peruvian women rely on such support when making a decision about migrating. It is the cultural legitimacy of this kind of 'collective motherhood' that enables women to excercise a transnational motherhood while simultanouesly rely on the physical presence of other female members of their extended families who take an important role in looking after children and child rearing.

Transnational fatherhood

Unlike women, for some men, a break-up with their partner in Peru may also mean the interruption of their role as provider for their children. After a break-up with his partner Marlo changed his priorities.

> M: I totally forgot, I said to myself. *Why should I work? What for? Why should I be sending* (money)*? I am going to have fun, motherfucker!* I began to buy clothing for myself. At that time, I did not live in El Bosque any longer. I had moved here (into a compound). Things that I bought for example… I bought myself a TV set. It lasted one and half months and pum! I gave it away. I bought myself a music set. I had it two months and I gave it away; a microwave the same.
> L: Who did you gave these items to?
> M: To friends that were drinking with me. They would tell me: *How nice, my brother. Shit, I earn so little, not like you. You earn fine. How I wish to buy* (this) *for myself.*

Many men, however, continue to provide for their children through remittances. Unlike with women, for Peruvian men, as has been found by Parreñas among transnational Philipino households (2005), fatherhood in the context of its associated gender definition has not been redefined. Exerting a distant fatherhood mostly consists on finding ways to reassert men's authority within the household. In cases where men stay behind in Peru, they are left with the responsibility of looking after the children. In those cases though, there will be a woman relative playing the role of a substitute mother. Parreñas' findings are applicable to the dynamics found among Peruvian migrants in Chile, similarly then it is possible to assert that "the expansion of mothering duties in transnational families increases the work of women, in the same way that narrow constructions of fathering limits the responsibility of men" (2005:47). As Parreñas discovered, fathers left behind get away with having fewer responsibilities than the mothers left behind" (ibid).

6.3 National and gender identities

> "People from the jungle, the indigenous there, they eat snakes," said my neighbour Luis – with a distance conferred by his coastal urban identity – referring to Consuelo, who is originally from the jungle. "She is very stubborn; because she is *serrana*," said Luis, Ñato, and Graciela who are also urban, in reference to Angelica who comes originally from the *sierra* (mountains).

In general, this community of migrants shares great commonalities. Mostly, they are *mestizos*, speaking Spanish as their first language. The majority is Catholic, urban and has had access to formal education. In addition, they come from low or lower middle income families. However, regional, racial and class differences also appear to be relevant within the migrant community and eventually emerge.

> *El Ché,* the Peruvian man who had lived in Argentina for sometime where he acquired a strong Argentinean accent arrives and joins us. We have been talking about everything and nothing in particular. He shows us photos from Argentina and Peru. It is clear that he was better off than the others, in the past. During the conversation *el Ché* establishes and marks the difference between him and the others in the compound. He explains to me that the *polladas* are of the *barriadas* (shantytowns) and not of the higher social sectors in Peru.

> Then Tania enters my room, smoking and dressed in a tight pink t-shirt that shows her bared – and bulky – midriff. She tells *Ché* that her friend has failed to her. *Una punta* is the world she uses; meaning a friend to travel with to Peru at Christmastime. These trips average three days and any thing can happen, they all assured me. "Robberies; people rob a lot at this time of the year, and in addition to this, they drink a lot too". I asked where does it happen? "*Everywhere",* they answer. They agree that Christmas is an especially dangerous time.
> *El Ché* then tells me that to say *una punta;* it is using the language of the *achorados*, meaning that it is low-class, *lumpen* jargon. Tania does not acknowledge Luis' explanation, as he continues outlining, in depth, the differences between the people of the *barriadas* and himself.

Existing internal differences as well as boundaries are also negotiated. Marlo, referring to his fellow Peruvians expresses himself in this way:

> They (other Peruvian men) get angry (about not having good jobs in Chile). But when they have jobs, they don't look after them. That is what makes me upset. I get *colera* (anger)! Why don't they look after their jobs? When there is a moment to drink, one can drink. Over the weekend, I think, Saturday night you can get drunk; Sunday not anymore, because you have to go to work. The jobs (available) here in construction are heavy. Why are you going to start drinking on a Sunday? Well you can on a Sunday drink half a day, no more. But these ones, they throw themselves (into alcohol) *pucha*! It looks as if the world is going to end!

While *el Ché* is aware he belongs to a different social class, Marlo holds a deep criticism towards his fellow country people. Yet, the need to provide for families left behind brings migrants, with their varied identities, together in a space of close and intimate interaction. Maybe for the first time, they are confronted with the need to withhold their differences and recognise each other as the same – and hopefully, an unproblematic – national identity.[91] In this context, food plays a central role.

6.3.1 Food and national identities

Although I did not focus on food initially, in my observation of this community, the importance of how community members' lives were structured around food became more apparent. It became evident general concerns about their well-being, about health and illness in particular, were often expressed in the language of food. This is done by talking and recalling memories of meals, cooking and eating traditional food. Food seemed to be the 'centrepiece' around which the migrants' collective lives were articulated.

As such, it proved to be a path into the subject of strategies to maintain migrants' well-being, which I was investigating. Food sharing made up a substantial part of practices and rituals performed in the close community. This corroborated in practice as well as symbolically, their sense of belonging to a community. As Cohen put it "the reality of community lies in its members' perceptions of the vitality of its culture.

[91] During the time I spent in the compound as well as among Peruvians in general, the issue of politics – which in Peru itself creates great division – was never raised. Ñato for example, would never disclose in front of his fellow country people his own political involvement in the past. For him, talking about politics was to be avoided at all costs. In contrast, food talks did not appear as a problematic component of Peruvian national identity.

People construct community symbolically, making it a resource and repository of meaning and a referent of their identity" (Cohen 1985:118).

Food talks

In general, Peruvian migrants very often complained about having to eat frosen food, or food that was cooked some time ago and stored for days. They complained that food consumption in Chile was restricted to indoor venues as opposed to street eating venues in Peru. Street vendors are common in Peru and provide freshly cooked food. Migrants also complained that Chilean people eat very little and rush through meals. Chileans were also accused of eating tasteless, insipid, junk food. These migrants felt seafood available for consumption in the Chilean markets is not fresh. For example, in Chile, fish is frosen and transported to the city days after being caught. Rather than debating on the veracity of such statements, I would like to reflect on what seems to underpin migrants' opinions. Ultimately, it was the clash of ideas and principles of what is good and healthy food that was the greatest problem for them. These clashes, I will argue, helped them to draw their boundaries as a national community and to reaffirm themselves in opposition to the society in which they are living.

Even though the actual act of eating is central, talking about food seems at times to be even more important than what they actually ate or cooked. Furthermore, as observed, the ability to cook traditional Peruvian dishes was often limited by the availability and affordability of obtaining the necessary ingredients in Chile. However for migrants, eating real Peruvian food in Chile seems to be impossible. Whenever they used similar Chilean ingredients, as opposed to the authentic Peruvian ingredients, the migrants often commented that Peruvian dishes cooked with Chilean ingredients never taste the same.

The importance of talking about food became more evident to me while sharing the living space with the migrants. It was the length and frequency with which people engaged in food-related conversations and the vivid character of their descriptions which lead me to suspect there was something else being stated. When conversing about food. This had to be something which transcended actual food but at the same time was intimately linked to migrants' bodies, self and identity. Food talks appeared to be central to the community as experienced by its members. Community, in this sense is not here understood as a social structure but rather as a symbolic construct. Or as Cohen has put it, community is "the thinking about it" (Cohen 1985:98).

In fact it was interesting to note that while talking about Peruvian food, there were no internal clashes. Neither regional antagonism, nor class, nor gender hierarchies came into play. Women and men participated equally in the discussion, as well as people from the sierra and from the coast. Each participant seemed free to add comments to the collective picture. They used their own culinary experience and subjective preferences as well as memories of meals, recipes or fruits they used to eat and dishes they used to cook back home. Each element would be celebrated and included without opposition. It was as if each one was allowed to bring into this evocative scenario, their regional specialities and these memories were taken with pleasure into everyone's repertoire. In addition, accounts of the variety, size, colour, taste and nutritional value of the food produced in Peru were often presented as proof of the richness of their homeland. Such

things were offered up as proof of the goodness of Peruvian nature and the abundance of its diverse landscape.

It appears what migrants actually evoked through this collective remembrance was a primordial element of their cultural identity assembled in the palatable texture of their traditional food. As a result of this exercise, it would nurture a positive relationship to their common native soil, as described in the next account.

> *Vivir al lado del mar es mas sabroso…* (Living near by the seaside is more delicious) were lyrics sung by Tony in between courses during a meal shared at the migrants housing compound. He sang in remembrance of the delicious fish eaten in his coastal hometown in Peru. Migrants also recounted then that in Peru, even with just a little money, a fresh, big fish could be purchased. "The fish are so delicious, fresh… as if they just jumped out of the sea".
>
> *Field notes, January 2003*

In contrast, comments about Chilean food inevitably led to the undisputable conclusion of the superiority of the Peruvian food. The dynamics of these food related conversations reveal how feelings regarding their national identity are channelled. Conversations around food were frequently held while talking about Peru. Memories of Peruvian cuisine were connected with a feeling of nostalgia and longing for being back in Peru. Through the language of food, migrants constructed their collective sense of selves, which was explicitly informed by contrast with regards the others' (Cohen 1985); in this case Chileans.

Conversations about food always occurred while sharing a meal with other migrants. This also happened while shopping for food products, when two or more people engaged in such an activity. Whereas with me, a Chilean citizen, these conversations took on another aspect. They tended to be more descriptive of the size, colour, and taste of vegetables and fruit, and quality of the meat produced in Peru, since it was implicitly assumed that I was not familiar with it.

In my opinion, such comparisons helped the migrants to reposition themselves in their unbalanced relationship with their host country. The interpretation I propose here is that remembering and appraising Peruvian food and Peru's natural resources allows migrants to strengthen their common cultural identity. It also allows them to reconcile themselves with a country which has been steadily 'expelling their people'.[92]

By placing emphasis on what the Peruvian natural environment gives them, Peruvian migrants acknowledge belonging to a country that – despite its many problems (unemployment, corruption, political instability, and violence) – remains faithful to its people and can provide for its population. As Demetrio, who was once a fisherman in Chimbote, often said: *en Peru nadie se muere de hambre* (in Peru nobody dies of hunger). In contrast, the harshness of Chilean society is expressed through deriding the lack of Chilean natural products, specifically its colourless and tasteless food. Chile is seen a country which gives them jobs but does not feed them.

[92] It is estimated that more than 2.6 million of people make up the so called "Peruvian Diaspora". In the last two decades, Peruvian citizens have been steadily leaving Peru, migrating to various countries in Europe, USA and Japan. In Latin America, Peruvian migrants have mostly migrated to Argentina, and Venezuela; and only lately to Chile (Berg & Karsten Paerregaard 2005:11-34).

Cooking and gender relations

Transformation of the foreign world into their own Peruvian space took place in the compound. Together with music**,** food was central among the various elements used by migrants to make an inhospitable building a home. Migrants gathered around food and enjoyed eating in their own Peruvian way. As in the case described next, food helped to create and enact the social world which supported migrants' well-being and restored the ability of the community members to act, outside the foreign world. It also allowed these migrants to consolidate their relationships as neighbours. However, other relations, such as the traditional sexual division of labour were not transformed. Cooking has continued to be 'a woman's task'.

> As the Christmas celebrations was getting closer, my neighbour Lucho, proposed to Ñato and me that we organise a *pollada* to gather money for Christmas presents for us and the 4 other *vecinos* (neighbours) living in our corridor. Ñato proposed to invite all people in the house to participate. Lucho was opposed to this, arguing he did not get along with some of the people there and that he knew in advance, some of them would not cooperate and would get the Christmas gifts anyway. He did not mention names.
> Lucho was unemployed at this time and he could foresee how sad it would be spending Christmas without any money to celebrate. A *pollada* was a feasible way to pull resources together and give nice presents to our closest neighbours. He counted on the help of his partner Rosita to cook the *pollada.* So, he suggested the chosen day should match Rosita's day off, which only happened every two weeks.
> Lucho said he would convince the neighbours and give them tickets to sell. With the ticket money, he would buy the ingredients for the menu. Lucho emphasised meal portions should be *"*one quarter of a chicken per person, not less*",* stressing this would be a 'real' *pollada* like the ones in Peru.[93]
> Tasks involved in the preparation of the *pollada* were several. Firstly, we had to get the housing committee's authorisation, produce the invitations and spread the information among the people in the neighbouring buildings. Lucho and Ñato did the shopping from the nearest supermarket. The cooking and serving was done by Rosita and involved a Friday evening and the whole of Saturday, with the occasional help from us the neighbours in the corridor. The day of the *pollada* was spent frying, serving and cleaning up from 10:00 in the morning until 5:00 in the afternoon.
> Throughout the day, people popped in. They sat on the chairs placed along the corridor, ate and chatted for a while. Some complained and left disappointedly since alcohol was not sold and music was not being played. This was a condition imposed by the administration committee when authorising the *pollada* to us. The money generated from selling the *polladas* amounted to $100 Dollars, US. The profits were invested into six Christmas grocery baskets.
> When the money was put together, Lucho went to purchase the groceries. We agreed upon meeting at his room two days later to make up the packages.[94] We used cardboard boxes wrapped in transparent paper. Greeting cards proclaiming Merry Christmas was included with each one. Afterwards Ñato, Lucho and I, ceremoniously knocked at each one of the surrounding neighbours' doors. After formal greetings were exchanged, we delivered the packages to the smiling recipients as they stood in the corridor. We made these deliveries without Rosita, as she had already returned to her work. However, nobody bothered to ask about her. After receiving their gift packets, each person quickly returned to their room, and that was it!

[93] See endnote.
[94] See endnote.

> Although the dispersing of gifts was a rather short ceremony, it gave us three a feeling of having achieved what we planned. And, in the end, to some extent, the 'spirit' of Christmas was created.
>
> *Field notes, December 2002*

The task of cooking was allocated to a woman – Rosita. She was burdened with the mission of cooking for 80 people. She probably felt powerless to oppose being allocated this task and had no alternative but to devote one of her few weekends off to additional domestic work. Actually, her role was central to the success of the *pollada,* which generated the cash resources to purchase Christmas presents for the neighbours. She contributed to the construction of social relations among people with whom she only spent one weekend every two weeks, as she really was not part of the "neighbouring" relationship. Still, the housing compound and her partner's room were the only places she felt were "at least a little bit of her own". However, the invisibility of her role and the lack of recognition given to her, in the relations constructed, were evident in the end. The ceremony of distributing the Christmas presents to each of the neighbours was carried out without Rosita's presence or acknowledgement.

The task of cooking and the responsibility of feeding in the context of the Peruvian culture are assigned to women within the current traditional sexual division of labour. Men's work is deemed to be more demanding and difficult than what a woman does. According to it, man, the breadwinner demands from woman. The housewife, therefore, must care for her man's well-being and support him through feeding. This will restore his exhausted strength. He is also entitled to the greatest share of a "right diet," meaning his needs come ahead of the rest of the family. Doing this assures the replenishment of a man's potency and protects him from getting sick. A good variety of dishes and a well-balanced nutritional meal are vital for maintaining the hard worker's good health. In the following quote, a migrant man became furious at his partner who failed in her duties. She had been feeding him with the same meal over and over again. He accused her of putting his health on risk, by giving him an inappropriate diet. The lack of variety rather than nutritional value was cited as probable instigator of illness, placing the economic stability of the family at risk. His suspicion of what she was using the family's food budget for, made him even more violent.

> One evening I came back (from work), my daughter was playing. And she (his spouse) says to me: *Take it*, *a stew,* (to what Marlo responded) *you son of a bitch! Who the hell* (do) *you think you are?!!* (He reacted very angry) *I give you money every week and you give me this…!* I threw it away, into the garbage bin. *I am fed-up! Son of a bitch! Every day, stew! Son of a bitch! What do you do with the money?*
> *But Marlo...!* (His wife said to him.) *I do it with affection.*
> *What affection is this shit? You should care for my health! I get my ass out working, and what for? You should care for me!* (mimicking an angry voice). I told her: *What if I get ill? Who the hell is going to go to work? Who is going to support you and the baby?*

Migrant couples tend to act in compliance with this order as long as men are involved in paid work and the women are not. In this new context, the task of cooking tended to be assigned to women. And, often relationships among migrants were initiated and consolidated through a woman cooking for a man. Women have the opportunity to take advantage of their role as "the cook". In this way, they can use food as a means to

exert influence over men. This is because migrants believe food has an influence on their behaviour.[95]

However, one of the consequences of involvement of migrant women in paid work is change in the traditional order. In some cases a gradual redistribution of the traditional gender assigned tasks had taken place. So, for many couples, feeding each other tends to be seen increasingly as a mutual obligation. In situations where food sharing was not based on family relationships, negotiations had to be carried out among men and women as well as the various resources and tasks involved. In the compound for example, shopping, cooking, washing up were assigned independently of gender and men eventually participated in cooking duties. Lucho, who knew how to cook, would do this for himself and for Ñato during weekdays, when Rosita was not there. At this time, both men were unemployed and spent much of their time at the housing compound.

Although the sexual division of labour is now challenged and this forces men to take part in "female" activities such as cooking, still men – even the younger ones – in the compound were ashamed of being seen cooking. Demetrio junior (14) and Marcos (20) did cook meals and, as I heard it, they did it quite well. However, they considered such activity to be embarrassing as they were doing "woman's" tasks.

Traditional Peruvian gender order is further altered by the influence of Chile's own gender order. Gender relations among Chileans prompt a more equalitarian distribution in the sexual division of labour among Peruvian migrant couples.

6.3.2 Gender identities

The current international migration has created a new scenario for changes in gender identities and partner relationships. One reason for this may be found in the leading role women have taken on in this migration. The sustained economic crises in Peru forced women in great numbers, to search for means of survival outside the home. As this particular economic crisis persisted and employment became even scarcer, women have since seen themselves compelled to search for other means of survival outside the country.

Contributing factors inducing women to migrate abroad are economic niches available for them in domestic service in various host countries. The existence of consolidated communities of migrants living outside Peru facilitates the "settling-in" process in the destination country. As a result, an unprecedented number of women have taken on these endeavours alone. Men in these arrangements are left behind in Peru, waiting to be called upon by their partners when a suitable job opportunity comes up in the host country.

This section discusses changes in gender identities and relations occurring as a result of the dynamic of this migration. Migration often reshapes gender relations with a relative increase in women's power as documented for Mexican migrant women (Hogendau-Sotelo 1992) and Puerto Rican women (Alicea 1997) in the U.S. This

[95] A soup made of fish heads called *chilcano,* for example, is believed to especially influence men's sexual drive.

section examines the changes derived form women's engagement in the labour market as well as the influence of the host society upon gender relations. It also looks at the conflicts derived from this interaction. Specifically, it examines men's attempts to assert their general authority as well as the forms of control they exert over women's sexuality, as women gain greater freedom in Chile. Another gender dimension addressed here are changes in body image migrants experience while living in Chile.

The effect of women's economic role; between emancipation and obedience

There is an outstanding presence of women among Peruvian migrants. Most of these women migrated, pursuing the primary goal of sending remittances to their families in Peru. The survey showed women not only outnumber men but also they are first to arrive in the country. Typically, after having gained job stability and a sufficient income, they bring other family members to Chile. However in many cases, women prefer to sacrifice themselves and endure the situation of living without their families and work as long-term live in-nannies, perhaps for several years. This is often done to save enough money to eventually return home. Most women who visited over weekends, who came as weekend visitors to the compound, were in that situation

> Lili was a woman in her mid-thirties who came from Chimbote. She worked as live-in domestic and had already lived in Chile six for months. She used to spend her Sundays at the housing compound and often stayed at Ñato's room. I remember the first time I met her. It was a cold Sunday afternoon and she was lying squeezed onto Ñato's bed with two other women friends and Ñato himself. I walked into the room.
> Ñato formally introduced us by saying: *She is an anthropologist writing her thesis. She is studying us: the Peruvians migrants.* Lily replied by asking me: *Migrants? Are we migrants?* Uncomfortable, I said: *Yes, I am studying Peruvian migrants who have come to Chile, like you, to work.* This was the first time Lily had heard this term and certainly was not happy to be referred to in this manner. She made the point very clear to me. *Do you know,* she continued, *we are going to leave this country? We are not going to stay here!*

She did not want to be labeled a 'migrant' in my study. She warned me that if I counted on her as a research subject, she and many others like her would most likely disappear. No matter how much I attempted to engage her as a "subject of study", Lily, like many others I classified as 'migrants' were actually ready to leave the migrant life as soon as they possibly could.

One Sunday after that, Lili told me how she planned to cope with the situation she was currently in.

> I want to resist (leaving) Chile and do not go back to Peru, because I want to leave (Chile) and do not come back (forever). I saw one friend of mine who, after short holidays in Peru, came back even sadder than when she left. She was crying and crying so much…

Thinking of her having to return to her current situation after spending some time in Peru was something Lili could already foresee as being very difficult. "Knowing that now whenever I talk to them (her children) on the phone, I go back to my room and cry there". The economic situation in Chimbote is so bad, that for her, returning home for longer than "just a visit" was not possible. There are no jobs there. Even though her husband was employed, the money he made was not enough to support the family. Lili

migrated because of her family's economic need. She explained the way she managed her finances and what her goals were. From her salary of USD $280 each month, she was sending USD 260 to her family.

The money sent home was used for the family's maintenance and her children's school fees. However, she wanted to invest in goods to take back to Peru, to make her efforts more visible. In the previous month she had sent only USD $100, and saved $160 to buy a refrigerator and a stereo to take with her when she returns to Peru. The months she could do this were the ones with no extra expenses such as school fees, materials, uniforms, or health-related expenditures. These extraordinary expenses were paid out of the remittances she sent. Besides the cash she sent every month, she bought clothing for her children. So in the end, every month she is left with just US $20 to spend on transportation and food for the Sundays when she has the day off.

Lili, and many other migrant women like her, would have preferred to remain with their families in Peru. But, despite being caught in a quite constrained position, Lili – and other migrant women in Chile – enjoy certain economic autonomy in deciding how the money they have earned is to be used. Women's participation in paid work also involves exposure to a more 'liberal' environment and allows them greater autonomy as compared with their situation in Peru.

Women's increased autonomy however, may be only apparent or in some aspects greater than in others. Guarnizo has pointed out: "Instead of being a social equaliser that empowers all migrants alike, transnational migration tends to reproduce and even exacerbate class, gender and regional inequalities" (Guarnizo 1997:45).

The complexity of the way transmigrant women renegotiate power shows that "while migration may provide some opportunities for enhancing women's status, such processes are not inherent within migration" (Yeoh 2004:149). In transnational migration women continue to maintain connections with their homelands– kinship networks, with religious and cultural traditions. In these contacts, patriarchal structures which limit women maybe renewed. For these women, living amidst their community involves exposure to various forms of social control. Such control is exerted on account of continuous contact maintained by members of the community with their families in Peru.

An example of this can be found in the ideology which legitimises and values women's lack of knowledge and experience in sexual matters. This continues to prevail among female migrants in spite of the fact that, in Chile, they do have more freedom. Among gender constructs, there is the commonly accepted notion of a 'decent woman'. This is somebody who does not know anything about sexuality and contraceptives until she is married – be it a legal or socially consented union. Therefore, information and decision-making about sexuality and reproduction is only legitimate for women to obtain through a man (her partner), in the context of a socially consented union.

> Among the varying questions I was asked, I was actually surprised to be queried several times by women in the compound whether I was a *señorita* or not. By that question they meant whether or not I had sexual experience. This is because they knew I was single. Tania once even gave me her advice on the matter. I should never tell my boyfriend that I am not a virgin, because if I do, in the future he may bring that information up and use it against me.

Field notes, November 2002

Family control on the younger women and particularly in regard to her sexuality, is to some extent, lost when women migrates. This is either because the family is not there to exert it – or because involvement in paid work gives a woman more opportunities and independence to interact with men. As do other migrants, young single women often take part in the migrant community's social gatherings in Chile.

Women in Chile, opposed to the limitations imposed on them, at home in Peru – see themselves enjoying more freedom to take their own decisions, to explore the 'outside world' and to engage in more liberal behaviour. This behaviour is more of a norm for women in the new cultural context. Examples of this include: going out to dance in groups of only women, or to smoke, or to drink in public. Needless to say, the possibility of freely engaging in this behaviour as well as in love relationships – which are not been censored by parents or males in the family – is now open for women, but has always been available for men. Nevertheless, in the face of these new opportunities for women, "innovative" forms of control of them have been put into place.

> Johnny knew Olgüita's partner and family back in Chimbote. She felt obliged to be *nice to him* by buying him beers to keep his silence about her activities in Chile. – Olgüita liked to go out to dance and this could be construed that she was being unfaithful to her husband, even though she was not. Migrants were often caught by surprise with a phone call from Peru, asking if the stories the family had heard about them were true or not.
>
> *Field notes, January 2003*

According to the traditional patriarchal order, men in Peru generally exert the most authority. However, this Peruvian norm has some exceptions.

> Don Hugo and *Señora* Angelica are from Pacasmayo. As people in the compound say, they are *serranos* (from the highlands). As a *serrana,* she is considered to have a very difficult and strong character. Neighbours comment that Hugo lets himself be dominated by his wife. This is absolutely not the norm among women from other groups originating in Peru. However, for Peruvians, one sign of *Chilenizarse* (to become like Chilean) happens when a woman begins to "boss" her man.
>
> *Field notes, November 2002*

As they call it, a process of *Chilenización* takes place in terms of gender relations[96] that is when women become more autonomous and men get involved in domestic labour. Elena tells her experience.

> E: I see here is different. Many times I have been invited by my Chilean colleagues, I go to their houses and I see their husbands helping them to do the laundry… When I saw that, I was left with my mouth open. I was so, so surprised looking at him; how he was doing the laundry. And then, my friend she was talking to me, and I

[96] The term *Chilenizarc*e has also other connotations. It was used for the first time in the context of the annexation of Peruvian territory into Chile as a result of the Pacific War, in 1879. The *Chilenizacion* of these territories involved as a deliberate policy implemented by Chile at the time aimed at and incorporate the territory into the Chilean domain. Measures taken at that time involved relocating the Chilean population into these new annexed territories as well they imposed Chilean symbolism and icons upon the original Peruvian population.

saw him serving us. He put the kettle on, set the table and then served us tea! Then he sat with us while the washing machine was on… Then I saw him hanging the clothes in the washing line… I got back so excited and I told my husband… and he said ah 'he must be a *saco largo'* (a *long sack).*

L: What is a *saco largo?*

E: A man who is bossed by the woman... I told him *you are wrong*… and then he told me *ah! Maybe he is a'mantenido*' (a man supported by his wife) and then he said *I am not a mantenido...* Few days later another colleague invited me and the same thing, the husband helped the wife in everything. Then here, next to us came to live a Chilean couple, the same thing. He would wax, mop the floors, he would cook, he would wash, and waited for his wife with the house clean and fragrant and he was also working… So I told him is this man bossed by his wife?... – *No* – he said … Now he helps me to rinse, to hang the washing. He helps me to cook, but before he would never. He would sit and say to me: *Elena, a glass of water, Elena, my shoes. Elena, put my socks on. ...*This was while he was watching TV …. So there was no support… I sometimes talk to my husband. I tell him, how can you want me to come back home and meet my obligations with you in our intimate relations if I am feeling tired from working, tired from the home work, tired from everything? …I told him; I don't even feel like saying *hi, how are you?* Now he says: *Elena, we Peruvians, we are wrong. – You see?* – I told him. He was very hurt when I told him if I were single I would be with a Chilean man.

However, while changes do take place they don't necessarily go smooth. One means men use to assert their authority is physical violence. Violence against women tends to be the norm in Peru and it also happens to be the same in Chile. When domestic violence occurs, members of the community will not intervene even in the event of a physically violent fight. However, women soon become aware of the existent legislation in Chile against domestic violence. More importantly, they also learned of the more efficient mechanisms to punish it. Migrant women began to threaten their men with calling the police. In this way, they were able to protect themselves from being beaten. The threat in itself operates as a deterrent for violent men, as they know they will be punished by the police.

Body images

Changing of bodily traits, reflect some of the transformations observed among these migrants. Such alterations often occur along gender lines. Women increasingly begin to dye their hair. Men in turn, acquire tattoos. Younger migrant men living in Chile have taken to wearing an earring and have fashionable haircuts. All these body fashions are common among Chilean citizens.

Greater affordability of new and more fashionable clothing makes it a factor of interest as well as differentiation between migrants and their own community. This differentiation can be observed also among their families back in Peru who are recipients of the items their relatives send from Chile.[97] So wearing the latest fashion

[97] The concept of social remittance (Levitt 2001) provides an understanding of the changes that result from migrants' being in contact with the new culture and society. These may be new behaviour patterns, values or life orientations. The concept of social remittance suggests those changes not only affect migrants themselves but also their environment at home. This means changes can also affect people who may have not travelled outside their home country but are in contact with migrants; thus becoming influenced by the cultural patterns of another society.

item or a trendy brand clearly signals the difference in once having or currently having a relative living and working abroad.

> The Campos family is packing up their room. They are going back to Peru. Amparito, the youngest daughter, shows me the 'hip clothing' she is going to wear when she arrives in Chimbote. She has a pair of pants with strings along both sides of the legs – very fashionable among youngsters. She is also taking music videos of very popular Brazilian groups. This music was played on the radio stations all the time and was called *aché* music. She says she will teach her friends in Chimbote how to dance.
> Demetrio's son then in an angry voice mumbles… *Ah Chileans… they think they are such a big thing*...I know he is not been attending school, so I ask whether he is planning to resume his studies in Peru. *Yes*, said Graciela with conviction. *This one is going to go to school.* And she added, "He is going to do physical exercise. He grew fatter and bigger, largely bigger. In Chile, he has turned into a *muchachón* (youngster). He smokes. He has been invited to drink". Ñato who had entered the room just before said… *Nephew, when are you going to drink with me? You have never drunk with me…*
>
> *Field notes, February, 2003*

In downtown Santiago, there is a lack of public spaces to practice sports. This is one of the reasons why migrant men had stopped exercising as they once had in Peru. However, there were also other reasons, as Ñato once related to me. "Practicing sports involve eating healthier and bigger quantities of food, and this I simply can't afford".

In general changes in body traits reflect an ongoing process of acculturation from their previous uses in Peru to bodily fashions prevalent in Chile. Body size and shape has increasingly begun to be an issue for women. In Chile, they are more often engaged in dieting and expressed a desire to lose weight.

Chame is complaining she has put on weight. She tells me how her mother in Peru, after seeing her in a recent photograph, commented to her on the phone that she must be doing very fine – as she looked more chubby. But Chame felt very upset to be told she looked fatter. After some time, we were joined but a few other younger women in the compound. Maria Elena, Tania and Amparo also said they were interested in losing weight.

> The group decided to start doing exercises and gathered on the open terrace. Directed by Maria Elena's friend who knew some exercises and showed them how do to sit-ups and jumps. They explained their increase in weight was because they said are eating more calories in Chile. While doing these exercises, they were giving each other diet tips.
> One of the more peculiar tips was to wrap plastic bags around one's waist to reduce that area. Several of them were convinced this would melt kilos from the tummies. Chamé admitted that when she does not wear a bra it makes her look like she has lost her shape and gained weight. This exercise initiative, however, did not last very long and I never again saw them exercising.
> Maria Elena finally told me she thinks the amount of food eaten in rural Peru is too much, as compared to what is eaten in Germany or the United States. She feels she is eating better now than she did in Peru because her diet includes more vegetables and salads.
>
> *Field notes, December 2002*

6.4 Frontiers between Peruvians and Chileans

Neighbours' at the compound discussed the differences they perceived to exist between Chileans and Peruvians.

Lili: *Peruvians are marginalised here* (in Chile). *I prefer to keep quiet* (meaning to not to respond to a provocation).

Ñato: *We, Peruvians, like dancing and drinking copete* (alcohol). *But we also know how to show respect,* (far) *more than Chileans do. In Peru for example, the mourning of a dead person lasts an entire year. During that time, one should not dance. Here people do not show the same respect.*

Chela: *We, Peruvians are also more humanitarian than Chileans. In Chimbote, the Hospital gives care to everybody. Here* (in Chile)*, if you don't have Isapre* (private health insurance)*, you must wait 7 or 8 months* (to get free care)*. Here, if you don't have money, you die.*

Demetrio: *But over there* (in Peru), *it is also like this – the Indio of the jungle lives on crops of coffee and cassava. They hunt with a rifle. Over there, there are no hospitals.* (This implies the lifestyle of the Peruvian indigenous people is very basic.)

Field notes October, 2002

As Cohen has stated it "…by definition, the boundary marks the beginning and end of a community" (Cohen 1985:12), and he further asserts "the boundary encapsulates the identity of a community and like, the identity of an individual, is called into being by the exigencies of social interaction" (idem). This section looks at the differences Peruvian migrants perceive to exist in regard to Chilean society.[98]

Migrants expressed their criticism to the informal manners Chilean have as well as the way Chileans speak. Particularly the fact they swear so often in front of everybody was very unpleasant for Peruvians, whom I never heard swearing.

In migrants' view, Chilean youngsters do not show enough respect to their elders. What makes it worse is that, in their view, teachers should not correct them. In addition, school-age youngsters smoke in public and the skirts of schoolgirls' uniforms are short, exposing their legs. This is for them, very inappropriate. Actually, something like this would be unthinkable among youngsters in Peru. Girls in Peru, as always somebody very emphatically would describe "wear their uniform skits at the knee".

Amparo, who is a good student, tells me how she was bullied by her schoolmates in Chile. *They told me that I am Peruvian and they we have come to take the jobs from Chileans*. When I ask her what she says to them she answers, *I don't say anything, but if they beat me I tell the teacher and she punishes them.* She then shows me the booklets Demetrio, her father bought for her to use at school. There is one with the list of Chilean Presidents since the time of the country's independence.

Amparo is learning their names and the years when they were in power. She is memorising them all, as she has to sit for an examination the next day. It is a long list of Spanish names and surnames and does not tell anything to me that I am Chilean. I wonder what these names can represent for her. I ask her if they have discussed the Pacific War in

[98] In general migrants would express their criticism towards the Chilean society in front of me always preceded by asking me to excuse them for expressing these opinions. This however was always done in a very polite way.

her history class, and what happened between Chile and Peru. *No,* she says, *my teacher does not know the history of Peru*.

Field notes, November 2002

Criticisms expressed by the migrants were stated as signs of decadency and corruption within Chilean society. Peruvians see themselves as superior in terms of their values and moral principles. However, migrants also often affirm they admire Chilean society for its hygiene and more developed technology. Women observe there is more respect among men and women. As well, Chileans value a more equal relationship between men and women than do Peruvians.

6.4.1 Migrants' change of status in Chile

Economic migration is basically the search for better economic prospect – for a new and better future life 'somewhere else,' outside Peru. Migrants depart on their economic endeavours, often motivated by illusions and expectations of new, bright horizons that will open to them, securing their families' economic survival. Perhaps such expectations are something inherent to every migrating endeavour.

However, once in Chile, migrants realise opportunities available to them are quite limited. As it is often the case, migrants experience a lowering of their social status. This became clear when comparing their current employment situations with their educational backgrounds or previous labour experience. For women, job opportunities are absolutely restricted to domestic work. However, men do have more jobs available to them but always, they remain within the lowest strata of the labour market.

The lack of opportunities and bad working conditions often deflate migrant's earlier expectations. In the long term, if such adverse circumstances continue, this may damage migrants' sense of self-esteem and self worth. In this section, some of their personal experiences working within the Chilean labour market are discussed.

Peruvians working in Chile are often presented with tasks that they feel undermine their sense of self and dignity

Don Hugo is a professional manager he studied in the University in Peru. Yet his first job in Chile was in construction. It was a job he described as involving *brute strength.* As he is very thin and rather short, this kind of work was not physically suitable for him. He remembers with certain ambivalent feelings that, considering his lack of physical strength, he was not given the most difficult work. However, his Chilean boss used to tell him, in a rather mocking manner, *lets' see Peruanito, is it hard the work or not?* To this, he would answer: *Yes, but not as hard as it is in Peru.*

Field notes, November 2002

As a qualified mechanic Luciano knew he had more options. He refused to accept tasks below his qualifications.

Luciano remembers his previous job, which he quit because he was asked to lift sandbags. He refused saying: *I am a mechanic and not a loader.* Luciano lives with his son in Chile. His son was a medical student in Peru who now has suspended his studies to make some money in Chile. He now cleans cars.

Field notes, November 2002

Ñato's case illustrates the difficulties migrants have in achieving any improvement in their working conditions. He, over the years, has gone downwards economically.

> After 7 years of work Ñato has barely accumulated any wealth, nor has he saved any money. It seems his economic situation has actually worsened over that time. In fact, as he has told me, he has moved house several times, but has never lived in worse material conditions as they exist in the migrant housing of Bandera Street. Furthermore, he told me, he did not want his family to know where he was living, but one of his brothers unexpectedly came to visit him from Peru and found it out.
> Soon after, I came in contact with him and the migrant community. He got fired and spent three months formally unemployed. However, he worked as my fieldwork assistant. He used to work as technician's assistant, installing air-conditioning equipment.
> He earned the minimum wage in spite of the many promise s initially made to him by the firm. After four years of working, promotions, training and wage increases were never executed. The only thing he got from the company, as he disappointedly gave evidence by showing me kind of improvised certificate of recognition. Here, the firm states his status of "a trustworthy worker". As time clearly showed, improvements to his working condition never took place.
> Later, he and two co-workers began to engage in "pololos," independent casual work, often done to complement a scarce salary. Although this work was done in their "off time," the employer learned of their activities and the three workers were fired. This was because the firm considered them to be engaged in "disloyal practices". Eventually, he found work again but he was not satisfied with the salary or the working conditions. Although I asked several times, he did not tell me what kind of job he is doing. He was probably ashamed of it.
>
> *Field notes, December 2002*

Migrants in Chile, often go through degrading experiences, as Mary recounted. "I had to sleep on the floor at a friend's place, something I never had done before in my life". These experiences are especially shocking to migrants when they first arrive. I spent several days in the office at *Parroquia Italiana*, a Catholic Church which helps Peruvian women find jobs as domestics. I remember Miriam. We talked while she waited to be called for an interview. Previously, she worked in an office in Lima and had tertiary education. Now she was going through the shock of being *'a nanny'* in Chile. It was her expectation this would not last longer than a few months. This was her experience.

> After two months working in Chile, Miriam lost her job as domestic worker. Her *patrona* told her she could not continue working in the household. This was done without giving her any further explanation. To make things worse, Miriam had already sent her entire monthly salary to Peru to support her two children. She had no money on hand to take care of herself, and for this reason, she was very concerned. This meant it was imperative she find a new job that very day.
> In our conversation, she bitterly complained about how in Chile, the *patrone*s (masters) – a term she strongly disliked because of its slavery connotations – did not treat women well. Her own experience was a good example. In the household where she worked, the family once had an unexpected guest. This was at dinnertime, so to solve the problem; her meal was given to the guest. She felt disrespected and saw this as a lack of consideration for her as a human being. She compared this situation to an occasion when her *patrones* promptly went out to buy dog food when it had run out, demonstrating they had more concern for the dogs than they had for her.

Miriam was also quite critical of the Peruvian community in Chile. She described them as: *losing themselves.* Women working as nannies, she observed, go through so much hardship that *they end up not caring about themselves. You see them after some time in Chile and they start to disregard their appearance.*
Miriam further commented on how people used to tell her: *Go to the disco! You will forget and it will cheer you up. You should distract yourself.* But for her, people just drank in those places. She thought music played in discos and dancehalls was the music of the *Pueblos Jóvenes* (Shantytowns in Peru). *Chicha music* she described it, which she obviously disliked. She added this was the music of the people from the *lowest strata* of society. This for her, was as an example of how, generally, Peruvian people living in Chile had begun to degrade themselves. The day ended and Miriam did not find a new job. That night, she went to sleep in a friend's room in the compound.

Filedwork notes, August 2002

6.4.2 Experiencing discrimination

Varying degrees and forms of violence, discrimination and racism can be recognised as engrained in the relationship between the Chilean society and Peruvian migrants. Acknowledging this adverse climate allows an understanding of the reasons why migrant's social life tends to be concentrated among members of their own community. Indeed, not only in collective housing but also in the places they gather to spend leisure time. These are almost exclusively Peruvian spaces such as dancehalls, restaurants, plazas, churches, etc.

It is very likely this is a means of protecting themselves from the permanent threat to their physical and moral integrity. The simple act of walking on a public street can give rise to discriminatory abuse. To be recognised by their national identity places Peruvians in a vulnerable position. They are often the target of insults and aggressions perpetrated by the Chilean population.

The event described next is eloquent in that it shows how everyday violence and discrimination can manifest. This was an evening where a group of us where coming from a Peruvian dancing spot in Patronato neighbourhood, returning to the compound.

Santiago, Saturday 1 February 2003

Toni, Chamé and I walk down Patronato Street. The night is warm. It is February in Santiago, very calm. It is two thirty in the morning. We talk a little about the dance and the party we have just left.
Chamé: The place is nice isn't it?
Toni: Hey, did you see how don Luciano danced? Did you notice? He dances well doesn't he?
Chamé: And the granny, she's quite old and she really dances well too. What rhythm she has, don't you think?
Lorena: Yes, it's true. – I think to myself: what energy, they've been working all week, they must have been tired, but as soon as we arrived they started dancing immediately.
Toni: ehh. Why don't we.... Why don't we go down this street down here
-Yes, let's go that way...-
The three of us instinctively take another route. We all spot a group about a block and a half away... They look drunk. They are walking down Bellavista Street. I think that they will stop there.
- Let's go this way- I say

I've never walked these streets at this hour. I wonder if it's dangerous. Well, there are three of us, there's a man amongst us, I thought... We reach Bellavista Street with Independencia Avenue without my even noticing it. The group that has been walking parallel to us towards Independencia Avenue has almost reached the same intersection. You can tell some of them are very drunk. Amongst them is a woman. I seem to recall having seen her pregnant. That image of her being pregnant calmed me a bit. We are about to meet the group. There's no way we can take another detour. I continue to talk as though to distract Toni and Chamé, as well as myself.

Chamé: Hey Toni, if they say anything, don't answer back. Please, Toni, don't answer back.

Toni: Okay Chamé, but anyway, what would I say to them?

We continue to walk. I know that Toni and Chamé have begun to fear something that I don't really fear, and I think, could it be that they are exaggerating,

I had my own plan – we will go past the group and then simply head home, to Bandera Street. We will cross the last bit of the park and there we'll be! But then, one of them shouts, quite ferocious and exalted, loud shouts, but who is he shouting at? I try to understand what's going on. I see one of them, a young man, clearly quite drunk. He goes past me shouting and does not look at me. It is now evident, they are shouting at my friends.

Motherfucking Peruvian! Fucking Peruvian! We go on, we cross the street, almost out of their sight. They have stopped a taxicab. They continue to shout. I feel embarrassed, very embarrassed. Toni and Chamé continue to walk and I go from embarrassment to anger. They are almost all inside the taxicab and are shouting even louder now, shouts that are more vulgar and violent....

Man 1: Come and suck my dick you motherfucking Peruvian.

I can't take it any longer, and in a childish gesture I stick out my tongue at them, as I used to do when I got in a fight when I was small.

Man 1: What's your problem, you stupid bitch?

And then.... I decide to let go of my anger and I shout out loud

Lorena: And what's your problem, you motherfucker? I shout, breaking Toni and Chamé's agreement not to answer back. It's just that I felt so embarrassed that I wanted the earth to swallow me, I wanted the abuse not to be directed to the Peruvians. I wished we hadn't seen or heard them. But there it was; the shouts resounding in my ears. I felt that I had every right to walk in the city with my friends. I thought: whose country is this anyway?

Man 2: Peruvian, suck my pigeon… This obscene gesture shows us what he means by his pigeon (penis).

Lorena: Go to hell you stupid wanker….

Meanwhile, he continues to ramble on about the Peruvian sucking his dick.

The other one butts in. Motherfucking Peruvian, get out of our country! You Peruvian sons of whores, and you, you fucking bitch, shut the hell up! He, of course, is referring to me now.

The car is now right beside us as we walk. The heads of the drunks peer out of the windows, their drunken mouths continue to shout. All I know is that Chamé and Toni are walking by my side, I haven't wanted to look at them as I know this is my responsibility, although I know that I've dragged them into it all the same. But now I hear that Chamé has joined me, I hear her scream in very good Spanish.

Chamé: You stupid people! Who do you think we are? You get out of here!!

Chamé then catches on to my swearing and continues Mother-fuckers!!

They've gone now. They are no longer close enough for us to hear them.

Toni says to us: Why did you do that for? And you, Chamé, didn't you tell me to keep quiet? And Chamé says to me: you see señorita? Why I don't go out? We hardly ever go out with Toni... We try not to go out, this always happens. It always happens to us. Always, if I don't give a beggar a coin, señorita, that same beggar insults me: *Peruvian, get out of our country, motherfucker...*

We continue to walk. We are almost next to the building next to General Velasquez Street where a number of brothels, bars, streets are located and taxis stop. We walk briskly until a thin boy, a teenage crack addict, comes towards us and asks Toni for some money.
Toni: Hey boy, I already gave you some money today.
Boy: Go to hell you fucking Peruvian says the boy. He crosses the street and goes back to sit next to another boy next to a brothel whose door is guarded by a thin woman.
I'm not sure why Toni and Chamé have crossed the street to go towards the boy. And I'm thinking to myself what can you get out of talking to an adolescent drug addict? But Toni finds it necessary to clear some things up with him. I am tired, exhausted by the tension we have experienced. I decide to wait on this side of the street.
Tony: Hey boy, you know me. I give you money every day. I let you go into the building in Bandera, and you insult me like this? I'm not going to give you any more money and I won't let you go back in the building from now on.
The boy defends himself but then the woman standing at the door of the brothel intervenes, screaming.
Woman: And you, fucking Peruvian, go to hell. Get out of here, Peruvian leeches.
Chamé: I haven't come here to ask anyone for anything, I've come here to work and I pay my taxes.
Woman: Get out of here, you starving Peruvian.
Chamé: I'm not starving, I work, I earn my money, pay my taxes, no one gives me anything, I earn it with my own efforts. Not like you! I don't have to suck anyone's pinga (dick)!
Woman: Peruvian leech! Motherfucker!
Chamé: Well maybe, but I don't have to suck anyone's pinga.
Both of them continue shouting at each other. I look and think I'm unable to go on. I can't answer to any more abuse. I feel they are now going overboard. I know that I set the pace. I know I influenced this behaviour. I'm not sure what to do. I do nothing.
Toni says Enough, Chamé, let's go.
Two middle aged men have been standing next to a car watching us the whole time and they've said nothing. Chamé notes that these two men didn't intervene at all. She interprets this as though they have supported her. If they didn't support her, they would have said something against her.
Chamé: Señorita Lorena, do you think they understood what pinga means?
Lorena: Of course, Chamé, if they didn't know that word they've figured it out by now.
Chamé: Yes, the thing is that here the word is not common, is it?
I'm exhausted. We go into the building. We go to Chamé and Toni's room and I really feel safe there. I ask them for a glass of water. I sit there with them and think to myself now I know what it feels like to be and to feel protected, safe. I valued the place, the dwelling, the refuge. No one is going to abuse us here. To be Peruvian here has no stigma.

While this event reflects the constant threat the street represents for migrants, it also shows the logic of their own adaptation mechanisms to face aggression and discrimination. In addition, it shows how I, as a researcher intervened, and in an unintended way – exposed migrants to the possibility the event could have unfolded in an even more violent way.

As it was I who set the pace with regards to directly answering, my two friends in last episode confronted the boy. This in turn, led to even more aggression. These issues were addressed in chapter 1 in terms of health consequences of different strategies in dealing with discrimination. Migrants who develop avoidance strategies towards discrimination are not only protecting their own personal security but also their psychological well-being. These are the topics of exploration of the following chapters.

Part III

Migrants' Mental Health Status in Chile: Old and new illness experiences, idioms of distress and Coping mechanisms in a hostile context

Part three explores the surfacing of illness experiences of Peruvians living and working in Chile. Most migrants' emotional distress is directly connected to their experience of being uprooted, of having left their families behind, and of having lost their social/emotional support. Part three deals with migrants' experiences of emotional distress connected to both the displacement of their lives as well as the social and economic exclusion to which migrants are exposed in the host society. Related to exclusion, migrants' emotional distress is linked to the poor living and working conditions they must endure in the new country.

Migrants' social suffering may trigger a variety of forms of emotional distress. Some of these forms are already known and previously experienced by them, while others are new to them and experienced for the first time while living in the host country. The term "emotional distress" is therefore used in this context to refer to a broad range of forms of distress elicited by the group studied. These include *depression*, *stress* and *nerves, heart illness*, *envy*, *daño* and *chucaque.* Migrants belonging to this group were, at the time of the study, not seeking medical assistance.

The three chapters of part three examine experiences and perceptions of emotional distress as well as changes in meanings and forms of managing distress resulting from migrants' interaction with various agents in the new society. They explore the idioms used by migrants in expressing this distress and debate the extent to which these experiences disclose the nature of migrants' relationships with the Chilean society. Ultimately, the impact of this relationship upon migrants' bodies and subjectivities is also here assessed.

Two perspectives are applied in the analysis of migrants' emotional suffering. Firstly, the perspective that sees human suffering and specifically emotional distress as a socially produced condition; as an experience emerging from structures of power and domination in which migrants' lives are embedded. Secondly, the perspective that views emotional distress inter-subjectively constructed, also as an idiom through which migrants interpret, articulate and communicate social experiences of suffering.

Through the chapters I explore how personal narratives convey migrants' 'lived world', their suffering and the action undertaken to manage that suffering. This exploration follows the cross-cultural stance of the anthropology of emotions, which aims at "investigating indigenous definitions of situations of loss, blocked goals and the socially organised response to them" (Lutz 1985:92). The analysis looks at the cultural construction of migrants' goals and motivations emerging from this construction. Further, it examines forms of expression migrants' emotional distress may take in the face of loss and frustrated goals. Concepts of explanatory models, chain complex and prototypes are used as crosscutting analytical tools and are applied to the analysis of migrants' narratives (Groleau 2006).

Chapter seven presents an overview of migrants' mental health status after their arrival in Chile. This assessment includes a measurement of the presence of depressive and anxiety symptoms as defined in standard medical terms among a sample of migrants. Contextual factors surrounding migrants' emotional suffering are considered by establishing the relationship between the presence of these symptoms and migrants' family situation, employment situation, legal status, as well as access to health-care. This chapter also introduces illness narratives of a smaller group of migrants chosen from the previous group and opens up the analysis of migrant's personal accounts which are also explored in depth in the following two chapters. Short biographical notes of the interviewed group are presented at the end of part III.

One question immediately addressed in the analysis of the narratives is how migrants perceive, experience and interpret their own emotional distress. In light of the disruptive effect of migration, chapter seven examines various situations where migrants' emotional distress emerges. The analysis explores migrants' family circumstances as well as their marginal position in the host society. It discusses the extent to which these forms of distress reflect the displacement of migrants' lives as well as broader social and economic forms of oppression migrants are subjected to while living in Chile.

The analysis compares the cultural construction Peruvians made of their own emotional distress in Peru with the construction they have fabricated in the Chilean context. Chapter eight begins by presenting folk forms of distress that can be observed only within the community of migrants – such as *daño, evil eye* and *chucaque,* which in turn, emerge as a consequence of migrant's positioning in a hostile context.

In order to understand the connection between migrants' subjectivities and the effect of shifting contexts it is necessary to look at the influencing components. These are cultural systems, values and meanings mediating the connection between social relations and the individual's affection as well as cognition. Here existent cultural structures underlying migrants' own experiences and explanations of their distress are examined. I investigated migrants' use of the category of 'nerves' as an explanatory model to understand what happens in their bodies while experiencing various forms of emotional distress. Migrants' conceptions of the self-in-relation-to-others are

also examined, as well as how this relation is interrupted by migration, thus causing emotional distress.

Migration also involves coming into contact with new languages and socially organised responses regarding migrants' old and new forms of emotional distress. Chapter eight discusses the process of transformation of expressions of migrants' emotional distress taking place in Chile. The analysis of narratives indicates migrants' expression of emotional distress is moving away from the use of a popular language of affliction prevalent in Peru. Folk categories of *nerves*, *weakness* and *sadness* are being replaced with the use of medicalised language through the incorporation of the terms *depression* and *stress*. These latter terms have been initially appropriated by Chilean people, incorporated into their vocabulary and currently circulating in Chile as popular labels of affliction. However, unlike the Chilean population, Peruvian migrants seem to resist medical treatment associated with these illnesses.

Using an interpretative perspective, *depression* and *stress* are approached as "experienced by the sufferer as a reality (…) viewed as a set of symptoms or a condition expressed and interpreted in local idioms, and using local explanatory frames" (Good 1985:381). The discussion then focuses on the extent to which this new language of distress serves migrants to understand and communicate new forms of suffering as well as adjusting to the challenges of a changing and often adverse environment. It deals with the question of whether or not this language serves to communicate experiences, which result from the power relations in which migrants' lives are embedded in the host country. Specifically, here, I look at their interactions as patients with medical doctors and as workers with their Chilean bosses.

Chapter nine gives an account of both the socially and medically organised responses to migrants' distress in the new environment. Through a brief comparison between migrants' previous and current experiences of distress, the discussion centres on circumstances underlying the current mechanisms migrants put in motion to deal with their distress. This chapter also discusses how notions of masculinity and femininity influence the coping mechanisms used by migrants. Specifically social practices, such as dancing and drinking among the migrant community, are explored and then focus upon the use of alcohol among distressed male migrants.

This chapter also analyses the ways in which migrants' emotional distress is dealt with in the medical sphere as well as in the workplace. In the first sphere, an incipient process of medicalisation of migrant's emotional distress is observed and migrants' strategies to resist this process are discussed. In the latter sphere, attention is placed on women domestic workers.

Forms of managing distress are seen in the context of employer-employees relationship. Among these aspects, difficulties in accessing medical care are often linked to restrictions imposed by employers upon the women's mobility. Finally, this chapter discusses the relationship between idioms of distress and coping mechanisms migrants use. In addition, the effect of this relationship on

migrants' well-being, on their bodies and agency over their distress is discussed.

Chapter VII

Migrants' Emotional Distress in the Context of their Displaced Lives and Social Exclusion

7.1 Introduction

Assesing the mental health problems of Peruvian migrants in Chile must begin by taking into consideration the fact that most remain outside the healthcare system. As it is often the case with migrants elsewhere, in Chile, migrants face multiple barriers to accessing healthcare. These may include illegal status, difficulties in obtaining permission from employers to attend medical consultations, lack of money/health insurance as well as a lack of access to information about where to find help. Access to care is particularly difficult when it comes to mental health issues as there are cultural barriers which foster negative perceptions Peruvians often have regarding psychological consultation. They see this as something unwanted and strange, not as an alternative to overcome their problems. Rather, migrants fear being labeled or stigmatised as 'crazy people' if knowledge of their seeking mental healthcare becomes known by other members of the community.

A culturally sensitive approach to mental health problems of migrants must take into account the above-mentioned barriers. This chapter provides of an overview of mental health status of a group of Peruvian migrants in Chile, through an approach that deals with migrants' lack of access to healthcare. Gathering of the information took place among migrants in their community. This required a process of involvement and building trust between migrants and the researcher. Additionally, the protection of individuals' confidentiality within their own community was vital.

The analysis presented here delves into the intertwined relationship of displacement and exclusion and mental health. This relationship is explored from both an *etic* and *emic* perspective, as well as throughout two levels of analysis.

From an intermediate level of analysis, I examined the mental health status of a sample of migrants. In this group I conducted a screening for symptoms of depression and anxiety. In addition, I examined the test results in its relation to various social variables which characterised this group. From a micro level, I examined individual illness experiences of a sub-sample of migrants, exploring the various social and cultural contexts where migrant's emotional distress emerges.

7.2 Migrants' mental health status

This section starts by presenting migrants' self-reports on their mental health problems since arriving in Chile. These responses were an initial indication of the daunting

problems related to the experience of being a migrant worker in Chile. In the light of these first findings, it became clear to me there is a need to study this area of health problems among this particular migrant community. A subsequent phase of the fieldwork, which is presented next in this section, involved the screening for depression and anxiety symptoms among a sample of migrants. The decision to conduct a screening was based upon the need to assess migrants' mental health status with a medically validated measurement.

Finally, this section introduces a smaller secondary group of migrants who scored high in the mental health test. This group was selected to participate in in-depth interviews. The intention here was to delve into their illness experiences to gather the plurality of meanings migrants give to their symptoms of emotional distress. Through their narratives, these migrants described in their own terms, their symptoms and experiences of emotional distress detected in the screening previously conducted.

7.2.1 Migrants' mental health self-report

The first measurement of migrants' mental health problems was obtained through the household survey carried out in the exploratory phase of my fieldwork. It included specific questions designed to gather migrants' self-assessment of their problems. Almost 60% of the 150 of the men and women in the sample group[99] declared they had suffered some form of emotional distress during the six months prior to the survey. Migrants defined their health problems in their own terms, most commonly as *worrying too much*, secondly as *nerves* and thirdly as *depression*.

The most prevalent answer: 'worrying too much' was elicited in close connection with the way the question was formulated; *have you been worried about your state of mind lately?*[100] However, this response seems to also reflect a subjective and emotional state that eventually – as migrants asserted later in their narratives – can have an impact on the person's physical health. Worrying was described as manifesting in 'thinking too much,' which in turn, caused headaches.

The category of *nerves*, already discussed in the theoretical chapter, refers to a known and prevalent folk category among the Latin American population. This category emerged again in migrants' narratives of emotional distress, and it will be discussed at the end of this section. In the third place response, migrants reported on *depression.* However, migrants' self-reports of *depression* do not necessarily match its medical definition, as the majority of this group had not been medically diagnosed. As well, none of them were receiving medical care for this problem at the time of the survey.[101] The survey's results showed that *depression* was used as a self-identifying category of distress and incorporated into migrants' narratives of their experiences in Chile. This was confirmed further on in their interviews.

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[99] See sample composition in the methodology chapter.

[100] Not only the questionnaire but also the relationship established with migrants should be constructed in a culturally appropriate way. The question about mental health problems could not be raised as such. I approached the mental health aspects of migrants' experiences with this open question, thereby avoiding framing migrant's distress in a specific category of mental health problems.

[101] This information was gathered through a subsequent question in the same instrument.

In order to assess with a medically validated measurement of migrants' emotional distress, a mental health test was applied among a representative sample of migrants. The test screened for symptoms of depression and anxiety.

Depression as a disease is eminently an 'expert, medical construction'. A medical diagnosis of depression generally will be based on the presence of three types of symptoms:

a) Affective (sadness, irritability, joylessness);
b) Cognitive (difficulty concentrating, memory disturbance) and
c) Vegetative (sleep, appetite and energy disturbance).

However, depression also refers to a diversity of categories, it can be a transitory mood or emotion experienced at various times. Depression can also be a symptom associated with a variety of psychiatric disorders (schizophrenia, for example) or it can be a commonly diagnosed mental illness (Kleinman 1985:2).

Anxiety symptoms were also included in the screening conducted. The inclusion of anxiety symptoms was based on three criteria. Firstly in medical terms, symptoms of depression and anxiety often overlap. Secondly, anxiety may also overlap with the self-defining category of *nerves*. Lastly, based on the screening I could discern on whether or not migrants report these symptoms in their narratives. Some of the most common symptoms of anxiety are:[102]

a) Somatic: headaches, dizziness or light-headedness, nausea and/or vomiting, diarrhoea, sweating, numbness, difficulty in breathing, and sensations of tightness in the chest, neck, shoulders, or hands.
b) Behavioural: pacing, trembling, general restlessness and hyperventilation.
c) Cognitive: recurrent or obsessive thoughts, confusion, or inability to concentrate.
d) Emotional: tension or nervousness, panic, or terror.

However, there is an important distinction between anxiety as a feeling or experience, and anxiety disorder as a psychiatric diagnosis. A person may feel anxious without having an anxiety disorder. Also a person facing a clear and present danger or a realistic fear is not usually considered to be in a state of anxiety. Additionally, anxiety frequently occurs as a symptom in other categories of psychiatric disturbance (ibid).

I next explain how the screening for symptoms of depression and anxiety was conducted among a second group of migrants in a subsequent phase of the fieldwork.

7.2.2 Screening of depression and anxiety symptoms

The screening for symptoms of depression and anxiety was conducted among a group of migrants in their community. The instruments applied were: the Goldberg General Health Questionnaire (GHQ-12) and the John Hopkins Check List-27. Background information of the tests and rationale of this method is presented in the chapter on methodology.[103] The screening conducted does not aim to show the prevalence of

[102] www.medterms.com

[103] These tests have been used in international studies and have already been applied to the Peruvian population in Peru. The questionnaires were used in the study and carried out by Pedersen, D., Jefrey Gamarra, Maria Elena Planas and Consuelo Errazuriz (2001). Volencia politica y salud en las

depression and anxiety symptoms among the general migrant population in Chile. Instead, it aims at examining the mental health status of a particular group of migrants.

The sample consisted of 58 migrants, men and women living and working under similar circumstances as the first group, to which the household survey was applied in the first place (Santiago downtown). However, as explained in the methodology chapter this second group lived in a different district of the city (District of *Estación Central*). Migrants in this sample, as well as those in the household survey sample, had not been medically diagnosed at the time the tests were applied.

Table VII-1 Sample Composition

Age	Men	Women
20-24	**8**	**7**
25-29	**5**	**7**
30-34	**7**	**7**
35-39	**4**	**4**
40-44	**2**	**1**
45 -49	**1**	**2**
50 and more	**1**	**2**
Total	28	30

The test results compare levels of distress among migrants according to social variables such as work, legal and marital status, among others. As well, they illustrate the relationship between symptoms of distress and socio-economic variables. This, in turn, allows the outlining of the socio-economic context in which migrants' distress emerges. However it is important to stress that the limited number of cases included in this sample does not allow for statistical significance, therefore the results presented here **can not** be extrapolated to a larger migrant population. Yet, they can be considered as indicative of trends that will require further research.

An additional purpose of the screening was the selecting of a smaller secondary group, who having shown high symptoms of depression and anxiety most acutely, can be regarded as needing professional assistance.[104]

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comundiades alto-andinas de Ayacucho, Peru Lima, Douglas Hospital Research Centre, McGill University, Montreal(Canada), Instituto para la Paz y el Desarrollo de Ayacucho, Ayacucho (Peru), Universidad Peruana Cayetano Heredia, Lima (Peru).
The instrument was translated into *quechua* language and validated among Peruvian *quechua* speaking population. I used the Spanish version of the test given that it is the language used by migrants in Chile. This test had not been used previously in Chile.

[104] The in-depth interviews conducted subsequently allowed me to elucidate the reasons why these migrants, while needing it, did not seek medical help.

The screened group – unless requested – was not provided with their test scores.[105] As it was becoming evident in their narratives, this information would not have assisted these migrants in overcoming their emotional distress in any way. Indeed, labeling their distress with a medical category would have added another burden to their already difficult circumstances. This would have prompted them to unsuccessfully demand care from the medical system. If access were obtained they would have probably been given an inadequate response.

Not informing migrants of their test scores unless asked involved however, some responsibility on my behalf –being available to assist those migrants in finding alternative ways to deal with their emotional distress. However, I was careful not to develop a relationship of dependency. Often by listening to their problems, which they were not sharing with anybody else, migrants felt relieved – being able to express with to me. As it was vitally important, I kept the confidentiality they requested.

7.2.3 Eliciting narratives of emotional distress

The follow up in-depth interview was introduced after the test application was finished as a continuation of the conversation initiated by the test's questionnaire. The smaller group of migrants used for in depth interviews were chosen among those migrants in the screened group. They were the people who scored relatively high in symptoms of depression and anxiety. Their willingness to be interviewed was an additional criteria used in selecting this group. The cases selected in the smaller, secondary group included men and women of various ages, various family situation and migratory experiences. Short biographic notes of the groups selected are presented in Annex 4.

The selection of a smaller group for an in-depth study, allowed for a comparison between the information provided by the test and migrant's narratives of emotional distress. Such a comparison, however, needs to attend to the diverse nature of the information produced by each one of these methods. Thus, while the screening offers information on standards of symptoms of depression and anxiety set by the medical science, the anthropological approach offers insights into individual's illness experiences. It pays heed to people's perceptions, meanings and experiences of emotional distress.

7.3 Symptoms of anxiety and depression and migrants' perceptions of their emotional distress

7.3.1 General results

General results of the tests showed a higher percentage of mental health problems among migrants than in the previous measurement based on the migrants' self report.

[105] Only in one instance did the interviewee ask for her score – and the response was given to her weeks after the interview had taken place. While the interviewee had already been advised by a medical doctor about a possible diagnosis of depression, she was reluctant to accept this diagnosis as a true fact. She refused to take the medical route to deal with her distress. In our conversation alternatives to deal with her emotional distress were sought.

The test showed that 67,2 % of migrants in the sample presented symptoms of anxiety and depression on three levels – moderate, medium and high. Symptoms of anxiety and depression among the total group are distributed in the following way:

Table VII-2: Symptoms of Anxiety and Depression

	None	1st degree	2nd degree	3rd degree
Anxiety	32,5	20,7%	32,8%	13,8%
Depression	32,5	24,1%	37,9%	5,2%

If we consider that second and third degree symptoms in this test are indicative of the need for professional assistance, then it can be asserted that nearly 45% of the total sample would need professional intervention.

7.3.2 Gender and symptoms of anxiety and depression

Gender appears to be a relevant dimension to understanding events associated and dynamics involved in migrants' illness experiences of emotional distress. Various ways, in which gender exerts an influence, are discussed further on. An initial indication of gender differences appears in the mental health test results.

Results show the mental health state of men is worse than that of women. 71,4% of men shows symptoms of anxiety and depression versus a 63,3% of the women. Migrants' score of anxiety and depressive symptoms will be presented separately.

Regarding symptoms of anxiety according to sex, the test showed that men tend to concentrate in the first and second degree of severity of these kinds of symptoms. Conversely, women present higher percentages of anxiety than men in the second and third degrees of severity of these symptoms. It then can be said that symptoms of anxiety are more acute among women than among men in this group.

Table VII-3: Symptoms of Anxiety According to Sex

	None	1st degree	2nd degree	3rd degree
Men	28,6%	28,6%	32,1%	10,7%
Women	36,4%	13,3%	33,3%	16,7%

Regarding symptoms of depression in relation to sex; the test applied showed the men's symptoms were more concentrated in the first and second degrees of depression than exhibited by women. By the same token, women showed a slight increase compared to men in third degree symptoms – the more acute symptoms of depression.

Table VII-4: Symptoms of Depression According to Sex

	None	1st degree	2nd degree	3rd degree
Men	28,6%	28,6%	39,3%	3,6%
Women	36,4 %	20 %	36,7%	6,7%

Percentages indicate that men in the screened group tend to suffer more than women from symptoms of depression but women display more acute symptoms of anxiety than

men. Given the existent sexual division of labour among migrants, one possible explanation for women's relatively higher degrees of anxiety may be found – as it will be seen further on – to be the result of the multiple demands placed upon them, coming from the productive and reproductive spheres. Indeed, as women's narratives will show, the responsibility for the children's well-being continues to rely upon them. Furthermore, this proved to be true in all cases, independently of whether the children were or were not living with their mothers in the host country.

Age and symptoms of anxiety and depression

In general, the youngest age groups in the sample show more symptoms of anxiety and depression than those in older age groups.

Table VII-5: Symptoms of Anxiety and Depression According to Age

Age Groups	None	Symptoms of Anxiety and Depression
20-29	27,0%	63,0%
30-39	55,5%	45,5%
40 and more	33,3%	66,7%

63% of migrants within the 20–29 age group show symptoms of anxiety and depression. Contributing factors to higher symptoms of anxiety and depression within this age group can be found in their lack of social support from family members. Younger migrants are distant from their own families in Peru, and in many cases, they have not yet formed a family of their own. When Javier came to Chile, it was his first time living outside his parent's home. He wasn't use to having to pay his own expenses or to provide for others.

> My sisters brought me (to Chile), but I did not like to live with my sisters… But I just had an aunt (also living in Chile)… *Aunt, can I live with you?* OK, she says. The two first months was OK. The third months so, so, and the fourth month all looking at me bad, bad. That look you have to put money in for this, for that. ...This is not enough… and one has all the pressure that one has to contribute. I had never good communication with my sisters, so that is why I decided to go and live with my aunt.

In the age group 30-39 symptoms of anxiety and depression is noticeably lower. This age group, in general, exhibits a better mental health status compared to all other age groups within the sample. 55.5% of migrants within this particular age group do not show any symptoms of depression or anxiety at all. The decrease in symptoms of depression and anxiety in this group may be related to their marital status. Most of the married migrants are within this age group 30-34 and as we will see further on, marriage seems to be a protective factor in migrants' mental health. Symptoms of depression and anxiety increase again in the older group of 40 years and above. However, it is less clear whether there are family related factors associated to this particular age group which can be influencing the increase in distress.

7.3.3 Perception of symptoms of emotional distress as narrated by the respondents

Symptoms described by migrants, in their narratives, as indicative of *depression* and *stress* are many and various[106]. These affective symptoms include sadness, joylessness and irritability, as inferred from migrants' illness narratives. Indeed, migrants often express that when feeling emotionally distressed, they attempted to avoid social contact, to isolate themselves or escape from their current difficult situation. This might be achieved by locking themselves in a room, by physically going to 'some other place,' or by wanting to run away and never come back.

Vegetative symptoms are also common among migrants and may manifest themselves as 'sleep disturbances.' These can include 'feeling sleepy' during the day or not being able to fall asleep at night. Additional symptoms can be lack of appetite and/or a lack of energy. Migrants express this last symptom as a feeling of *weakness*[107] in their bodies (in their own terms is expressed as: *decaído, desganado, débil, sin energía)*. Cognitive symptoms may also be present but less frequently. Such symptoms are often expressed as feeling *spaced out*, *muddle-headed* or constantly thinking of their problems. Feeling confused and disoriented was also reported.

In addition, migrants also experienced emotional distress somatically. *Depression,* as described by those interviewed is a feeling of uncontrollable trembling in the body, as it will be discussed next; such symptoms are often called *nerves.* Others describe a sensation of a 'knot' in the throat, pain and tightness in the heart, pressure in the chest, resulting in breathing difficulties, headaches and dizziness.

Stress described in somatic terms, can be a feeling a constant pain in the stomach; a sensation of a ball bouncing inside the stomach; intense pressure in the head, headaches or pain in the brain. Other symptoms include stiff muscles, temporary paralysis in the fingers and hands; pain in the (nape) of the neck and shoulders.

It is interesting to notice that some discrepancies appear when comparing the test results with migrants' narratives. For example, while depression appears as a self-defining category of distress in migrants' narratives, anxiety – although detected in the test responses of the migrants – is not recognised by them in their own narratives. Additionally, migrants in this second smaller group also referred to their distress using other folk-forms of emotional distress.

In most of the cases, ten out of fourteen, migrants stated that depression and stress are new experiences they have begun to suffer since arriving in Chile. In two other cases, however, episodes of depression were not new to them; they had experienced it previously in Peru where they had been medically diagnosed. Two interviewees used other categories of distress – heart illness and stomach problems – to identify their experiences of emotional distress.

[106] Table A, B and C in Annex 4 summarise the symptoms migrants experience in their own terms.
[107] The language of *weakness* as well as of *nerves,* was extensively used by migrants to describe what happens in the body as an explanation of their experiences of depression and stress.

7.3.4 Nerves in migrants' explanations of their emotional distress

As seen before, the variety of symptoms expressed by the group in their narratives is wide. However, *nerves* often appears in migrants' narratives as both a symptom as well as an explanatory model of their various forms of emotional distress.[108] As it can be observed, notions of *depression*, *stress* and *nerves*, coexist and overlap in migrants' accounts. Furthermore, *nerves*, emerges as an underlying frame of reference for migrants attempting to understand what happens in their bodies when they experience various forms of emotional distress.

Stress is described by Rosita as a state of *nervousness;* an incontrollable state which triggers several bodily reactions including muscular rigidity, *lack of air,* a decrease in body temperature and even loss of consciousness. Furthermore, *nerves* seem to move (or *jump*) throughout her body affecting specific organs such as her colon.

R: It was like... sometimes something happens to me. That immediately my nerves get taken, and I feel like a lack of air. It is as if air is lacking, as if they were the nerves… My fingers got like this (stiff). I couldn't… I couldn't (move them). They were hard, like rigid.
L: What happened then?
R: The nerves jumped like to the colon. I don't know anymore, I don't remember.
L: And how were you feeling?
R: I was like as if I was gone. I was cold, I got totally cold. My feet were completely cold, cold.
L: Had it happened to you before?
R: No, never before. ...I've heard of it before though, but I had not seen it. That this (the stress) is a nervous state… I never gave importance to it. I was never interested on this issue. I sort of let it go, but now… I don't know.

Even though *stress* as well as *nerves* are both new experiences for Rosita, this last term, *nerves,* appears closer to the experiences of distress she previously had in Peru. And consequently, it helps her to understand the terminology of stress as she has already incorporated it into her language of distress.

The recurrence in the use of *nerves* among migrants, to explain other new forms of distress, is maybe due to the fact that nerves retains a multiplicity of somatic effects. It captures a socio-somatic dimension, linking social problems with physical distress (Kirmayer 1994). The potential of the concept of nerves linking different dimensions together becomes evident as Rosita explains her physical reaction in connection with the challenges of her life. Similarly, Oscar points to the effects his working conditions have upon his nerves. He sees himself as being a *nervous person,* which prompts him to become stressed. At present, his condition of "being a nervous person" is a permanent one. Yet, he stated earlier, he embodied his "nervous condition" during childhood.

I don't know sometimes it (his work) upsets my nerves. It is the work itself, since I am a nervous (person). It is (my work) what upsets my nerves but I try to control myself; not to be so nervous. I am very nervous because my mother, when I was a child, she used to

[108] Explanatory models conceptualised by Kleinman are based on "casual thinking which may involve conventional models, causal attributions or more elaborated models involving specific processes or mechanisms" (Groleau *et al* 2006).

shout at me… And due to that, I became nervous. Sometimes when I urinate all my body shakes entirely.

Felix sees nerves as affecting him in one specific organ. It is undermining his health gradually and causing him physical pain. However, as in the previous case, Felix uses the language of nerves to addresses the relation between the emotional and the physical realm.

L: What do you think that happens inside your body? Can you explain what happens to you?
F: I think are the nerves. For me, are only the nerves or, I may have a stomach ulcer because of my nerves. Because I realise that sometimes I am eating quietly, but I argue with her (his partner) and the pain begins. That is all. The gases increase, and all that. I think that's all.
L: And nerves, did you have them when you lived in Peru?
F: Yes that, yes

The term *nerves* is also used by some migrants to describe other and known forms of distress such as *heart illness*. Cesar describes his health problems as heart illness, and he explains what happens in his body as nerves and tension.

L: What happens in your body that explains your health problem?
C: The nerves
L: How does it work?
C: It is like... I feel like this...with the tension
L: How does it work, if you could explain it to me? How do you feel it?
C: Like a little bit dizzy.
L: Why do you get dizzy?
C: (These are) the same worries. It begins when you are thinking that you want to find a solution in a way and it does not work. And you cannot find a solution, and more it mines you more.

In the case presented above, '*nerves'* is used to describe a state of tension and dizziness triggered by subjective states; such as the continual thinking of unresolved problems. In summary, *nerves* refers (at times) to a condition inherited or acquired which predisposes the person to suffer from stress. Other times, '*nerves'* refers to a specific event; of getting nervous within a more extended experience of depression. *Nerves* as a popular category of distress can also overlap depression and stress and sometimes the terms are interchangeable in common usage.

Nerves, in general, comprise a broad language used by migrants to describe a wide range of afflictions in every day life. In this context, the use of nerves in explaining depression and stress points to the interrelation between the social, emotional and physical realm. There is an additional factor which allows migrants' to use the term *nerves* to overlap with depression and stress. In this usage the psychological dimension of the problem – contained in the medical definition of these categories of distress – is not addressed. As seen in the symptoms perceived by migrants, the psychological dimension of these forms of distress is not present. In other words, *nerves* explaining *depression* and *stress* is congruent with migrants' understanding of physical and emotional dimensions as being central to their experiences of distress.

Overall, the use of the terminology *nerves* to explain what happens in the body, when referring to depression and stress, should be placed in the context where these categories are new language involving "the unknown" for migrants. Through its use, migrants are able to grasp and understand their current experiences of emotional distress by using a known frame of reference. *Nerves* is a central category in the explanatory model used in previous experiences which today act as prototypical for migrants.

In explaining symptoms experienced while suffering from depression, Mary refers to an episode when her *nerves* suddenly 'got her,' causing her body to tremble, losing control of it. The following event describes this.

L: What happened to you?
M: The nerves got me, in my body. I could not control myself.
L: Did it happen when you had a problem?
M: No… It happened all of the sudden… I was watching TV and I felt as my body would start to do like this…like this (trembling), very quickly… I lost the strength and the stability, and I wondered why? And then I remembered my mother when she used to take cold showers (when she had similar symptoms). With her, it would go away and it did work for me too…

The connection of her own current experiences mirroring similar ones that her mother had in the past seems to be a clear prototype which guides Mary's understanding of her distress.[109] This allows her to explain her distress and find the way to cope with her trembling by taking a cold shower. In Mary's description nerves represents 'episodes' framed within a more long-term depression.

Through this present usage, migrants keep continuity between their past and their current experiences. This is particularly important as, by definition, migrants' lives truly are displaced, as they are living far from their homes, in an environment where they lack the safety net needed in times of illness.

7.4 Displacement, exclusion and the arising of migrants' emotional distress in Chile

This section opens the analysis of migrants' narratives by presenting their memories the circumstances that trigger migrant's emotional distress. The concept of chain complex helps to identify the events surrounding migrants' illness experiences.[110] The question posed to migrants was: *what was going on in your life when you began to feel ill?* Even though a causal link of life events and illnesses cannot be established, the question posed framed the experience of illness within migrants' biographies and the immediacy of the context where these experiences emerged. The question I ultimately seek to answer in broader terms is: *do changes in life conditions resulting from migration as*

[109] Prototypes are "representations based on the subject's or others' previous experiences from which he/she reasons analogously, using images and metaphors to understand the symptom, illness, or health behaviour" (ibid).
[110] Chain complexes are "representations that use metonymic reasoning to link past events to current experiences. The subject provides a narrative composed of a chain of events linked to the current pathology but not identified as the cause of the medical condition" (ibid).

well as the challenges of the new life context, relate to the surfacing of their illnesses? So the focus of the analysis is around the circumstances and events surrounding the raising of symptoms as described by migrants in their narratives. The analysis takes an *emic* perspective, exploring how these symptoms are connected to life events since their arrival in Chile. Thus, symptoms of emotional distress perceived by migrants and described in their narratives are interpreted in my analysis as a language of social distress.

A contextually related approach to illness requires identifying those various social levels and social relations where the symptoms of distress emerge. My approach to illness as interpersonally shaped experience seeks to 'disaggregate' the various social levels constructing the experience of emotional distress. In this analysis, symptoms of depression and anxiety as related to numerous social variables are also included.

My approach in line with anthropology of emotions, also seeks to identify in those adverse relationship experiences of loss and frustrated goals, what leads to emotional suffering for migrants (Lutz 1986). The interpersonal relations which characterise the circumstances where migrants live and work in Chile are discussed as well, as the nature of migrant's social interactions which trigger various forms of distress.

The aim of this analysis is to achieve a better understanding of illness experiences as embedded in social relations in shifting local contexts. Local contexts, succinctly defined here are cultural systems compressing social relations and cultural meanings that systematically relate the social structure and the individual, generating pathological or therapeutic processes (Kleinman 1988).

In this particular case, however, the 'local context' is disrupted and social relations as well as cultural meanings have – to some extent – lost their coherence, balance and systematic character. Migrants moving to live and work in Chile get displaced from their social and emotional centres – their families and homes in Peru. Their condition of displacement and uprootedness becomes compounded with their marginal insertion in the new country.

To face this disjuncture, migrants often appraise their circumstances as transitory and invest their efforts into keeping their lives together. However, their circumstances tend to acquire a permanent character. The resulting effect upon migrants' lives and well-being may be felt in the long term. In summary, what is presented next is a closer look at what personal displacement and social exclusion does to migrants' emotional well-being.

The contexts described were selected based on migrants' assessments of the constellation of events, interactions and relations affecting their emotional well-being. The first two spheres examined deal with consequences of the displacement of migrants' lives. Firstly, it describes migrants' troubled love relationships and looks at the emotional cost involved in these conflictive couplings. The changing of gender and partner relations in the context of this migration, are also discussed here. The second context depicts the dynamics of transnational families and examines how migration interferes in these close relationships and impacts migrant's emotional well-being. The following two spheres described, deal with the emotional and physical consequences of migrants' social exclusion. It firstly examines migrants' work environment and

detrimental labour relations which characterise the jobs migrant men and women have access to in Chile and lastly, the context of illegality which is how many migrants live their lives in Chile.

7.4.1 Conjugal relationships and emotional distress

To migrate causes great tensions in the stability of partner relationships. Couples often face problems in remaining loyal to each other. This is particularly true when one partner stay away for extended periods – even years. New relationships are often formed in the host country among lonely migrants. Men and women, now living the same migrant life – sharing houses and rooms, combined with the emotional burden of being far from home and family – share a close physical proximity and common experience. They have similar needs of emotional support and can offer each other company. This is why many "temporary relationships"[111] among migrants are quite frequent. However, these "second commitments" are not exempted from considerable emotional strain and painful break-ups. Information regarding such new couplings or love affairs among migrants in Chile is often quickly communicated back home by other migrants. This subsequently can trigger long distant conflicts.

The above seems to be corroborated by the test results. Being married seems to be a protective factor related to the mental health of migrants. In general, migrants who merely cohabit with a partner and single migrants show higher symptoms of anxiety and depression. Existent literature shows people in marriages tend to have lower levels of anxiety and depression and this also applies for migrants (Junghanss 1998).

Table VII-6: Symptoms of anxiety and depression and marital status

Marital status	None	Symptoms of anxiety and depression
Single	22,2 %	77,8%
Living together	27,6 %	72,4%
Married	36,7 %	63,3%
Separated	40,0 %	60,0%

Similarities are found among migrants with different marital status – married and separated. Single migrants exhibit the most acute mental health status among all the groups. The second place is occupied by those migrants who cohabitate with their partners. The relationship between marital status and mental health is confirmed among the groups showing better mental health status. Almost half of the married group does not show symptoms of anxiety and depression. This is followed by the separated group[112] who do not show any of these symptoms.

There is also a relation between the place of residence of a partner and the person's mental health status. Living far from a partner appears to have a negative impact on migrants' state of mental health. All the members of the group whose partners resided in Peru presented some degree of anxiety and depression. However, those migrants who

[111] Migrants refer to their permanent and stable relationships in Peru as *my first commitment* (*mi primer compromiso*) and to the other which has been initiated in the context of temporary relationship as *my second commitment* (*mi segundo compromiso*).

[112] The status of separated describes couples that are not in a relationship anymore. The legal status of divorced is almost inexistent among migrants.

lived with their partners in Chile exhibited a lesser percentage of these symptoms. Excluded from this relation are single and separated migrants.

Migrants' narratives show clearly the impact migration has had on conjugal relationships. Particularly, they demonstrate how migration affects most severely those whose partners and spouses were left behind. The complexity of conjugal relationships and the emotional cost involved become manifested especially among unmarried couples. However men, more than women, tend to focus on the emotional impact caused by broken love relationships and/or bitter memories of past loves. As explained before, break-ups and contradictions in love relationships are entrenched within the dynamics of this current migration from Peru, as well as in the productive role women have taken. Significant factors are increased personal freedoms women migrants enjoy in Chile as well as the influence the new cultural context has upon them.

Marlo, 43 years old, works in construction and lives alone in his room. After several love disappointments, he expresses what, in his view, has caused him emotional distress.

> Not being able to form a good family (his voice is broken). To have a direct communication, like any normal couple. Never. Let's say we have had so many snags, maybe from my side, but also from her side. You know that when one is a lad one is sometimes. Everyone makes mistakes in life. Why? Due to lack of experience.

The international migration has further accentuated contradictions between gender ideals and the reality, and this often is manifested in partner relationships. Some couples reunite others undergo breakdowns and then the setting up of new relationships. However, as observed in migrant's narratives, it is mostly men who express suffering over failed love relationships. To a large extent – we can argue – men's emotional suffering is sourced in the tension of these unsolved gender contradictions. Felix (32 years old), after breaking up with his partner who lived in Peru, has endured a few other failed experiences. He expresses how he has unsuccessfully tried to overcome the problems in his love relationships.

> To me, all that I carry inside, the break-up I have had with my partner. I have tried to fight, fight to get better, but I have not been able to overcome it and it is if I have got traumatised, something like that. I don't like to fight with women, although sometimes I let my bad temper to come out, but I don't like it. (Felix)

This is not the first time Felix has been betrayed by a partner. However, he is now experiencing stomach aches as a result of conflicts in his current love relationship.

> L: When do you feel these symptoms more acutely?
> F: For example, when I argue with her (his current partner). Yes, because this weakness got me in a discussion I had with her.
> L: That sensation in your stomach?
> F: Yes, in my stomach, when I argue with her. When I fight with her (his partner), or get to know some things that really make me fear; fear to find out certain things…

Marlo recalls the painful memories of finding out his partner had betrayed him. The decision he took was to send all his family back to Peru.

Yes I embarked them (in a bus back to Peru) and bye, bye (he said to them). That is all. I did not wait to say goodbye, nothing. *Good luck, take care my daughter, ok daddy, I am sorry, I have to leave, I am busy* – I left. It was (he is crying) a shot that hurt too much. That is why I don't trust women much. I am a guy that first likes to talk. I like to talk to and establish a dialogue. (Such as) 'Hey' please don't do this to me.

When I asked Marlo when he started feeling emotionally distressed, he said:

M: (I have got) this issue since about two and half years ago. Due to so many love problems (that he has had).
L: Since your partner left you?
M: Mmm.
L: From that moment? Do you relate your distress with that event?
M: How do I relate them both?
L: Yes. Or let's say – do you think the cause of your sadness is that she left?
M: Look, how can I say it? One has to be strong in this life and move forward that is all. I hope one day I will not be betrayed by women anymore, then… (he cries)

Johnny had a sad love story too. Not having his visa/work permit documentation in order, he could not leave the country to join his partner in Argentina. This frustration led him to drink in excess and to not eat regularly. It is this latter factor, he thinks, that is the cause of his stomach aches. However, in his narrative, Johnny does not establish a direct linkage between the affective and emotional dimension that led him to abuse alcohol and his current somatic symptoms. It seems that for Johnny, abuse of alcohol – and the consequent disarray in his eating habits – is the direct cause of his symptoms. Additionally, his current working conditions – long hours of painting and exposure to strong chemicals – have in his view, aggravated his somatic symptoms.

L: When do you feel the stomach ache?
J: When I drink, the next day. When I drink and when I have worked in excess, when I paint for long hours (as he breathes-in the paint's fumes). ...When I was fine (before his love disappointment), I was never… I wasn't a drinker. I was quiet. Yes, I would go out to *carretear* (partying and drinking) once a week or every two weeks. It was something else then (his life) because I did not have the problems I have now.

Conjugal relationships however, are only one – although very important – dimension of how migration affects families. In the next section, I look at the impact separation from family members has upon migrants' personal well-being.

7.4.2 Transnational families and emotional distress

Migration is often a last resort of a family in the Peruvian economic context, where jobs are simply not available or salaries are very low. Economic migration is often times a desperate response; the only available solution to the urgent need to provide the family with economic support. Most migrants have no other alternative but to leave their families behind in order to provide subsistence for parents, siblings or children.

It is only after they have left Peru that migrants evaluate the emotional cost of their migration endeavours. Daily interaction with family members gets interrupted, and along with it, the emotional support associated with the comfort of having family

support close by. Parents and family members get older, fall ill or die while migrants are away. At the time of departure, migrants are often aware of the unpredictable but imminent events of a death or illness of a close family member. An unexpected phone call from home may bring sad news. Blind-sided and far from home, such migrants are often unable to join their loved ones to look after them, or to adequately mourn their loss.

Women, who have left their children behind, become distant mothers and suffer from the physical distance with their children. They also grieve the fact of not being able to see their children growing up. Children in turn, over time, learn to relate to other caregivers – who in this case are often women – as they would their own mothers. The majority of the screened group has their children living with them in Chile. This group shows only a slightly better mental health than those whose children are either living in Peru or scattered between Chile and Peru or a third country.

Table VII-7: Symptoms of Anxiety and Depression, and Place of Residence of Children

Residence of children	**None**	**Symptoms of anxiety And depression**
All the children reside in Peru	28,4%	71,6%
Children reside in Peru and Chile	25,0%	75,0%
Children reside in Chile	30,0%	70,0%

70% of migrants with their children in Chile show symptoms of anxiety and depression, 75% of migrants whose children are scattered between countries show these symptoms, and 71,6% of migrants who have all their children out of the country present those symptoms. However, migrants whose children are all in Chile comprise 62,5% of the total group with a third degree of anxiety. This suggests a relation between symptoms of anxiety and the presence of children in the host country. Conversely, symptoms of depression among this group do not appear to relate to the place of residence of the migrants' children. Thus, these results seem to indicate that living with the children in Chile, does not protect migrants' mental health. One influencing factor making life more difficult for migrant parents in Chile is the absence of extended family and social networks.

Migrants' narratives relate the multiple challenges they must face when their families are left behind. It is precisely because migration involves changes in family dynamics that alternative caring arrangements have to be found, if migrants want to maintain their places within their family units. This relationship can be maintained through phone calls, letters, e-mails, presents, photos and particularly, through the remittance of money. The latter helps to assert migrants' authority, not only with their children but also more importantly, with other adults within their families.

Gladys, a 47-year-old domestic worker, is responsible for economically supporting her family in Peru. She continues to occupy the main authoritative role as her husband, although remaining at home with the children provides minimal support. The difficulty of being mother, authority figure and economic provider from a far distance, triggers Gladys' symptoms of distress.

> Well, let's say when I have to… when I call to Peru. The situation of my children is what makes my blood pressure to rise up. Sometimes calling home makes me feel terrorised,

because when I call there, there is always something new. Sometimes I make a plan, I talk to my children, and they tell me things are like this. After two or three days pum! They call me. …A problem arises… It is then when – as people say here – I feel the *bajon* (I feel down). And then I begin with the headaches and I get quite depressed, so I have taken the *Anaprin* (headache remedy).

However, for Gladys ill health and motherhood coincided, particularly in the context of poverty and scarcity.

L: How could one prevent this health problem?
G: Well not having problems (she laughs).
L: It is very difficult.
G: Uff just imagine! A life without problems! It would not be a life. (One has to) just try to make it less (of a burden)....To be able to carry on, but sometimes, one says *well they are grown ups* (her children). *I am not going to*...(worry) but it is difficult. When one is a mother, it is difficult. Sometimes they (her friends) tell me, *but leave them. They are your children but you end up getting sick. Every time they tell you something, you get sick. You end up sick.*

As families reunite in the host country, additional problems can also surface. Lacking the social support network in the new country, tasks and responsibilities of childcare fall completely upon women, who must also carry out paid work.

Mary, who is 38 years old, never wanted to bring her children "to live this life in Chile". She felt the living conditions migrants must endure away from their own country were not suitable for them. "Children are locked in these rooms while their parents go out to work". But Mary had little choice. Her mother was demanding more and more money from her for her children's maintenance in Peru; money she absolutely could not put together. Sadly, her family actually believed Mary was having a "good life in Chile". They thought she was spending her salary going out to dances and buying expensive clothing as they deduced from the photographs they received from her.

Some time after Mary's children were sent to Chile, her workload increased and she could not cope with all the pressure. Her symptoms of distress were several. She lost weight and her hair grew white. She felt like doing nothing, and also wanted to isolate herself. She associates this to a multiplicity of the demands on her.

I did not eat … my hair turned white… I promise you, I did not feel like doing anything, anything. Only (wanted) to sleep… I would stay in, go to the toilet… (and then) go back (to my room). I did not even feel like cleaning myself. Only… I don't know… I lost control of myself like crazy I was… I was like crazy because my sister used to tell me: "Hey Mary! My mother... she is calling you on the phone!*"* I did not go to answer because I knew my mother would ask me for money and I didn't (have it). I could not. She would tell me: *"*Listen, your brother has problems". So that was it, but for me, I would tell her (sister) *"*Tell my mother that I am not here*,"* so my mother also began to worry about me … She would ask me what is going on? I wasn't like this before… And it began since … the change of life (style), since my daughters arrived, because they demanded more (of me).

Moving away from the emotional and physical closeness of family can also be very traumatic. This is especially true for migrants. Being part of a family and a community is an essential dimension of their identity and their concept of self. In migrant's

narratives of their lives in Peru, it is easy to understand the extent in which the support of family members helps to buffer the emotional impact of difficulties and daily challenges. Being far from family exacerbates migrants' emotional liability. However, migrants see themselves obliged to endure the situation as they are providing crucial economic support to their families. Rocio (28 years old) misses her family, particularly her mother with whom she used to share the joys and pains of her everyday life in Peru. She can't sleep, and often feels anxious. This weighs heavily upon her and is experienced as an "oppressive weight" on her chest.

L: When do you experience your distress symptoms?
R: When I can't communicate with my mother or when I don't know anything about them, I get worried and I can't sleep. I say to myself: why don't they call me? Maybe they are sick? And I don't know anything (about them). It is then when I get a little bit ill. ... When I am quiet, I feel oppression on my chest. And quickly I say ah she is bad! (her mother) and I feel anxious to call her. That whole day I feel bad. I am anxious to go and call to see how they are.

To cope with her sadness and nostalgia, Rocío plays home videos of her family in Peru. In that way, she feels they are there with her and she gets some comfort. With the same purpose, Marlo has written the names of his significant others on his body.

L: Is that a heart? (the tattoo on his chest)
M: (A heart) that flies very high.
L: When have you done it?
M: Two years ago. I did it because I wanted to have the names of my two daughters written down here. Here Paola and Leni there. But at the end, I could not get them written because it was bleeding too much and it began to drip.
L: Who did it to you?
M: A Chilean friend, he had a fake machine, and he himself made it to me, that is why it needs more red colour here.
L: Why did you decide to have the tattoo done?
M: Because I have them always present in my mind.
L: What are your future plans?
M: To carry on, to go ahead for the well-being of my family.

As aforementioned, the possibility of a dramatic family event exists as a permanent threat for migrants while they are away from home. Rosita lost her mother and brother within a very short time while she was still living in Peru. She then migrated and left her children behind, in the care of her sister in-law. For Rosita, to work as a live-in nanny, far away from her children was very difficult. And, the situation was worsened as she did not have the support of her mother anymore. Isolated at work, she did not have anybody to rely upon and endured her suffering on her own. One day, she called home. She received bad news and suffered a nervous break down.

R: (I put up with my distress) on my own… I never told my boss anything. Never. One time, I don't know what happened to me… One time, my hands were like this (stiff), my hands become like… They got stiff, were my nerves. My arm was hard all over.
L: Do you remember what had happened then?
R: I don't remember why it was… It was because I called home, I think.
L: Some bad news, maybe?

R: Yes, and I was there. And suddenly it happens to me as if quickly it would get to my nerves. Like that. And I felt like I was lacking air, like the air was lacking, like nerves…

Having left a family behind becomes a permanent concern for migrants, who feel responsible for their families' material well-being.

L: What is your health problem Cesar?
C: Let's say the health problem is that one is always thinking on what one leaves (behind). Mmm… When one leaves one's (own) country to (live in) another country. …What is one's mother; how a family is constituted, that is…
L: What symptoms do you experience with this situation?
C: In what? In the preoccupation (I feel) about them. Because one feels preoccupied if really – if really – are they doing as we are doing here? Are they better or worse? Always thinking on them (the family).

This concern is, to some extent, relieved by sending gifts to the family on birthdays, Mother's Day or Christmas. Conversations around planning what present will be sent to family members in Peru were very frequent. It was as if the sending of presents would set achievable goals for migrants. And, in doing so, this would help them to cope with the distance and their concern for the family's well-being. The sending of presents also served the purpose of sharing with those left behind, the benefits of the migration endeavour and their more easy access to modern technology. Among valuable items sent were mobile phones, DVDs, as well as clothing. However, calls received from Peru often brought urgent and additional requests for migrants to quickly provide money to meet unexpected family needs.

Marlo was very worried because he had not been able to send money to Peru for his nephew's studies. This was a promise he made to the family. In this way, he expects to help his family to move forward and have a better future.

M: I promised to help my nephew, a nephew, you see?
L: To help him?
M: To help him in his studies because he finished secondary school. He is in Peru, I did send (money) the first time, but this time I haven't been able to send, you see? Because of 'expenses here', 'expenses there'… The money is becoming shorter every day because things everyday are more expensive, and the dollar is also about to shoot up. So, I have being very worried about this. Because I should have sent already US 200 dollars, for him to quickly study. And that is what is making me *'*cabezón*'* (literally *'*big headed*,'* meaning: my head is full*)*. I want to keep money aside and I can't. One thing is missing, another thing is missing. I run out of gas, fuck the room! (rent).

Such situations fill migrants' subjective and emotional world with worries and concerns for their significant others. Migrants complain that their families in Peru do not always understand how difficult it is for them to save money and send it back to Peru. For young Peruvians like Javier, being an economic migrant meant suddenly taking on the role of provider for his family of origin in Peru. Javier felt the pressure of being unemployed in Chile and having to pay his living expenses without anyone to rely upon.

L: So that was the pressure you felt?

J: Yes, because sometimes one doesn't have a job. So how are you going to give it (the money)? So you say 'well I give it to you next month', ok? But then you get it (distress) due to the pressure that you have to get the money together. Money to give, to give (how are you going to do it)? If you don't have a job where (to get the money) from? And depression (he felt) because I was far away from everybody.

For both men and women, being far from their families causes emotional suffering, increasing their emotional liability and vulnerability. Migrants lack the support of family. This creates an emotional void often filled up by a constant concern for their well-being. As a way to cope with this feeling, migrants often try to compensate by sending presents to their loved ones. This in turn creates expectations in the recipients of these presents. In some cases, it becomes a pressing demand. When the money is not available, such expectations and pressure creates even more distress among migrants.

7.4.3 Emotional distress and work situation

In general, Peruvian migrant workers in Chile are exposed to precarious working conditions, with both direct and indirect impacts on their physical and mental health. Tests results reveal – for men and women together – that anxiety and depression are not strongly related to work status, although some minor variation seems to correlate with work stability as it will be shown in the next table.

Table VII-8: Symptoms of Anxiety and Depression and Labour Status

Labour status	None	Symptoms of anxiety and depression
Not working	28,6%	71,4 %
Looking for a job	25,0%	75,0%
Working	33,3%	66,6%
Unemployed	25%	75,0%

In terms of levels of anxiety and depression differences among various categories of work status – the employed, those looking for a job and people not working are not so pronounced. However, those who are employed show slightly less symptoms than those migrants who have other work status. Indeed, those migrants who are looking for a job show a slight increase in anxiety and depressive symptoms. Slightly less anxiety and depressive symptoms are experienced among those who are not working. Increased anxiety seems to be therefore naturally linked to lack of job opportunities. Even though those who are working also display some levels of anxiety, it is to a lesser extent than those who are unemployed.

Gladys gives an account of what it is like for Peruvian migrant to enter into the Chilean labour market

L: Do you feel this society puts limits on you?
G: Well, it is as if one would have a contagious disease. They (Chileans) move away (from you) or they begin to insult us (Peruvians). (They say things like) *You come to take our jobs!* But it is not like that because if an employer does not want a foreigner, (he) does not hire us and that's it! (The employer) hires one fellow Chilean …Some (employers) say *why I don't hire a Chilean? Because the Chilean demands this and that*… Unfortunately, to a Chilean (worker), you have to give it all… But instead to us, they don't because *ah you are a foreigner*, one month, two

> months three months as probationary period they say. …(While) working, we don't get paid the same. We don't get our social security paid. They (employers) only pay it after we have (obtained) the I-D.… And, we can't have access to public health, so medical care, we don't have. And why? Because our employers are not paying our health insurance. And how do we work? We work more (than 8) hours …because a Chilean (worker) says *I work my 8 hours from this time to time and then I leave.* But us? If one doesn't have a job, one has to do it .We have to accept what ever comes, but sometimes people abuse. (They) abuse us foreigners.

What has been described by Gladys applies equally to men and women migrant workers in Chile; however gender differences are relevant in the understanding of the relationship between work conditions and mental health. Male and female migrants occupy gender-segregated jobs involving different health risks and this must be taken into account.

Male migrants most often find work in construction, a physically demanding activity which is associated with health risks. Their situation is aggravated by the lack of health insurance as they often work illegally or under temporary contracts. Migrant women mostly work in domestic service, in demanding and isolating live-in regimes with great impact on their emotional well-being. Work environment and working conditions create pathological processes for both male and female migrants.

Women's work environment

Women working as domestic workers, particularly those working in live-in situations, find themselves in a weak position to negotiate better working conditions or to defend their rights as workers.[113]

Women working in live-in regimes report that frequently they are overloaded with additional work and extra hours assigned to them unilaterally, without extra monetary compensation. Women face limitations to fully make use of their days off or they must perform additional tasks before they are allowed to leave their employers' households. They also reported suffering from social and physical isolation in employers' households. They are often badly treated and are faced with conflicting employer-employee relations. All these factors have great emotional impact on them.

Staab and Maher (2006) refer to similarly abusive working conditions that the domestic workers they interviewed were subjected to, in Chilean households

> The Peruvian women interviewed did not stress low salaries as one of the problems they experienced at work, but they did complain about the non-payment of their salary, sometimes for more than a month's work. Migrant workers also reported inadequate food, verbal abuses, violation of personal privacy, and working hours long beyond those estipulated by labour laws or aor agreed in the work contract (2006:7).

[113] This is not different from work regimes Peruvian migrant women working as domestic workers are exposed to in other destinations such as Barcelona, as studied by Escriva (2000).

Below follows the narrative of Marianela. She describes the poor working conditions of each of her jobs and how it affects her health and consequently, triggers pathological processes.

Marianela, works as a live-in nanny and her job has had negative emotional impact on her. She finds herself unable to speak out or confront her employers about the unfair working conditions she endures on a daily basis. She describes her symptoms of distress experienced at work as *nerves, weakness* and feeling of having a *knock in her throat,* that later becomes fear.

> I begin to feel my body; the nerves begin to make my body tremble. I feel a weakness and it is like a knot that I feel (in her throat) and I can't… Words do not come out; I want to (speak out). I go there and get half way and then return, is like a fear I have got… which I have got here for the different jobs I have had and due to the treatment (that she gets at work) it is like I've got traumatised. I want to speak out, but it is something that does not come out of me so I keep quiet. But I want to get it out. I want to say what I feel, for good or bad, but just say it – and I can't.

Marianela said she felt tension; she loses her appetite and feels disorientated. In her view, this happens when "things get out of place" at work.

> L: How do you relate these events with your health problem?
> M: The same tensions that I have, the same anguish feelings. I am not calm anymore, I do not eat well. I don't eat properly anymore, I am thinking on that… I cannot work. I see confusions in my head, and so all that I believe, disturbs the organism (her body). Yes, the organism is totally altered, so it disorientates me, I see myself disorientated. …To see myself without any support (makes it) is worse. It complicates my life. Yes, it is worse. I get complicated because in a moment, I see myself lost. Yet, in another moment I get my strength back and I try to go ahead on my own.

Marianela describes how adverse experiences in the workplace are converted into body sensations and emotions. The bad work situation triggers emotions which intrude into her body-mind, altering its vegetative and cognitive functions. Disturbances in her mind arise as she continues thinking about her problems. This then shifts the functioning of her body and her sense of orientation. Marianela sees the cause of her distress as anchored in the unfair labour practices she has to deal with every day, compounded by her sense of lack of social support. She thinks she developed her depression because she had remained silent and did not express her discontent in the workplace. Too many times, she was confronted with upsetting situations and on-the-job conditions that were unilaterally changed. She felt she was never consulted when decisions were made regarding the tasks she had to perform. Even now, she feels she is often informed at the last minute about having to cook or clean for extra people while being paid the same salary. This situation made her feel she is not worth anything.

Gladys feels tension and gets headaches as she worries for her family. In addition, when the demands of her work mount up, she cannot freely express how she feels. She wants "to explode*"* but she has to "swallow her exasperation". The metaphor is used to describe her distress picture. It demonstrates the lack of freedom she experiences at work, where she cannot express what bothers her. This increases her blood pressure.

> I don't know what to think. It worries me and makes me feel tense and that affects me. Then, here sometimes in my work with… Now as I am looking after the children and sometimes they behave badly, and I get exasperated and I wish to explode but I have to swallow it... And all that has an influence, so there is a moment when I can't stand it anymore and I get the headaches and my blood pressure rises…
> Living and working in a household located in a wealthy neighbourhood on Santiago's outskirts is a common and isolating experience for many female migrants. Rosita could not bear the effect her job had upon her emotional well-being and decided to quit, even though she had been well paid. She expressed it in this way: "I was stressed. That confinement was killing me… I was missing my children so much".

In such "enclosed" working environments, women cannot meet with their friends and have no one to talk to or share their worries and concerns. This social isolation gradually undermines these women emotionally. Soon after Irma arrived in Chile, she began working as live-nanny in a household outside Santiago. She remembers the solitude and sadness of the long days spent alone at the employers' household.

Working as a live-in domestic worker can also expose women to conflictive relationships with members of the household. Women's ability to keep a safe emotional space in a household diminishes as the line between work-related conflicts and personal life cannot be clearly drawn. The status of a domestic worker inside the household is often ambiguous as close emotional bonds are often created particularly with the children, whom they may look after. However, they are not seen as equal members of the household or as workers in their own right.

> The authority women domestic workers have over their employers' children is very ambiguous. These women look after the employers' children most of the day and are seen as the main person responsible for their well-being. However, parents take control when they return to the household and may easily de-authorise the domestic worker. Children soon learn who makes the ultimate decision in the house. The domestic worker's authority is therefore weakened in the eyes of the children. However, her responsibility to monitor and care for them remains the same.

Irma was experiencing conflicts with members of the family she worked for. The increasing tension remained with her even after her work day has ended. She often felt hurt, sad and lonely, and could not create an independent emotional space. Additionally, she did not have the necessary support to assert herself in her workplace, which was her employers' household. Her own room (inside the employer's house), she experienced as a space of isolation, rather than a place of privacy.

> It is the tension, Irma explained. For example, if I had a problem, a discussion (with her employers), like it happened the other day. It made me feel very bad. Let's say it hurt me inside if somebody comes… because in one way or another I feel affection for them (the family she works for). And I don't like them to behave like that with me ...I become worried, why do they behave like that? Why do they hurt me so much? ...And the sadness… I feel it in a moment, especially when I finish all my duties and I go to rest in my room… (I am) alone only with a TV in front of me to relate to and that is if you turn it on… With your tray there for dinner and all that, instead of sharing the dinner table with somebody and then go to your room.

Only a minority of women work in activities other than domestic service. Lily is the only Peruvian women among all the workers in the work floor of a small manufacturing

firm. Yet, her experience has not been very different from other women working in domestic services. She also feels badly treated, isolated and she does not trust her co-workers.

> I don't feel supported in my work from anybody. I feel they treat me bad, as if I was a 'weird insect.' They think I don't have feelings, that I don't care what they say to me. They see me crying and it is as if nothing was happening, as if they don't care. They just want to know about me to spread it around, so then I would be in everybody's mouth. Only telling one and then everybody knows. I told her (boss) that nothing has happened to me, nothing. I cried alone that was all. I wanted somebody would have told me pucha! At least (that somebody) would have told me, would have hugged me and told me – I support you – something like that.

Holper's study on Peruvian women working as live-in nannies in Chilean households reveals the pathogenic process experienced by migrant women as a result of the oppressive work environment expressed on weight loss.

> This process of weight loss occurs within the micro-political context of the household. Its isolation facilitates the female employer to exert control over the nanny's life and body. Through overt control on food intake, movement, and communication with the outside world, through humiliation and through constant time pressure, the body –self is literately kept small (Holper 2003:101).

Holper's findings are confirmed in our own study.

Men's work environment

Men have different work experiences. Marlo, Dago, Javier, Johnny and Felix work in highly demanding manual labour, which causes them physical strains. Dago was told by a doctor in Peru that he should not lift heavy weight as he suffers from a problem in his spinal cord. Yet, in his current work in construction, he must lift heavy cement bags. He foresees that he will suffer from physical health problems in the future but there is nothing he can do now to avoid it.

Felix does not mind the physical demands of his job that of paving roads. But he does worry about his irregular eating patterns at work where he cannot take proper breaks to eat during the day. He believes this is damaging to his health, causing his recurrent stomach aches.

Javier complains about the very heavy physical demands of his job in construction, describing his exhausting physical tasks – kneeing, standing, and bending as "killing". "Being in that pampas with all that heat, without food… The waist aches, the shoulders ache, the legs too, but what can one do? ... Just carry on that is all". Javier pushes himself, going long hours without drinking enough water or eating proper food. He is still young and he cannot afford to be concerned by the long-term consequences of his work on his health.

Johnny is a self-employed car painter. He complains about health damage caused by his job. Particularly, he is concerned about being exposed to noxious fumes when painting cars. This, he believes, is affecting his lungs and the cause of his stomach aches. Although he works independently, he (unrealistically) expects his clients to

provide him with suitable protection such as face masks, etc. but this has never happened.

> I used to protect myself with disposable masks. But this only gives 10 percent protection. There are other masks with filters but the boss should provide them. But the boss doesn't want to... He is only concerned that you finish the job up and to get the money. He is really not at all there.

As the physical demands of men's work impacts negatively on their health, they tend to see those demands as the cause of their somatic problems. Felix and Johnny see their work conditions as the cause of their – otherwise inexplicable – stomach aches. Felix thinks his stomach problems are related to the job he performs which is altering his eating patterns.

> F: I feel like tiredness. I used to be very active (in Peru). I used to do weights, play football. I did a lot besides working and studying. Here I don't have time to do these activities.
> L: Does your work have anything to do with it (his distress)?
> F: Let's say we work paving roads. We sometimes have to start…, we take the (material from the) trucks at 6:00 a.m. and work up until 6:00 in the afternoon. You don't have time to feed yourself, because if you (stop to) eat, the mixture gets hard. So sometimes we stop eating or we eat in a hurry. It may be 10, 15 minutes that you eat something and then (we must) go back to work. That may be what makes my stomach sick.

Oscar is the only one among the group of men who points to his working conditions as the cause of his emotional distress. The reason for this however, is obvious. He is self-employed and works under heavy pressure to meet customer demands.

7.4.4 'Illegal' status and emotional distress

There is a clear relation between prevalence of symptoms of anxiety and depression and the residence status of migrants in the country. These symptoms increase as the legal stability in the country decreases. Migrants with residence permits show the least of these symptoms. By comparison migrants with temporary visas display slightly higher symptoms. Among migrants who are in an irregular status,[114] these symptoms increase.

Table VII-9: Symptoms of anxiety and depression and visa status

Visa status	None	Symptoms of anxiety and depression
Permanent Resident	53,3%	46,7%
Temporary visa	52,6%	47,4%
Tourist visa	33,3%	66,7%
Irregular	28,6%	71,4%

'Illegality' and mental health status led to high scores. Those who have an irregular status (no visa or expired visas) have the highest depression and anxiety levels of all.

[114] This group includes migrants who do not have current visa status. I avoid the use of the term "illegal" as they may have entered Chile legally but their visas have since lapsed.

Those without visas or work contracts – as illustrated by the experiences of Cesar, Johnny, Elena and Dago – exhibited far more symptoms of anxiety and depression.

In the case of those migrant workers who hold tourist visas they are, in essence, breaking the law by working in Chile. This 'illegal' situation may contribute to generate fear and emotional turmoil.

Dago had arrived only recently in Chile and did not have regular legal status. Since his arrival, his health situation had not improved. When asked about what situations made his symptoms of distress emerge, he said it happened when he thought and worried about his family in Peru. His distress also increased when walking on the street and in other public places. He would get physically agitated by thoughts and worries about his family. He also feared he would be caught by the police.

> It is sometimes due to the worries, a worry. I feel as if I lack something… Sometimes I get nervous. I become tense…. no? I am like … thinking, no? What is happening over there? (in Peru). And I become agitated not having done any physical effort. …I become agitated, thinking... What is happening there? Are they fine or not? (His family in Peru) And also I get desperate. I become fearful. I feel a little bit scared, because as they say (his fellow Peruvians) that there are lots of illegal (immigrants) here. …Sometimes I feel scared of walking around here… I used to go out when I had my documents in order. But now that I don't have my documents I am scared of going out… And I am worried… I am thinking that suddenly any day, when I am going to work, downtown… something can happen to me.

In general migrants who possess temporary visas have the right to legally find work in Chile for a 12-month period. These visas are strictly attached to contracts and therefore do not allow workers to change jobs or seek out a better situation. At the end of the 12-months period, if there is no new contract, a new visa will not be issued by the Chilean government, resulting in a sense of instability in the minds of these workers.

Table VII-10: Symptoms of anxiety and depression and work contract

Work contract and health insurance	None	Symptoms of anxiety and depression
Without work contract	36,7%	63,3%
With work contract	52,2%	47,8%
Without health insurance	33,3%	66,7%
With health insurance	56,0%	44,0%

Higher symptoms of anxiety and depression are present among those migrants who are not in a possession of a work contract. In contrast, those migrants who do have work contracts show a lower percentage. With regards to health insurance, the difference between those migrants who are not covered and migrants covered by health insurance are more pronounced. The latter, those with coverage, are less affected by these symptoms. As it can be observed, work contract and health insurance are indicators of the quality of employment and this factor does have an influence on migrants' mental health.

To sum up, the discussion presented above seems to be confirmed by a principal component analysis where the first two axes explain 48% of the total scattering of this

data base according to 8 variables. The first axis – that explains 35 % of the total scattering – shows a positive correlatation between symptoms of anxiety and depression and the following variables: being a man, young, not being legally married, being unemployed or working without contract and health insurance as well as having an irregular visa.

7.5 Conclusions

The aim of this chapter was to assess migrants' mental health status and to establish the relationship between their health problems and the living/working conditions in which they find themselves in the new country.

The results of the household survey conducted initially were a first indication showing the presence of various forms of emotional distress among the group of migrants selected. Sixty percent of the sample had suffered from some form of emotional distress over the previous 6 months. *Worrying too much, nerves* and *depression* were the most uttered forms of distress.

In their narratives, migrants recognised *depression*, *stress* and other folk forms of distress. Interestingly, anxiety – measured in the mental health test – as a form of distress was not mentioned. However, '*nerves'* was widely used as a symptom as well as an explanatory model. Indeed, '*nerves'* is used by migrants to link the physiological and social causes leading to emotional distress. In addition, the use of *nerves* in explaining *depression* and *stress* assists migrants in reaching an understanding of current forms of distress emerging in the midst of various on-going changes. In facing new experiences, a known frame of reference helps them to keep continuity in the way they perceive their bodies reacting to the challenges arising from the environment.

The effects of displacement in migrant's health were examined by looking at their conjugal relationships and family dynamics. The displacement of migrants' lives due to migration often leads to separations and the forming of new partnerships. Through the narratives was possible to gather that sources of emotional suffering for adult men (Marlo, Felix, Johnny) concentrated in the sphere of love and partner relationships. Feelings of betrayal are common and have left these men with emotional wounds. Typically, when migrant men establish new relationships, they tend to repeat the patterns they made in past couplings. Recreating similar conflictive relationships often can further burden their already unstable emotional state. The test results showed that men in this group have worse mental health status than do women**.** Among our male interviewees, Marlo illustrates the more critical condition of men. Marlo has been depressed for two years, has attempted suicide and shows an absence of resources to overcome his situation. Johnny in turn, does not acknowledge his emotional distress as part of his illness experience. Instead, he identifies his physical symptoms – his stomach aches – as the problem. Men, as demonstrated in the cases of Marlo, Johnny, Felix, Cesar and Javier, tend to resort to drinking in order to cope with emotional suffering. However, alcohol consumption causes additional health problems.

Women, on the other hand, seemed to show more acute symptoms of anxiety, and men more of depression. This can be related to the way in which migration interferes with family life and weakens migrants' nets of social support. Indeed, anxiety, in the

case of women, seems to be related to the presence of children with them in Chile. This can be explained by women's double involvement in paid and reproductive work and their lack of an extended family to rely upon. Mary's illustrates pressure she experienced when her two daughters came to live with her and her husband in Chile. She was working full-time and still had to tend to her family after her regular work was done. Her workload increased but she lacked an extended family network to rely upon. Elena felt her burden increased when her daughter came to live with her Chile. Rocío confirms the presence of children and increased anxiety to be all too real. She has all three of her children with her in Chile.

The various ways in which a family situation can be altered due to migration and how it affects migrants' mental health are highlighted by the test results. These results indicate the presence of a partner in the country does have a positive impact upon mental health. However, the opposite can be illustrated by Gladys whose children and partner live in Peru. Her partner does not play any role in her economic or emotional support or that of her children.

Marital status plays a role in migrants' mental health in two ways. Those who are married as well as those who are separated present better mental health indicators than single people. Single migrants showed the greatest mental health problem indicators. Irma's story illustrates the difficult side of being single and alone in a foreign country. Rosita also had a similar experience as a woman separated from her husband and living alone in Chile.

This chapter has examined the effect displacement has upon migrants' lives within shifting local contexts and the disruption of social relations which characterise their transnational lives. Those values and meanings which mediate connections between social relations and structures, with individuals' physiology, emotions and cognition were examined here. The various settings depicted here showed how such connections are rifted, interrupted and altered.

The effects of exclusion upon migrants' health were explored by looking at individual migrant's work environments and their legal status in the country. The labour sphere proved to be a significant source of distress for many migrants. The workplace clearly reflects exclusion and emphasises their marginal insertion in the labour market of the host society.

Those employed displayed the highest number of mental health problems of all. Interestingly, however, depressive symptoms do not appear to be related to unemployment. On the contrary, those who held jobs showed higher symptoms of depression. This may indicate an existing relationship between the working environment/conditions and depressive symptoms. As seen in the narratives, this situation seems to be negatively affecting women more, as a group. Specific work-related problems can be illustrated by the experiences of Marianela, Lili and Irma. Their emotional distress was related to their work environment.

Indeed, women working in domestic service often must confront abusive working conditions. Lacking information and social support, women endure the accumulative emotional impact of their work relations. In addition women feel isolated as a result of their live-in work regimes. This isolation sharply contrasts with their memories of being

a central part of their families in Peru. It also causes increased concern in women as they often long for their children and other close family members who are far away. Women experience the impact of work conditions both emotionally and physically.

Men on the other hand, suffer the impact their work environment often solely in terms of their physical health. Very likely, it is the nature of the work men performs that assists them in drawing a line between their personal and emotional life, and the work sphere. Men's work does not require them to live and work in the same place, as is the case with women, who work as live-in domestics. The work environment of men does not create a 'total reality'[115] which may erode a person emotionally and physically, as it can happen for women.

Regarding legal status, it also offers an indication of the impact of exclusion upon migrant's mental health. Results show there are slightly higher degrees of anxiety among those migrants who possess temporary or tourist visas. Not surprisingly, more anxiety was found among those migrants in this group who do not have a work contract and are not covered by health insurance.

In summary, the analysis conducted examined the interactions which characterise these shattered lives in disrupted local contexts, as embedded and connected with the broader socio-cultural and economic processes and structures. Additionally, in the analysis of illness narratives, close attention is paid to cultural themes as they connect to the migrants' the emotional realm. In the analysis of illness narratives, the focus is placed on what is at stake in migrants' emotional world, as well as what triggers their various symptoms and forms of distress.

In this chapter, I have looked at how culture influences the way emotional distress is experienced in the context of social displacement and economic exclusion. Individuals in these interactions are viewed as motivated by their own interests and agency, yet their circumstances are also determined by the power positions and place they occupy in the social and economic structure. In the following chapters bodies and subjectivities will be placed at the core as I analyse the forms and meanings that suffering takes.

[115] This idea relates to the concept of a "total institution" developed by Irwin Goffman, to refer to institutions such as hospitals or prisons, in which the individuals' entire life is regulated by the norms of such institutions. To some extent, women working as live-in domestics experience their own world as limited by the enclosure of their employers' household.

Chapter VIII

Continuities and Changes in Migrants' Illness Experiences and Idioms of Emotional Distress

8.1 Introduction

This chapter discusses migrants' experiences of emotional distress while living in Chile. It examines continuities in the forms of distress suffered by migrants as they may be triggered by new and sometimes shocking experiences in the host society. It also examines the extent to which other and new forms of emotional distress experienced in the host society differ from emotional distress experienced while they were living in Peru.

The migrant community appears to be the context in which traditional and long outdated forms and idioms of distress prevail. *Daño, evil eye* or *ojo* (eye) and *chucaque* are common folk-forms of distress experienced by migrants. Such beliefs are characteristic of the Latin American population that comprises an enduring component of this cultural tradition. Migrants also experience in their bodies, a form of *oppression in the chest,* or a *hard feeling in the stomach.* This suffering is typically caused by the displacement of their lives as well as their concerns for the well-being of their families left behind in Peru.

As observed, when migrants relate to the broader Chilean society and interact with various actors outside their own community, their experiences of emotional distress change. In addition to this, the language they use to communicate their distress also changes. The process of incorporating new idioms of distress into migrants' illness experiences is examined through the analysis of the language used by migrants. This occurs in a variety of local contexts while in interaction with various interlocutors. Special attention is placed upon the power relations embedded in these interactions. These include where they live and where they work – inside and outside their own community. This will be illustrated in this chapter.

The diversity of forms and situations in which idioms are articulated and rearticulated are also addressed here. For example old bodily idioms emerge in connection with experiences of humiliation faced by migrants in Chile and the displacement of their lives while living and working in the country. New idioms such as *depression* and *stress* instead, emerge discursively, and articulated in 'illness identity talks' in connection with migrants' experience of social exclusion.

Overall, this chapter aims to discuss the extent in which changes in illness experiences and idioms of distress reflect the position migrants occupy in the socio-economic structure of the host society. The underlying assumption is changes in illness experiences reflect changes taking place in the life circumstances of migrants residing

and working in Chile. This, in turn, is a result of their interaction with the new and often hostile social/cultural milieu.

8.2 Old idioms and experiences of distress emerging under new circumstances

A useful distinction to examine illness experiences is formulated by Good and Good. They distinguish between two types of illness categories – first, those that focus on a set of symptoms called descriptive categories. Secondly, those categories that focus on the common cause of the disorder – even if the manifestation of the disorder varies widely – are defined as etiological categories (1994).

8.2.1 Conflicts in the community

Competence, envy and daño

> *No envidies al que trabaja* (don't envy the one that works)
> *Tu envidia es mi fortaleza* (your envy is my strength) - *Graffiti written on taxi-cabs in Chimbote, North Coast of Peru*

Daño is defined as magic actions performed by traditional, magic specialists aimed at harming the person's luck, instigating illness or bad fortune. The specialist performs *daño* at the request of a third person and is often instigated because of envy towards the targeted victim. Signs of being cursed are often read by migrants in association with a succession of unfortunate events, such as illness, loosing jobs, money, or robbery.

I became aware of the existence of envy feelings and *daño* when I witnessed the use of various protection devices among migrants in their rooms. Very frequently, I found in migrant's rooms plants hanging from a door (especially *Aloe Vera* but also *Rue plant*[116]*),* or the placements of pictures of Catholic Saints discretely in the corner of a room. One day I saw *Señora* Angelica in the compound of Bandera Street buying flowers for a bath. Flower baths, as I was informed, are used when someone suspects they have been cursed. It is believed the bath not only prevents but also cures *daño.*[117]

The close social and physical environments such as shared housing units, where migrants most often live in Santiago, are a good breeding ground for conflicts. Hence the possibility of being a victim of *daño* is also increased. This is because economic improvement and relative wealth can provoke the envy of others within the migrant social environment. However, the occurrence of *daño* in Chile seems to decrease due to the lack of specialists to perform the required rituals. Envy can come from two possible sources – from members of the migrant community in Chile and from people in their cities of origin.

[116] Rue or Ruta graveolens is commonly used in Chile to impede *daño* and envy feelings. The plant, it is believed, diverts and absorbs the harm intended to be inflicted upon a person. If the plant dries up and dies, one can be sure that *daño* was aimed at them. In Peru, *Salvia* (Aloe Vera) is used for the same purpose.
[117] Similar practices of protection against *daño* are described by Tamagno (2002) among Peruvian migrants in Milan, Italy.

> Let's say you live with Peruvians and they are your people, right? OK, they are your people, but if you live with Chileans, it is much better because a Peruvian (person) is always checking if you have something or if you don't have it. Whereas the Chilean, whether you have or not is the same (for them). They are not envying what you have.

Envy is related to competition amongst Peruvians. However, it appears to not exist among Peruvians towards Chileans. Envy does not arise with Chileans with whom there is no socio and cultural commonality – even though they may exist in a similar social stratum. *Daño,* in this context, can be seen as a mechanism of control – acting against the possibility of a member of such a community accumulating wealth. In line with Foster's idea of 'limited goods,' one feasible interpretation of *daño* in this context is: it is performed to prevent economic success of others (Foster 1965). Similarly, Taussig refers to an egalitarian social ethic as a feasible explanation for devil-beliefs.

> …They form part of an egalitarian social ethic that delegitimises those persons who gain more money and success than the rest of the social group. By imputing to the successful an allegiance to the devil, a restrain is imposed on would-be entrepreneurs. This fits well with the widespread opinion that envy is the motive for sorcery, and it also fits well with the image of "limited good" ascribed by George Foster to Latin American communities (Taussig 1984:15).

One migrant may consciously conspire to deprive other members of the community from accessing to an imagined or perceived level of limited wealth. Migrants often are confronted with the possibility of being cursed. This is because harm can also be conjured from a far distance – from Peru. This is accomplished by means of pictures or a piece of cloth belonging to the targeted person.

M: Uff! In Peru, there are so many dirty tricks. Uff! Quite a lot, a lot!
L: You said that using a photo can inflict *daño*?
M: Yes of course! They turn you around and they make you to go crazy, this and that. Or, they can conjure you up so you will not have any money. Never!

Although Mary interpreted her emotional distress as depression, she also considered herself a victim of *daño,* and her illness as a consequence of the harm done on her. She suspects it was performed in her compound.

> I had already problems with my child. Let's say if I changed his clothes (to new ones) or if one is wearing something that the rest cannot wear… I don't know! …Envy, do you understand? Because you have your things, (because) you treat yourself and go out with your children. (Or because) you take them (the children) out and come back maybe having bought something for them. People look at you like ... (with envy feelings). I say if somebody buys something for himself, nice! Because I say, we all have rights! That is why we work. But people do not take it as I do. Do you understand?

For her, the signs were all there. Her son fell ill. Then she began to feel very emotionally distressed. She lost her job and then began having arguments with her husband. This all happened in the same period of time.

L: Do you think that it was stress or envy (the cause of your distress)?
M: I believe it was all that together.

In Mary's understanding, her *depression* was just another sign of having been cursed. Since *daño* is, for Mary, the ultimate cause of her depression, *daño* is therefore an etiological category.

However, there is never any certainty of whether or not *daño* has been performed upon a person. But simply having the suspicion is enough for migrants to activate mechanisms of protection. Mary obtained her rue plant from her Chilean employer who was the first to diagnose her as being cursed. In Chile to be cursed is very similar to suffering from *daño*. Mary's Chilean employer was actually a specialised healer who operated an informal clinic to treat the public in Santiago. He performed a cleansing on Mary by imposing his hands on her head.

Later, a Peruvian friend visited Mary in her room and confirmed Mary's employer's diagnosis. That it was, indeed, *daño* that Mary was suffering. And it was obviously motivated by the envy of others.

> She came one day, saw me and got frightened! She then told me: *Mary there is a lot of envy here!* Yes, (Mary said) I have been told this and that (by her employer). And then she (her friend) looked at the rue plant (that was dry), and she told me: *you are going to make (it happen) that somebody (will) give Salvia (Aloe Vera) to you. And you are going to put it behind the (room's) door, to stop daño from coming in.* You can't steal it (the *Aloe Vera* plant), you can't buy it. Somebody well intended has to give it to you. That is the secret. The same with the rue, plant it has to be given to you.

Mary's friend had some knowledge of how to deal with *daño* by means of a traditional ritual. Such rituals are originally performed in the north of Peru by *curanderos* ('healers').[118] Mary's friend verified the presence of *daño* by reading in the ash of a cigarette, which she smoked in Mary's room. This friend also identified the means used to cause the *daño* (a photograph) as well as the general characteristics of the person who had inflicted this curse upon Mary. Mary believed her friend had also performed a ritual to clean her from *daño*.

> *She has photos of you and your sister, but don't worry* – she said to me (her friend). – *I also know* (how to do) *some jobs,* she told me. *I will not say anything, but I will do a cleansing to you, of everything. And I will not charge you anything.* I don't know if she has also done something (cleansing) to me, whether she has… How should I say it? Whether she *me levantó* (literally: *lifted me* – meaning cleansed) a bit or not? I don't know it.

[118] The most pure healing tradition in Peru is represented by healers in the north, who are also called *curanderos* or *maestros*. Particularly strong and credited are the maestros in Salala as well as those in Huancabamba. This last village is located high up in the Andean mountains in the Piura Region, which is also the nearest city. The place is difficult to access as it takes several days to get there. The power of these maestros in Huancabamba is believed to emanate from the "de las Huaringas" lakes that exist in this area. In fact, it is believed, these maestros maintain their powers due to their closeness to the lakes and their actual powers are conferred by the spirits of the lakes. In their 'lifting' performance they constantly refer to the power which emanate from various elements in nature and particularly from the lakes. In my visit to these maestros, I could witness the use of similar devices (cigarettes, ruda plants, photographs) in the diagnosis and cure of *daño.* These "props" are also used in the 'lifting' or *levantamiento* done to treat *daño.* These performances were conducted in a very complex and elaborated fashion, which extended for at least two days. This ceremony also involved the afflicted person making the journey to the "de las Huaringas" lakes, to bathe in the powerful waters.

Mary describes how eventually, the *daño* initially intended to harm her was redirected by the person who inflicted it towards Mary's nephew – her sister's daughter – causing the little girl a facial paralysis.

While her employer's' technique was new to Mary, she believed it was what really helped her to get better, as well as her son's recovery to good health. Was it really *daño* enacted upon Mary? This can never be known for sure. However what gave Mary a clear indication that it solved the problem is – after a short time following her employer's performance of the healing on her – things improved. She began to feel better. What is interesting in Mary's account is her use of various categories of distress in her interaction with various interlocutors.

In fact, in the previous chapter, we have seen how Mary recalls her mother's experiences of *nerves*, using that recollection as prototype to understand her own current experiences of distress. Here, Mary discusses the nature of her distress with her friend at home and with her employer at the workplace. With both she considers the possibility of having being cursed.

Also, with their assistance, she takes actions to reverse the *daño*. Mary's narrative will come back later in this chapter when she uses yet another label to understand her distress. What I would like to stress here is what Mary's experience demonstrates to us. Rather than seeing the use of these categories of distress as fixed, they have to be perceived in their fluidity. The use of various idioms of distress should be viewed as emerging from their diverse natures as well as in interaction with various interlocutors.

Crowdedness, babies and evil eye

Evil eye is described by migrants as unintended harm exerted mostly towards babies and small children caused by an adult's heavy gaze. Often *evil eye* or *ojo* is involuntarily infringed when admiring the child and the inflicting person may be unaware of the effect that his or her "heavy gaze" may have on the infant. Symptoms experienced by the child suffering from evil eye are several. Commonly, they are restlessness, difficulties falling asleep, excessive crying and/or lack of energy.

I knew of the existence of this and other culture-bound syndromes among the Peruvian community, however their prevalence did not become known to me through the household survey I carried out. Building trust with the community proved to be a gradual process, as was my approach to their health conceptions and beliefs. However, the next account shows how my own physical closeness did not guarantee that I would have immediate access to the migrants' health practices; especially ones they thought I wouldn't understand or would be critical of.

> The baby in the next room was very restless. *She has not had enough sleep, señora* Angelica, her mother, said to me when we met in the corridor. She was pacing back and forth with the baby in her arms. We talked a bit and I decided to go to my room to sleep. I was in my room when I heard *señora* Angelica's husband, *don* Hugo, arriving. The next thing I heard was him saying with great certainty: *Está ojeada* (she is suffering from *evil*

eye!)... *Who could have been? Our neighbour Lucho,* said *señora* Angelica, I could hear through the thin walls[119].

The couple then entered into their room and I heard a noise, as if something was being rubbed onto the baby's body. I heard crinkling, the noise of crumpling a piece of newspaper. I knew already about this common practice to cure evil eye among Peruvian migrants.

Then, *Don* Hugo said: *Where are the matches*? *In the kitchen*, I heard *señora* Angelica say. The whole procedure might have not taken any longer than five minutes.

Then I heard Don Hugo leave the room, going towards the kitchen area, in the corridor. After a short while, I decided to come out of my room with the excuse of getting some water to drink.

I saw *Don* Hugo from the back. He was standing facing the wall. He had lighted the piece of newspaper and was watching it burn on the floor. This confirmed that I was right. I wanted to see whether or not he would tell me about what he was doing. So I decided to speak up. *What is that, Don Hugo?* He turned back and I saw the surprise in his face.

Nothing, he tells me. Nothing, it is just to chase the cockroaches, Ah! I said. But why? They are so harmless… I know for sure, I have not yet gained their trust.

Field notes, January 2003

After that episode, I waited for some weeks, expecting that one day *Don* Hugo and *señora* Angelica would spontaneously talk about the existence of *evil eye* as well as other culturally-bound syndromes. But it did not happen that way. Only after I began to talk about other people and their experiences of the *evil eye*, in a manner that demonstrated I was not judgemental with regards to their belief in the existence of such illnesses, did they open up to me. *Don* Hugo even recalled the event I had witnessed in the corridor and confessed to me why he was burning the paper. He admitted it was because the baby had been sick because of the *evil eye*.

A second baby born in the compound was the daughter of Richard and Jenny. Soon after she was born, she was kept away from the gaze of the inhabitants of the place until she was protected with *Agua de Socorro* (literally translated as *help water*, which is *holy water*, blessed in the Catholic Church). Every time the baby was taken outside the, room her face was covered.

The young couple, with their newborn baby, were walking out of the housing compound. I saw them approaching and I walked towards them to get to know the baby. As they saw me approaching them, they covered the baby's face with a cloth and told me that I could not see her because *she is still very small.* I felt a little bit awkward but didn't say anything and let them go. I then asked Graciela, *why did they not want me to see the baby…?*

[119] As described in the ethnographic chapter (chapter V), symbolic kinship relationship of *compadrazgo* had been previously established between *señora* Angelica, *Don* Hugo and Lucho & Angela, the contiguous neighbours of the couple and their baby. This relationship of symbolic kinship is very relevant in the Latin America context. It is central mechanism in the creation of alliances and the channelling of social relations. In this case it was established on an occasion when the baby had fallen seriously ill and had to be rushed to the hospital. Luis and Angela helped the couple with money to cover the baby's medical care expenses. After this episode, *Agua de Socorro* was given to the baby and the role of Lucho & Angela as godparents was therefore confirmed. Such a relationship was aimed at increasing cooperation and to reduce possible conflicts among near neighbours. However, it does not exempt Lucho from involuntarily giving evil eye to his godchild.

> To this she replied: "they stop letting people see their baby now, because they are scared that somebody would give her evil eye (ojear). I don't know why they are so worried. The baby is not very pretty, anyway. She is very dark".
>
> *Field notes, February 2003*

From Graciela's comment, it is possible to infer the reasons which predispose a child to be affected by *evil eye*. An infant considered especially beautiful would be more exposed to the *envy gaze* of an adult. However, what is also implicit in Graciela's comment is the racial stereotype of beauty as associated with lighter skin colour.[120]

8.2.2 Discrimination and transgressions in the host society

Humiliation, embarrassment and chucaque

Also called *pudor* (sense of shame) or *vergüenza* (embarrassment), this is a culturally-bound syndrome, originating from the northern coast of Peru and known from Pre-Hispanic times. It is defined as a somatic reaction resulting from a situation of embarrassment. Symptoms of *chucaque* are headache, nausea, vomiting, diarrhoea, and more or less indefinite pain in the abdomen, dullness, lack of energy, and irritability. Its treatment varies according to where symptoms are localised in the body.

The occurrence of *chucaque* in the city of Santiago*,* its diagnosis and treatment is restricted to the Peruvian immigrant community. Migrants are aware of the fact that this syndrome is exclusive to their cultural group. Furthermore, the disbelief of the syndrome by medical doctors and other healthcare practitioners in Peru, contributes to increase migrants' resistance to acknowledge it with people outside their close circle. The reasons above may explain why *chucaque* was not reported in terms of health problems in the survey which I initially carried out. I only became aware of its existence when I began to share living space with migrants, and unexpectedly I witnessed migrants suffering from this disorder.

Rosita who worked as a live-in nanny and came every two weeks to spend her free days with her partner at the migrants' housing compound, was the first person I met who displayed symptoms of *chucaque*.

> Rosita had *chucaque.* The reason for her embarrassment was work-related. Her employer did not want to give her the weekend off. It was Friday evening and she was getting ready to leave. What caused the embarrassment for her was that she needed to ask her employer for a salary advance. The employer refused her request and argued with her. Rosita finally left the house empty handed.
>
> In the bus, while going to her shared room downtown, she was feeling nauseous and wanted to throw up. As she described to me later, she knew her feeling ill was due to *chucaque*. That was the first time I had heard of this syndrome.

After discovering of the existence of *chucaque,* I was able to gather more cases among the compound's inhabitants; to observe them and to watch them cure each other.

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[120]The racial ideology widespread among the migrant group, does not differ from the Chilean viewpoint in that it gives higher value to whiteness to the detriment of 'India-ness' and blackness. Although Peruvians are often victims of racism by members of the host society, this experience does not necessary erode their own racist ideology and practices.

I was interested to know more about the situations that trigger this syndrome in context of migrant's interaction with the host society. Tania the 20-year oldest daughter of Demetrio and Chela recounted her experience to me.

> After arriving into the country Tania went to look for a job at the Parroquia Italiana. The first day she felt lucky having found work in the house of an upper class lady. In her first day of work the *señora* asked her where she was from in Peru, and Tania told her from Chimbote. The lady then took Tania to the bathroom and asked her to bath in water with chlorine, because *Chimbotanos 'smell of fish'* (Chimbote is a harbour city).
> Tania felt very embarrassed and did not want to bathe in the chlorinated water, but she did not say anything to the lady. She locked herself in the bathroom and considered taking a shower. But before she could do that, the *señora* walked into the bathroom and forced her to bath in the water with chlorine. After that, Tania was sent to clean the swimming pool with a brush.
> She felt very humiliated and decided to quit the job on that same day. Before leaving, she said to the woman: *Do you know señora, I am not your slave!* Tania threw the coins the *señora* had given to her to pay for transportation into her face. She remembered that once she was back in the migrant's compound, she felt very sick from *chucaque. S*he had a terrible headache and had to be helped by her sibling to release it from her body.[121]
>
> *Field notes, November 2002*

Recalling their first work experiences in Chile, many migrants mention embarrassment as the most recurrent incidence after arrival. Unsettling situations in the new context are many and varied, particularly as migrants in Chile often see themselves exposed to situations in which their own sense of dignity and self-respect is being challenged. In fact, as in the cases described previously multiple experiences of personal discomfort come from oppressive working environments in which many migrants must work. This is particularly true of women working in domestic service, though men suffer from *chucaque* as well.

It was interesting to observe how, living in the context of Chile's more liberal society, had affected migrants' experiences of *chucaque*. In particular, they describe extremely embarrassing situations such as hearing people swear in daily interactions. Migrants were also shocked to see women and youngsters smoking cigarettes in public or in front of their parents as well as couples caressing and kissing in public. Many were flabbergasted to see schoolgirls wearing uniforms with short skirts.

As one informant pointed out, Peruvian women in Chile seem to gradually experience less *chucaque* than they did in Peru. This is perhaps because they eventually engage in more liberal behaviour themselves. Smoking in public, or dancing with other women as is often done in ballrooms on the weekends, are considered 'liberal behaviour.' Having left their families behind in Peru, these women, who are mostly

[121] It is necessary to compare both situations described in the light of the life circumstances of these two women. Whereas both women were confronted in the workplace with situation that challenged their sense of dignity, one of them quit her job and the other one didn't. Rosita's situation was more difficult since she has two daughters to support in Peru; Tania had no children and she was working to only support herself. Family responsibilities and economic needs force migrants to endure abusive work situations, which often results in negative health effects.

live-in nannies, are freed from the social control exerted over them by their family members.[122]

An exploration into this syndrome offers the possibility to examine ways in which the social world and physical bodies interact. Everyday experiences affect the physical body in a relation that is culturally framed. Bodies respond to culturally specific stimuli in idiosyncratic ways, especially when dealing with what is considered to be situations of embarrassment. In western cultures, blushing is a typical 'bodily sign of embarrassment'. However, for these migrants, embarrassment causes a succession of physical symptoms that can become extremely acute when proper treatment is not given in time.

Rosita arrived at the building of Bandera Street and there she received the proper treatment. She recovered a few hours later:

> In the building on Bandera Street, Rosita met Lucho, her partner. After a short talk, he decided to treat her; to relieve her from *chucaque*. He did this by pulling a tuft of her hair eight times. Each time, it made a cricked sound, which according to Lucho, was a sign that she, had a lot of *chucaque*. After this, however she continued feeling sick and felt the pain had descended to her navel.
> When I got to the building that day, Lucho was asking Olga to help treat Rosita. Olga said the fact that Rosita had been suffering from *chucaque* for the entire day cause it to be experienced in its more acute form. Now Rosita needed a different treatment. Olga cut an onion in slices, added salt and rubbed it on Rosita's belly button. Lying on her bed Rosita looked very pale and tired,. With some concern, Rosita told me she knew people could die of *chucaque.* I sat with her for a while until she felt better.
>
> *Field notes, November 2002*

As seen in the case of Tania and Rosita, the community plays an important role in the diagnosis and treatment of *chucaque*. Although opinions differ regarding the gender of the specialist; according to Rosita: *The treatment must come from man to woman, if she is ill, and vice-versa*. *To treat chucaque, one has to know how to do it. Not everybody can do it.* Migrants in the compound helped each other to relieve the socially caused *vergüenza* from their bodies as is described in the cases previously presented.[123]

The ill person and the helper share an understanding of the subjective experience of embarrassment, which might possibly be harmful to one's health. Both should also share a common understanding of what possible bodily reactions may result as consequence of the lived experience. However, *chucaque* sufferers may not always be aware of what it is they are suffering from and might only experience physical distress. In these cases the ill person and his or her closer circle get together to evaluate and

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[122] Olgüita stated: *In Peru, a woman should wait until a man comes to invite her to dance*. In a similar way, if a woman in Peru is caught smoking in public by her relatives or friends, she will experience extreme embarrassment and probably will suffer *chucaque*.

[123] As documented by Ozzie G. Simmons in "Popular and Modern Medicine in Mestizo Communities of Coastal Peru and Chile": "To cure *chucaque*, the patient's palms are placed flat in his face and he is lifted by the elbows until his bones make a cracking noise; the operation is repeated holding the patient around the waist; and finally, hairs are pulled out of the patient's head until one makes a cracking noise which breaks the *chucaque* (1955:65). However, what I observed of hair-pulling was not pulling individual hairs out of the head but instead; a tuft of hair was pulled eight times with enough strength to raise the scalp from the skull. Other treatments I observed included putting salt and a half of a lemon or slices of onion on the abdomen of the ill person when the symptom was localised in the stomach area.

conclude on a diagnosis. Hence, we can rightly affirm that the process of identifying the cause of *chucaque* is – at the same time – an opportunity for members of the community to provide and receive the so much needed emotional support. This is based on a shared understandings of the challenging situations faced, ones that often can only be found within the same cultural community.

However, the unexpected awkwardness experienced by recently arrived migrants in Chile resembles the social transgressions to which *chucaque* sufferers are exposed to in Peru as a treatment.[124] Such transgressions act as "immunisation experiences," after which the once very shy person turns into a *sinvergüenza,* a *shameless person.* Thus, it seems that long-term interaction with a more liberal society may well affect the prevalence of this syndrome among migrants. Indeed, changes in the cultural and social context may influence an individual's subjectivity; shifting what is experienced as "embarrassing". Therefore, the bodily reactions associated with these subjective experiences also change.

8.2.3 Uprootedness and the displacement of migrants' lives

The embodiment of a displaced self

The analysis of migrants' narratives has shown how they construe their self in reference to *others,* who are in *another place* (their places of origin). Indeed, migrants make sense of their present circumstances – as economic migrants – in reference to the life and well-being of their *significant others*, who are away.[125]

Yet, it seems that difficulties in bridging the gap between the *here* and *there*, block the continuity in migrants' relationship with their significant others. As it was discussed in the theoretical chapter, this can create a void which hinders the possibility for migrants to restore the definition of their own self and to achieve continuity in their sense of self – an element central to "personhood". Discontinuity in the self, in turn, produces emotional suffering ultimately experienced by migrants in their own bodies.

> My husband says that I am… in spite of the fact that I am married. I continue (to be) glued to my mother and father. My father does not fall ill so often. He is serious, but in his seriousness, when I talk to him I notice his sadness. He does not show it as my mother does. It is, how should I say? He likes to show himself as strong. But I know that inside, he also suffers because I am not there. ...But he says that is better that I am here, beside my husband and with my children.... (Her father says to her) *because that is the way you, as a daughter, have made a home, to be with your children. You are not always to be with us...* (Rocio)

Migrants' endeavours are mobilised by culturally defined motivations and goals. Failures to meet these goals are often identified by migrants as causing them distress.

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[124] Some cases of *chucaque* sufferers are put through treatment without knowing it. In order to be cured, social transgressions may involve *eating the same food a dog is eating* or *sleeping on somebody else's dirty underwear*. The person who does not know that he or she has *chucaque* is then cured from an intensified sense of shame by being exposed to experiences commonly considered embarrassing.

[125] This experience is, however, not exclusive to these particular groups of migrants. It is common to people living in Diasporas as well as among many other migrant groups.

L: How does it affect you to be far from them? (her family)
R: Not being able to be with them there, to help them in what is needed, not only economically but also morally, but to be with them.
L: How does it affect your state of mind?
R: (I feel) quite a lot of sadness. I feel like crying. But sometimes I say to myself: no I better don't cry. It will make things worse.

Migrant's notions of the self, the body and emotions are hybrid constructs in which remnant traits of the traditional Andean culture are prevalent. Such conceptions are relevant in understanding the processes of embodiment of migrants' experiences of emotional distress. For example, the boundaries of the symbolic body link migrants in Chile in relation to family members at a distance, and this symbolic connection is lived as an embodied experience. The extended boundaries of the self and of others become visible in migrant's bodily experiences. This is particularly evident when their own emotional suffering triggers an illness in a close family member – even when they are far away.

Women in particular, experience their own bodies and the bodies of their children as entities without distinct boundaries. The bond which links a mother and her child is seen as being created during pregnancy, childhood and throughout life, growing in its physical closeness. Such a bond becomes permanent, acting in the course of a lifetime as a sort of somatic chain, linking different generations together.

Migrants' emotional suffering is felt by mothers in spite of the distance, when they are living away from home. This is a two-sided bond which begins to be experienced early in life; when a child witnesses his/her mother's suffering. The next quote shows the emotional connection which links Rocio, a migrant woman, with her own mother in Peru and at the same time, to her small children living with her in Chile:

L: What happens if you cry?
R: Ah I get ill and I also make them ill (her family in Peru). Because my mother says that she feels, when something happens here, either to my other sister or to me. ...My mother tells me: *You, daughter, are very sentimental. You cry for everything. You have to be calmed for your babies.* She said (this) to me. … It happens when I am sometimes quiet. I feel oppression on my chest. I quickly say: ah! Maybe she is bad (her mother in Peru). I am yearning to call (home). That day when I feel bad, I feel such a longing to go and call them, to know how they are (doing).

Symptoms of *depression* are experienced as pain in the chest. In Rocio's experience, this symptom is produced by the distance from meaningful others.

L: Why do you believe your emotional distress is *depression*?
R: Because it is as if I feel something in my chest. I have always been there with my family and I have always looked after my family. I know what they go through there. I know that my mother sometimes is ill. But she does not want to tell me when I call, because she doesn't want me to become worried.

Distance from meaningful others is felt in the body and is described as being torn apart. The painful experience of *being here and there* at the same time is emotionally distressing. It is a recurrent incidence among migrants that while eating, their concern for the meaningful other's well-being becomes activated and manifested in their bodies. Thoughts and worries regarding migrants loved ones; the concern about whether or not

their family members are feeding themselves properly in Peru, are felt in the body in a way that the person cannot continue eating. Elena expresses the experience of been unable to eat as: *I got the sadness and it fills up everything.*

> (I want to) help my mother more. I start thinking at the time that she… When the time to eat comes and (she wonders) would she (her mother) be eating or not? Sometimes I am going to eat and suddenly I remember (her). And I say, I am going to eat and my mother might have not eaten. Then it gets hard here (points out her stomach) and (there) is (a feeling) as if I have eaten a lot.
> I worry a lot, so that my daughter or my husband looks at me and he says: *eat, eat, eat*, but for me… I got the sadness and it fills up everything. And I don't want anything and I become sad. All the same poh! So they (her daughter and husband) tell me *eat!* Sure they want me to eat and feel fine but they don't know what is going through my head. Do you understand me?

Similarly for Mary, concerns about her daughters would become especially hurting at the dinner table.

> I used to tell my husband; would be Gracel eating… and Jocy? I used to say that to him... I could not eat anymore, I would cry, cry at the dinner table, depressed and all that. …this (happened) about five years ago, ehh, I don't know, to be separated from them… affected me.

As discussed in the theoretical chapter, migrants' perceive their own-selves in relation to others. This becomes an embodied experience while eating and sharing food. It is as if feeding – and breastfeeding – would act as a material connection of such emotional bonds.

> I sometimes get worried about them (her sister's babies), because I have looked after their babies. I used to breast feed the two babies that they have.

Their inability to enjoy food is the embodied experience, confirming to these people, that each person's well-being depends on the well-being of those meaningful to them, even when they are physically far away. Cesar experiences his worries and concern for his mother in his heart. The pain he feels in his heart, in his reckoning, is a signal sent to him.

> C: Sometimes I have that… feeling about my mother, of how she would be. I get up and ask to myself: how would she be? …All the thinking of her is what attacks my heart… It announced itself to me because my heart hurt.
> L: What did it announce?
> C: That something was happening with my family in Peru.
> L: And did you call then
> C: Yes, I called and then I learnt what happened.
> L: How do you feel it as an announcement?
> C: I feel like, as if I lack air. I feel lots of pain (in his chest).

Goals set in migration are often expressed in terms of its material products – goods, clothing and other items planned to be purchased or already bought for family members in Peru. The many objects that circulate between Chile and Peru are embedded in a net of symbolic meanings and values, showing the caring and concern of one for the other. They are more than their simple materiality as they carry the attached affective value of

migrants' endeavours. Goods purchased by migrants compress the emotional dimension of migration. This circulation of gifts attempts to restore the interrupted connection between migrants and their significant others who still reside in Peru. Like many migrants Rocío saves a little money from her household budget to send presents to her mother and sister. Planning what she will send home from Chile helps her to lift her mood.

8.3 New experiences and idioms of distress emerging under new circumstances

> **…**when people belong to multiples setting, they come into contact with the regulatory powers and the hegemonic culture of more than one state (Levitt 2004:1013).

Regulatory powers not only act upon economic interactions and political processes but also influence peoples' notions of health and normality. This, in turn, impacts people's practices and their means to deal with illness and distress. Migrants' emotional distress is not merely a result of their new life and working conditions in the host society. It is also a *constructed* experience, which is *interpreted* and, in that process, incorporates dimensions of the new reality in which migrants are living. The new context provides migrants with new signs and meanings to identify; interpret and act upon their emotional distress. Moreover, it provides them with another language to communicate their experiences of suffering and distress. In that same process, illness experiences are transformed.

Depression and *stress* have begun to be used by migrants as idioms of distress in Chile. The introduction of variations in meanings of illness actually reflects more clearly the use of these medical categories as idioms of distress. Idioms emerge with the interaction of migrants with local actors in different social settings: migrants' co-workers, friends, employers, healthcare practitioners such as nurses and medical doctors are influencing agents. Entrenched in these interactions, are changes resulting from migrants' direct confrontation with a more modern society. In such instances, old notions and practices around illness and distress are challenged.

To understand this process, it may be useful to attend to Arce and Long's call to explore how "the ideas and practices of modernity are themselves appropriated and re-embedded in locally situated practices, thus accelerating the fragmentation and dispersal of modernity into constantly proliferating modernities" (Long 1998:1).[126]

[126] While the discussion around the existence of multiple modernities goes beyond the aim of this chapter, it may be necessary to define modernity and its referential concept of modernisation. Long and Arce distinguish 'modernity' from 'modernisation' and maintain the first can be seen as "a metaphor for new or emerging 'here-and-now' materialities, meanings and cultural styles seen in relation of some past state of things". (2000:2) Modernisation in turn, refers to "a comprehensive package of technical and institutional measures aimed at widespread societal transformation and underpinned by neo-evolutionary theoretical narratives" (ibid). In this sense, migrants value the more advanced modernisation of the Chilean society. However, they constantly distance themselves from those ideas and practices they perceive as 'decadent' modernity in the Chilean society. In the realm of health for example, it is possible to observe migrants tend to place more value on healing traditions such as the use of herbs, special types of food and products taken from nature. These resources they traditionally use to maintain health and treat various illnesses. Particularly, migrants value products originating in Peru (eg. *uña de gato*, *maca*) and distrust biomedicine and modern pharmaceutical products which Chileans predominantly use.

Migrants bring with them their own cultural backgrounds. This, in many ways, shapes the way they experience suffering and emotional distress. It also suggests the need to investigate the possibility that a variety of nosological categories may coexist in an individual's experience of illness. Therefore, two relevant questions must be asked: To what extent are people's notions and experiences of illness multiple and plural? Secondly, do they contain various and non-isomorphic explanatory models? This is also to say that migrants live their subjectivity and experience their emotional domain with hybrid cultural frames of reference. Such frames are simultaneous and divergent – one of the migrants' society of origin and the other of their host society.

In order to get a better grasp upon the coexistence and overlapping of peoples' 'modern' and 'traditional'[127] notions of illness, the body and distress, it may be useful to refer to the concept of 'counterwork.' This is a concept Parkin defines as "the rebounding effects of knowledge in its diversity" (Parkin 1995:144) and is used to study the intertwining of religious and medical knowledge and practice. This concept becomes significant in a context where individuals interact simultaneously with various cultural frames of reference in the realm of illness and distress. It assists us in looking at people's active role in the dispersion and hybridisation of medical knowledge. Indeed, through 'counterwork,' people themselves engage in a continuous negotiation about the nature of knowledge. – As Parkin put it: "the same people constantly relocate the origins of beliefs and behaviour" (ibid:148).

In spite of their current use of medical terminology, low income *mestizo* Peruvian migrants, have not (yet) transformed their narratives of emotional distress or mental illness into any 'objectified' area of reflection or specialised intervention. They are, instead, appropriating these medical categories to place them into their own living context and collective experiences. Typically, medical terminology is intertwined with other previously existent knowledge and categories of distress. Therefore, migrants do not define their narratives of distress in the field of specialised knowledge and have not yet entered the global trend as described by Lock (1993).

> Peoples' narrativisation of their experience of mental illness is a socially situated, individualised version of a body of cultural knowledge that, in modern society in particular, is increasingly impregnated by expert knowledge (Lock 1993:133).

The processes I have referred to above and the development of migrants' illness experiences, are analysed here. By development, I mean continuities and changes in the assemblage of elements which constitute illness experiences. In doing so, I look at continuities and changes in idioms, interpretations of the causes of illness, meanings as well as symptoms and means to manage illness as these changes manifest along shifting social contexts.

Categories of *depression* and *stress* circulating as idioms of distress are constructed as lay diagnosis among migrants. Diagnoses are often – but not always – based upon interpretations of the symptoms of distress experienced. As well, symptoms are not necessary the main criteria used for the diagnosis of a popular illness. Fabrega points at this idea when he asserts: "…social and moral characteristics of the ill individual and

[127] Although this distinction is necessary to refer to two distinct systems of beliefs, such distinction is at the same time, artificial, particularly when attending to the high degree of heterogeneity that even the most 'traditional' individuals frame their ideas and practices.

the kind of social stress that the person faces may be equally important in identifying and treating illness" (Fabrega 1970:304). As Good & Good affirm the meaning of medical discourse is constituted in its relationship to socially constructed illness reality (1994).

Categories of distress are borrowed from each other, compressing idioms which although hybrid, convey shared meanings and similar life experiences. The principle underlying this analogical reasoning is one in which similar life's circumstances are seen as producing a similar illness among people. This makes up an 'experiential' etiologic principle prevalent among these migrants.

However, the recent introduction of new categories now available for expressing their illness experiences may count as an explanation for their yet-unstable character and the multiplicity of meanings these categories acquire among migrants.

In the process of understanding their own experiences of distress, migrants often compare them with the experiences of other people who are close to them. Elena describes how she learned what *stress* was and how she could relate this category of distress to her own life experience. She recalled reading about stress in a magazine.

> (I read about) the stress of a mother who was abandoned by her husband. She was the mother of three children, and that she felt *stressed*, why? Because she had to give milk, food, everything to her children…

Having experienced a similar biographical situation, Elena could identify herself with the cause of this illness. Thus, she uses an etiological category, and understands her illness to be the same as the *stress* described in the magazine. However, Elena now uses the terms *stress*, *depression* and *nerves* indiscriminately in her narrative. In her view, they all refer to similar problems. For her, these are interchangeable names for the same illness, for which she had being diagnosed earlier in Peru. There she was diagnosed by a doctor as suffering from *nerves*. She recalls the discussion with this doctor regarding what *nerves* and *depression* were:

L: Was it the doctor in Peru who told you that you were depressed? Was that what he said?
E: Yes, he said that the problem was my nerves.
L: Ah! So he said it was nerves?
E: Yes, we call it depression and they call it nerves: *You are with all the nervousness,* he told me. *It is nothing else. It has gotten you (nerves), but you must be strong*.
L: Where was it called depression then?
E: In Peru, and I got used to that word.
L: Ah there…But the doctor there called it nerves?
E: Yes, nerves, nerves or depression as so many words that are changed or exchanged while speaking.

Elena uses the categories of nerves and depression as an equivalent diagnosis as she recalls it was used by her doctor in Peru. In Elena's interpretation, the category of nerves matches depression.

> I told him (the doctor) is this like *depression*? Like *nerves*? What is *depression*? (Asked the doctor to Elena)… *Depression*, I learnt that is when one closes oneself with all the

problems inside and that one does not have a way out, that is. So then he pointed out to me that yes; *nerves* was that. …That I should overcome it.

In this narrative, it is possible to observe Elena has engaged in 'counterwork' as she displaces the origin of *nerves* to the doctors' belief system and takes as her own the medical label of *depression,* to which she has already attached her own meanings. Elena juggles in this interplay of unlike categories, both 'hegemonic' (*depression* as biomedical category) and 'non hegemonic' (*nerves* as a culturally bounded syndrome) discourses.

In Chile, Elena has also incorporated a descriptive category of illness, taken from her Chilean colleague at work. This woman also considers herself to be suffering from *depression* and shares with Elena, the different problems causing it. So, Elena now uses both the 'descriptive category' for the same symptoms as well as an 'etiological' view for the same causes when explaining what *depression* is for her.

L: Is her *depression* (of her Chilean work colleague) the same as your *depression* or is it different?
E: For the reason of the problems it is different, because I have one sort of problems and they have other ones. So it is different, but is the same thing, the same thing.
L: Is it the same thing with regards to the symptoms or not?
E: I believe it must be the same. I think it is the same because they also say to me: *Elena, my arms ache; my legs ache. I feel pain in my brain, the head…* They told me Elena, *I sometimes feel as if I am going to die! I am smothered. I can't cry*, they told me. So I feel sad because I feel the same. So, only advice (Elena gives them), nothing else.

Mary began to think of herself as being depressed when a migrant friend came to her room to talk about the worrisome signs she had been observing in her. The friend commented on Mary's unusual behaviour.

You are bad Mary. You cannot treat your daughters that way… You used to dress up before… You are not the same Mary that we have known. …You are going through a bad period… You are getting depressed!!

Depression is not identified by a set of symptoms but by 'unacceptable behaviour' in the community's view.

Following this, Mary began to think *depression* was a possible diagnosis for her distress. She talked to another Peruvian friend who had been medically diagnosed with a *depression* to contrast her friend's experience with her own. Her friend was receiving medical attention for her depression. Mary identified herself with that diagnosis because like her friend, her entire body would tremble. This friend told Mary that she should go to the doctor soon, *before it was too late.* She then poured onto the table *the piles of medicines that she was taking.* To understand her emotional distress, Mary uses a medical diagnosis originally given to a migrant friend by a medical doctor. Mary's symptoms seem to fit the medical diagnosis of depression. However, both friends agree that it is best she does something to avoid medical treatment. Mary recalls that soon everybody was telling her she was *depressed*.

Mary has expressed previously in her narrative the possibility of suffering from *nerves* as her mother did in the past. Mary also explored and took actions against the possibility of having being cursed. Firstly she discussed it with a woman friend in her compound and later with her employer. This time, a second friend, who, having suffered from depression herself, shares with Mary her own experience. They both concluded that what Mary had was *depression.* However, at her work, her employer diagnosed her problem as stress.

> One day, the Señora told me, *you are stressed, Mary. You didn't take holidays last year. You worked... and you are still working. ...Don't get stressed!* (Mary's boss then drew a comparison) *It is like a car that you use, and use, and use. You use the car up until all of the sudden pum! It stops! Why? Because it needs maintenance*… That is what she would tell me.

In Chile, Marianela was told by a medical doctor that she suffered from depression.

L: And before, did somebody tell you that you had depression?
M: No.
L: They told you here?
M: Yes, here they told me.

Having been given the diagnosis of *depression* in Chile, Marianela interprets earlier forms of distress she experienced in Peru, including *convulsions* as also *depression*. In her view, these experiences are both *depression,* although different because her life circumstances allow symptoms to manifest themselves to an extreme in her home country. This is not something she has experienced while living in Chile. So for her, both illness experiences are different because her life circumstances have changed. In Chile, a contributing factor to her *depression* is related to lack of social support, which she needs to help her deal with her responsibilities as a mother.

L: So then, there you did not have the kind of depression you have had here?
M: Well (it) is because here it was for the same reason – for me to suddenly assume my son as my entire responsibility. There (in Peru), I did not feel it so much because in one way, or another… Sometimes my mother would take him (her son). She would look after him, but here it was something different to see myself alone, without the support of anyone.

Rather than recognising a similar set of symptoms, which would make her *depressions* the same illness, Marianela sees them as different forms of *depression* as they had manifested themselves differently in Peru and in Chile. Depression, as yet, is seen as an unstable category of emotional distress. However, the term has been given diverse meanings. In this case, it does not always encompass similar symptoms or causes.

Yet, contained in these new idioms, other pre-existent idioms of distress coexist and emerge. Thus, they become more evident as they manifest in specific bodily symptoms, similar to the embodiment idioms of the suffering self which have been described earlier.

One of the associated symptoms for migrants, when they feel sad and depressed is a headache – the end result of *thinking too much.*

L: What do you think that happens in your body that gives you headaches and a feeling of dizziness?
R: For example, I when I feel sad and depressed, I am crying in my bed, and then my headaches begin.
L: Why do you think the headaches begin?
R: Ah, it is because one is thinking so much. That is why one gets the headaches. One is thinking about what to do, or why I am here or anything else. …This also gives me headaches.

The perception of headaches as triggered by *thinking about what to do,* points to an underlying model in which the body is seen as immersed in the social world. According to this model, the activity of constant thinking, which responds to the affective dimension of *worrying too much* produces a physical effect in the form of headaches. Through headaches, the affective world is thus embodied. Headaches ultimately are the result – as an embodied effect – of the impossibility to act in the world, and change the present circumstances.

Oscar also makes the connection between headaches and thinking too much in his illness experience of *stress.*

You feel like the headaches (are) due to too much thinking. Would that be? For one to be thinking too much one starts feeling headaches?

The body is centrally located in the Andean conceptions of an interrelated social and natural world. It is a privileged conduit to convey meaning and communicate distress. Headaches have been also described as idioms of distress by Darghoud (2006). This terminology is used among poor urban Peruvian women to articulate shared notions of suffering within a larger context of dislocation. "Woven into [it are] experiences of solitude, headache; accounts are lived and told in dynamic temporal spaces, and narrate dissolution of family ties and tension associated with women's roles" (Darghouth 2006:1).

8.3.1 Exclusion and 'illness identity talks'

The analysis of the use of medical diagnoses as labels in idioms of distress to communicate new meanings of emotional distress, involves questions about the meanings given to these new illnesses: are these linked to values and social practices, to socio-cultural systems (economic, political, & others)? Are these idioms migrants use metaphors to address the social, economic and political order in which they are embedded?

In the context of our analysis, the meanings of illness reflect migrant's moral concerns and values. These, in turn, are derived from their particular – and marginal – position in the social and economic structure of the host society. Yet, idioms appear to be unstable often conveying various and sometimes contradictory meanings.

While *depression* is used by migrants to communicate moral concerns of their failure to provide for their families in Peru, s*tress* is used to communicate the physical and emotional cost of their precarious involvement in the labour force. Yet, at the same

time, *stress* is an indication of having successfully engaged in the Chilean labour market. This, as it will be argued, can be seen as a reflection of the migrants' direct relationship with a society they view with ambivalent feelings.

Through the use of distress idioms, migrants enter into a dialogue with others leading them to achieve forms of legitimacy. Moreover, through the use of idioms of distress, they also talk about themselves and engage in 'illness identity talks.' This is particularly important as meanings associated to illness may eventually lead to a redefinition of migrant's identities.

In this section I will discuss some of the lines through which migrants redefine their identities; as they engage in 'illness identity talks.'

Depression and migrant's (moral) failure

Marianela understands her depression as evidence of the difficulties she has developed in facing her problems at work. She sees it as her personal failure; of having become a *coward.*

L: And this? What happens to you here? Was it the first time?
M: I did not have this problem in Peru. I could face my problems in Peru. I would get into whatever place and I would put up with the situation. …Here, (in Chile) I became a little bit… let's say, a **coward**. Because I saw myself alone so, **I became a coward.** …Although I don't give up and always try to face (my problems). But in the work, I have, when I want something; it is very difficult for me to say it.

For Marlo *depression* denotes *weakness* or *being too soft.* Marlo reflects on his lack of endurance, since he cries at any moment. This is associated to the feeling that *one is not strong enough.* For Elena, depression means *to be a little bit weak.*For her, depression is associated with unsolved problems and with the feeling of *being useless.*

Yes, I believe I am useless more than anything else. Sometimes, when I don't have money, sometimes they ask me… (her children) one thing or another. And I can't. It is then when I call myself *useless* - that I am worth nothing. The feeling of sadness and without a way out…"

Elena associates her depression with the feeling that *one is not strong enough:*

…a little bit weak that is. And when I am thinking about my problems, I suddenly feel I am a **coward**. But sometimes, I realise there is some solution and it is then when it goes away a little bit.

Depression is new to Javier, but he says in Peru he experienced something similar to what he now describes as *depression*.

L: So in Peru people say you are with a '*long face*' and here people say you are '*down*.'
J: Yes.
L: And *depression*, where did you hear of that?
J: Everywhere… (in Chile) always one says… One looks at somebody and says he/she is with a *long face* or maybe has a *depression*.
L: And for you, what is *depression*?

J: I don't have it clear. To tell you right now, right now, I would not know how… but then let's say that you get something similar to *depression*, similar…
L: And for you, with your own words, what was it?
J: It was a problem. It can be (a problem) with a person. And I feel trapped without a way out … That I don't have anything to hold on to.

Javier struggled to define the term *depression*, although he had already incorporated the word into his language to communicate his experiences of distress. The term *depression*, in Javier's account, is given a more apprehensible meaning, when it is used in reference to life circumstances rather than a set of symptoms. The process of constructing meaning around what is originally a medical diagnosis, signals the onset of a new idiom of distress among migrants. With his appropriation of the term *depression,* Javier and his friends now have a new language to signify a difficult and new life experience.

Depression seems to be used in Chile together with other known culturally-bound syndromes such as *weakness* and *nerves*. In the Peruvian context, however, *weakness* is seen as a bodily related condition. In Chile, *weakness* is used to denote a moral failing; as being seen as not able to *endure,* and/or to *provide* material support for their families. The sense of failure and lack of resistance is a reflection of the marginal insertion migrants have within the labour market. Thus their meagre and insufficient return of economic "sweat" investment reinforces this mindset. However, the moral dimension which emerges in association with *depression* places the blame on the individual or his/her most immediate environment.

Javier's friends told him what he could be suffering from was depression. However in their usage, the term had already acquired a new meaning – being "*under pressure*".

L: Who told you that you have this problem of *depression*? Who called it depression?
J: I think that were my friends. That (they) saw me a bit down, sometimes happy, cheerful, sometimes sad, and upset with a bad face… *What happens to you?* (his friends used to ask him).. *No nothing, Nothing happens to me* (he said).
L: Were your friends Peruvians or Chileans?
J: Peruvians.
L: And did your friends tell you that you had depression?
J: Yes, and they told to me to move out, to move out (from his aunt's room).
L: So they used that word depression?
J: Yes *you are under pressure*.
L: That you experienced depression or were under pressure?
J: Both things.

Javier's friends are trying to comfort and support him and at the same time, are collaborating in attaching meanings to the use of the term 'depression' as expressed by them: 'you are under pressure'.

Stress and the burdens of a busy worker's life

Unlike *depression,* which is more often used in the context of a more personal failure, *stress* appears to be associated to productivity. It is indeed a language that can only be used by those who are inserted in a structure of production. Although this insertion may be marginal, it is preferred by migrants as it involves the generation of some revenue. *Stress*, therefore, signifies migrants' success as workers.

Most migrants say they have come to know about stress since arriving in Chile. Gladys recognises having had similar experiences in Peru which she describes as *tiredness* and *exhaustion.* However in Peru, she experienced it more acutely. In this case similar bodily states are experienced differently in connection with the shifting economic contexts in which the individual workers participate. Gladys' body incorporated the unsuccessful efforts she put into her work in Peru. In fact, she recalls those states of *tiredness* as barren. As she puts it: *I used to work more and earned less*. In that sense, *tiredness* and *stress* differ, as these forms of distress are outcomes of the efforts invested into productive work. Gladys new position as a worker in the host society, although marginal, does produce higher compensations as compared to Peru.

L: When you say you suffer from *stress*, what do you refer to?
G: Well, I feel tired, too exhausted. My mood that sometimes... ahhh (she massages her nape) ...And well, I imagine that must be stress.
L: Did you use the term *stress* to refer to your tiredness in Peru?
G: No. *Stress*, I have got to know it here. There (in Peru) I said *today I feel tired, exhausted*... There (*stress*) is not so common.
L: It is not so common… But, are they the same symptoms of what is called *stress* here?
G: I imagine it is the same. It has another name, but is the same.

For Gladys *stress* is the same kind of distress she had experienced before. Now, it has just been given another name. By the use of the new term *stress*, however similar, the experience is now open to incorporate other meanings.

L: So when you say here: *I have aches here and there. I am tired, exhausted.* Is it the same as you experienced in Peru?
G: Well, there I experienced it more because I used to work more and earned less…. That is why it was very tragic.

In this case, the differences between earlier forms of distress and her current *stress* did not involve variations in the kind of symptoms experienced, but it does in terms of in meanings attached to distress.

L: You were telling me that you have heard of *stress* here?
G: Here yes. Well, there (it) is not very common. There, it is called… One (might) say: Hey! I am worn out, tired. I am…it is tiredness, one says. And here, one says uf! I can't move. Uff! I am dead beat!! (While she says this, she is massaging her neck)… Ah? (She mimics somebody else saying this to her) *You are stressed. You are stressed, that is why*... It is that word… Well, at least I have gotten to know that word more here than there. …I tell to my daughter, some time when I come (from work). I say; *Uff! I am really tired*, and I go downstairs to the newspaper kiosk. Sometimes to buy something and he (the vendor) says to me: *Hi, how are you?* I say: *Uff, I am tired. I feel a pain my back*... He says: "*Ah! That is stress.*
L: Was that said by a Chilean?
G: A Chilean of course! Because the young boy from downstairs, he is Chilean… *Why don't you go out to dance?* (and so on) *You are still young.* I said: No, I am going to look for somebody that would give me a full massage!, Ja, ja! We laugh at that! And I don't know, but it seems that stress is very common here.

For Oscar *stress* was a new illness experience and a new language of distress all together. He does not recognise having had a previous related form of distress.

However, Oscar suffered depression in Peru from the age of 20. He overcame it and moved to Chile, where he then began to suffer from *stress*. Being *stressed* in the context of a neo-liberal society, with people working extensive numbers of hours, is the norm in Chile. In this kind of environment, people must often rely upon themselves to survive. To be able to subsist in such context is directly associated with self worth.

L: So, you overcame your depression but you later became stressed?
O: Yes, but I actually prefer stress rather than depression, because depression is too ugly
L: How is it?
O: You feel destroyed. You feel as if you are worth nothing, as (though) people were looking at you like. …You feel as if people look down on you but that is ones' (own) ideas ...But you feel like destroyed as if you are worth nothing, that it is pointless being in this earth so you don't care about anything anymore. …But now not. Now, I realise that not. …I have grown up. I devote myself to work. I love myself now, not a lot, but I love myself a little. But now, I learn to feel I am worth it. Before, I did not feel I was worth it. I almost killed myself. I tried to eliminate myself, now I wouldn't do it.

Oscar identifies the influence of different societal contexts in Peru and Chile which cause stress to emerge.

L: When did you start feeling stressed?
O: When I began to feel…don't know… bored. …like too pressurised with my work. Too much like… It was work, work, and work. Work all the week is work; nothing more. (That is) …because in comparison with my own country, here…, here everything is work. And one lives faster, but in Peru, one is like more… more… Over there, one is…. things are more calmed there. Things can be done more calmed there. Like that, more relaxed, but here not. Here, all is much accelerated, very accelerated. It is too much. I think this country is too accelerated, too much. Life goes on in a too accelerated way, too accelerated. Even people's mentality is here accelerated! That is why people suffer here from stress. That is what I am suffering from now.

Stress is associated with the busy, goal-driven lifestyle of the modern urban environment, with which Oscar prefers to identify. Accelerated city life produces *stress*, and he has learned to live with it. Along with *stress*, Oscar has adopted an urban style of life.

L: Your stress problem, has it changed you in any way?
O: Yes, too much. I live very accelerated, too accelerated. I think too much. In Peru, I did not think like this, …(Now) sometimes, (people) are telling me something and I am thinking about something else. (I am) actually too accelerated, too accelerated.

Oscar admits this life involves some problems, but it also gives him some rewards. Stress actually involves, for him, a new identity as a more mature person. In Oscar's use of the term *stress* there is an attempt to rework his own identity and to communicate with the local interlocutors. *Stress* is associated to the modernity; to a busy urban lifestyle; of being a grown-up hard worker.

L: So you are becoming like the Chileans, then?
O: Yes very much. I wasn't like this before.

L: Do you see your life (as being) different now that you have stress (in it)?
O: Yes because I feel I am more grown up. Let's say I feel more mature than what I was before. My mentality has also become more mature now; a lot with the people here, I talk to the most. I am more of a 'little gentleman' when I talk (to the Chilean people he works with). More tranquil. They (Chileans in the shops he works for) ask me and I answer, but anyway people in the shops, they like me. They do not humiliate me. They treat me well. They tell me: "*Oscar! Hi my black one",* they say to me. "*Hi my black one, you are here!"* And yes, I laugh with a smile and they also laugh. They also respond to me the same normal way. I try to be liked by people.

For Felix, *stress* refers to the multiplicity of factors which puts pressure on him. *Stress* is used as a means to synthesise his life circumstances.

L: What makes you think that you have stress?
F: I am only supposing it. Let's say I am not diagnosing myself either. I am making that supposition that I might have stress, because I have been working for five years non-stop. Yes, it can be stress; the pressure. I don't see my children. I miss them. I don't see my family. All that… Sometimes, I have problems with my partner and all that. Sometimes, there are problems of money. I cannot send remittances and I am late. They (the problems) get accumulated and I believe, I think, that it could be all that.

8.4 Conclusions

Firstly, a brief summary of the social dynamics along which culture-bound syndromes is produced. As ascertained, all these syndromes were observed to occur inside the migrant community. However, they differ in the nature of the social interactions which produce them. *Daño* occurs as an effect of conflict and economic competence, internal to the community. Specifically, it is produced by feelings of envy caused by what is seen as an individual's accumulation of wealth. This last aspect seems to relate to the idea of limited goods brought forward by Foster and by Tausig.

Evil eye seems to specifically affect children intensified by the crowded conditions in which migrants live in Chile. Relations of symbolic kinship are often established around parent and the children's godparents in order to prevent conflicts and protect children. However, it does not always prevent children from unintended harm inflicted upon them.

Chucaque may be caused by what is generally termed culture shock. This is the shocking effect their interfacing with a more liberal society and behaviours can have upon them as migrants. They perceive this as transgressions of their social norms. Yet, *Chucaque* tends to appear more in reference to migrant's interaction with the larger Chilean society. In particular, this occurs when migrants are confronted with experiences of discrimination. It often arises in the workplace, in situations where they interact with their Chilean employers. Here, migrants' sense of dignity may be challenged.

Therefore, *chucaque* can be seen as an embodied, somatic manifestation of abusive social relations in the workplace. This particular case can be compared with other

experiences of migrant illness in other contexts, especially when they are embedded in oppressive relationships and new forms of exploitation.

The raising of these traditional forms of distress in new contexts – as a response to new and disturbing experiences – shows how deeply these 'culturally bound syndromes' are embedded in migrants' cultural repertoire. They are an integral part of Latin American cultures. At the same time, it shows the resilience of migrants' cultural reservoir, as they make use of their own and long dated resources to cope with the difficult conditions of their lives as migrants – and by means of them – heal themselves.

By discussing these syndromes, this section also highlighted the connection between the forms and languages of emotional distress and the context where this distress emerges. It is in the close-knit migrant community where traditional or folk forms of distress emerge. It is in the community context where these forms of distress are voiced and dealt with.

While *daño* tends to mark existing divisions within the community, the same community proves to be very important in the *chucaque* treatment. Nevertheless, even in dealing with *daño*, evil eye and *chucaque*, each member gives and receives equally in the mutual understanding of common embodied experiences. It is often a reciprocal relationship-that of give and take.

The space bounded nature of these forms of distress help to visualise how they are shaped by social interactions. In the discussion, the contextual nature of experiences and idioms used to communicate distress was addressed. Developments – continuities and changes – in illness experiences emerged clearly when looking at migrants' previous experiences of distress – while living in Peru – and comparing them to their current experiences in Chile. Migrants' own life stories framed the analysis of these evolving experiences. In this comparison, I made note of changes and continuities in symptoms, as well as in meanings and interpretations of causes of distress when these factors are involved.

The analysis conducted showed that in the majority of the cases, *depression* and *stress* appear to be experienced for the first time after arriving in Chile. This not only conveys an illness experience but also, it compresses an idiom of distress. As it was seen, the terms *depression* and *stress* are increasingly incorporated into migrants' narratives. Yet, the psychological language associated with these illnesses is not being incorporated. This was confirmed in migrants' narratives of their symptoms of distress discussed in the previous chapter.

However, in its new meaning, *depression* and *stress* acquires a moral dimension for migrants closely connected with their exclusion and marginal insertion in the labour market. These are represented discursively in the form of illness identity talks. These categories of distress are used denoting their perception of *lack of resistance*; their feeling of *not being able to endure* adversity, or to provide material support for their families in Peru. In the case of *stress*, associated meanings are linked to modern lifestyle and the 'logic consequence' of their productive, although marginal, involvement in the Chilean labour force.

An underlying issue linked to the transformation in the experiences of emotional distress, is the categorisation of migrants emotional distress according to western nosology. This issue brings about the need to investigate mental health problems as diseases and illness experiences. A question to be asked is whether these forms of distress voiced by migrants as depression and stress, can or cannot be equated to the same categories, defined and comprehended by western medicine, psychology and psychiatry? In other words, is depression defined in western medicine and psychiatry the same as what migrants experience and elicit as *estar deprimido* (to be depressed). And, what should we understand when they say *pena* (grief) or *tristeza* (sadness) or being *nervioso* (nervousness), or *estar con preocupación* (to be worried)?

The answer that emerges as we look at these forms of distress throughout migrants' own narratives and experiences – is no, they are not equivalent. The reason for this ought to be found in the meanings these forms of distress have for the people concerned. A critical question should be asked. What meanings are lost when diagnosing these forms of distress according to psychiatric categories? Certainly, when placed into a medical diagnosis, these forms of distress are taken out of the socioeconomic context which gives rise to it. In another context, Farmer reviews the limits of the western medical nosology to classify *move san;* a blood disorder caused by malignant emotions in Haitian society. Farmer's work shows how, in a context of economic hardship, *move san* emerges as a moral barometer of existent conflictive social relations. The vast dimensions that are ignored in such classificatory attempts reflect the inability of the medical categories to give a comprehensive account of the multiple dimensions involved in this illness. In view of the limitations of the western biomedical model Farmer reminds us of the need to connect personal illness meaning with the larger political and social system; to attend closely " to the way in which illness (and other misfortune) is worked into narrative rendering of broader experiences" (Farmer 1988:80). Furthermore and beyond classificatory purposes, the consequences of a medical diagnosis should be also examined in detail. Special attention is required in cases where medical labelling leads to medicalisation of migrant's distress. As will be explored in the next chapter, this may not relieve distress; instead it may create additional burdens and other consequences for migrants.

Chapter IX

Old Ways of Coping with New Forms of Emotional Distress in Chile

9.1 Introduction

In this chapter, I discuss the manner in which migrants manage and cope with distress in Chile. I explore how they mobilise various resources to deal with illness and distress. The terms "coping" and "managing" differ in two respects. Firstly, coping involves strategies put in place by the affected person to deal with distress – which may or not be successful. Managing may involve a third person who may merely administer to this distress. Secondly, while in managing distress, the problem is not really addressed. With coping, the strategy used seeks to overcome the problem.

This chapter begins by discussing what has changed between previous experiences of distress and current ones. The lack of social support appears to be a significant change in the new challenges migrants face in the host society. I examine how this lack of social support introduces changes in migrants' illness experiences. I then discuss culturally framed practices and coping mechanisms that emerge refashioned in the new context. In doing so, I look at how notions of femininity and masculinity influence means of coping, expressing and interpreting emotional distress. While both men and women migrants seem to channel distress through dancing; drinking seems to be more practiced mostly by males. Here, I look particularly at the use of alcohol by migrant men as a mechanism to cope with emotional suffering in the absence of other resources.

In addition, I examine the connection between physical symptoms experienced by men and its emergent construction as idioms of distress. This is so, since men tend to read the physical strains caused by alcohol consumption and by the demands of their work as more viable explanations for the origin of the somatic problems experienced by them in periods of emotional distress. Other ways to manage emotional distress available to migrants are also discussed here. Migrants' typical means of coping with distress in the medical setting and at the workplace are examined. While migrants' access to medical care is limited, they are also confronted with – and resistant to – an incipient process of medicalisation of their emotional distress. This appears to take place especially in the case of women at the workplace.

In discussing the sphere of work, attention is placed mainly upon women. The nature of domestic work in which migrant women mostly engage, often involves live-in regimes. This situation places them in constant personal contact with their employers and limits their mobility outside the employers' household. All such factors lead to women's distress being revealed at the workplace and their employers getting involved in its management. The role employers play in facilitating or blocking migrant women's healthcare-seeking is also discussed here.

Throughout this chapter the relationship between language used to communicate distress as well as the coping mechanisms migrants put in motion is discussed. Specifically I am interested to explore the affects of this relationship upon migrants' bodies, subjectivities and general well-being. I especially look at the extent to which the use of language(s) empowers or disempowers migrants by providing or depriving them of their agency to manage their own distress.

9.2 Changes in illness experiences: confronting new plights in the absence of emotional support

This section looks at some of the forms of emotional distress that, in migrants' life stories and perspectives precede their current experiences. Changes in symptoms are signalled in reference to shifting social contexts where these forms of distress emerge. Absence of reliable social support appears to be a relevant factor related to mechanisms migrants set into motion in the new environment to cope with their emotional distress.

Rather than holding a dichotomist approach in which changes are framed within a 'before and after migration perspective', I propose they must be seen in a continuum. Along with this continuity, an analysis of illness and idioms of distress opens a window to observe how individuals position themselves in shifting contexts. Also, it reveals the extent to which continuities in migrants' marginal social standing is structuring their illness experiences.

Marianela had experienced emotional problems in Peru, but in a different way. There, she felt trapped in the situation where she "*did not have anywhere to go*". She describes the feelings of impotence she experienced while facing conflicts with her ex-husband in Peru. This situation in turn, triggered her *'convulsions.'*[128]

L: Is the experience you had in Peru different from your current experience?
M: Yes, the feeling of impotence (experienced in Peru) got me to an extreme (situation) that I ended up in a state of shock. (While in Peru) I reached an extreme that I began to convulse and I did not stop. They had to take me to hospital. The 'shaking' did not stop. I totally lost control. It was because I felt so impotent that I could do nothing. Nothing. Because I used to see him (her husband) all the time.

Contextual elements also appear to be relevant in explaining the new form Marianela's distress has taken. Also, the meaning conveyed to her through emotional distress must be taken into account. Convulsing was an extreme occurrence in Marianela's past illness experience. This took place in a more 'safe environment' as she had the social support she needed. Indeed, her social milieu witnessed her convulsions and helped her out. Although, it seems that Marianela's convulsions played out as 'a form of protest' enacting her feelings of impotence in the face of a situation she felt she could not otherwise change. Convulsions were then, her reaction to feelings of being trapped in a situation where she did not see a way out.

[128] *Convulsions* or *crises* are popular categories recognised by people in Peru and described in the study of Perales *et al* as: "People who fall down suddenly, yell, they roll their eyes from side to side, twist their bodies, foam at the mouth, their bodies go a royal colour of purple for a while; after all this they become sleepy and lay down and afterwards do not remember anything, sometimes they fall down and hurt themselves" (Perales *et al* 1995:56).

The emotion Marianela recalled as triggering her distress is exactly the same in Chile as it was in Peru – "a feeling of impotence". The difference in both experiences is entrenched in the resources she has available to manage her distress, and in the meaning she associates to the form in which her distress manifests. All of which, in turn, relate to the contexts where the distress emerged.

When Elena was going through her divorce in Peru, she suffered from a facial paralysis which later compromised her one arm and leg. She believes this problem was triggered by the depression she then suffered. As part of medical treatment, her doctor discussed her condition with her family and asked them to participate in the treatment. In Elena's view, her recovery was possible due to the support she got from her family and friends.

> My mother helped me a lot. She gave me so much love in a short period of time and got very attached to me. My friends too. Those who saw me like that, they invited me also. *Let's go Elena here and there*… I would forget about my things and I began to go out.
> I had reached a limit I am telling you. ...That people talked to me and I did not. I did not even hear. They would talk and it was not with me, the conversation. I was there but I don't know what was going on. I don't remember, and what everybody tells me – that I was like that, with a deep look (in her eyes)… I never knew (what the doctor said). "My mother told me: *daughter I talked to the doctor, and the doctor reprimanded me because I never gave you love, true* (love)*, I offer you that love, I love you so much, in my own way, but now I am going to show it more to you*". I thanked her. I felt as if I had been born again, as if my mother was loving me, as If was little girl like that. I am her only girl child.

In Chile, Elena found the support in the Catholic Church, from a community whose mission is to work for the migrant Catholic population. Members of this community came to visit Elena one day and found her crying in her room. Since then, they have been supporting her emotionally and have helped her to get access to a medical doctor. Elena is now part of the community and devoted to the Chilean Saint Padre Hurtado, patron of the Catholic mission.

While Elena is in better health now, she always fears her paralysis can affect her again. However, she knows she has to avoid taking on too many problems by herself and takes additional precautions.

> It is like a warning signal that I get, when I have too many problems. It [her body] gives me a warning signal. My face begins to tremble, like this, and the feeling of ants in my body. This, an arm, a leg, so it is like a warning signal that one gets. So one has to try to get better, to relax, to do exercises, to try to hide it. Because this is very treacherous eh?

For Felix, the symptoms of his current distress are the same as those he experienced in previous episodes he had in Peru. However, previously, he felt no pain in the stomach.

L: Have you experienced these health problems before?
F: Yes I believe, but I did not have stomach aches. But yes, I did have all the symptoms I am experiencing now. – The fear, the fright, I cried, and cried. ...When I listen to… for example, a melancholy music
L: So what has changed?

F: The pain in the stomach.

Depression as defined in the context of life in Chile is, for many migrants, a new experience. However, similar emotional states have been previously experienced by many migrants and are described as feeling *tristeza* (sadness). Clearly, sadness is a more recognisable feeling for migrants.

F: Here in Chile, I have heard of it (*depression*). Here in Chile, because *sadness* is very different to *depression*.
L: And, in Peru do you rather call it *sadness* (these emotional states)?
F: Yes *sadness*, I believe.

Felix describes the way in which *sadness* is dealt with in Peru – through emotional support given to the person affected.

L: And sadness? How is it dealt with in Peru?
F: Sadness. Sadness, well you feel the family support. …That what now is happening to me, I believe that if I were with my family I would not have any kind of illness. Your family is your support no matter how sad you may be. Your family is a permanent support. …Imagine, when my mother passed away for me to not be in that permanent (grief), my family, my uncle took me to practice sports. …There, I entertained myself. Sure I missed my mother but that sadness started to go away, as time passed by. Yes… as time passed by, and with the support of my father, of my brother, slowly we were killing that sadness together.

Sadness is understood as a consequence of difficult events that may happen in ones' life. Its causes are understood by the migrant's own milieu, which can often provide the one affected with the necessary emotional support. However, for Felix, depression is more difficult to cope with.

L: And depression, how do you deal with it?
F: Depression is difficult. For me, it is something difficult to solve.

Ideally, in migrants' own environment, coherence between the social order and the individual's emotional experience is expected to be maintained. For example, cases of strong identification with the mother or other close relative are not seen or judged in terms of normality or abnormality. Furthermore, the range of emotions and behaviours permitted within the frame of the individual's socially accepted role is very wide. It includes anger and violence as accepted behaviour if the "triggering reasons" are justified within the societal order.

When emotions are congruent with the social expectations (e.g. sadness from missing one's mother, worrying for one's children's well-being) even though these may overpower the person, they are taken as natural feelings. In situations where the emotion experienced by a person contradicts expectations, she or he is not seen as needing any process of 'cognitive adjustment,' such as one that may be achieved in therapy. In general, affection and emotional support of the person's own social environment is provided in situations where people go through difficult emotional states.

In the new environment, emotional support is difficult to obtain. Although, in Chile, the presence of a migrant community constitutes an important source of support providing migrants with information, contacts and material resources, generally, migrants distrust their fellow Peruvians. Migrants express that they do not easily confide their problems and their causes of emotional suffering to other members of the community. Moreover, members of the same community often act against their fellow Peruvians, spreading rumours and gossip which gets passed on to the migrants' families and friends in Peru. This causes the affected migrant even more tribulations and emotional suffering.

Generally and overall, distrust seems to be very present in the Peruvian society, and among migrants, this fundamental distrust is exacerbated by competence that exists among migrants. In fact, underlying migrants' mutual support is also a high degree of individualism. This is well expressed in the common saying *ser mosca (*to be fly-like*)* – a desirable personal trait among Peruvians. It means to be quick in reacting and able to take advantage of any opportunity for self-interest. In consequence, disclosure of personal information to others means opening up the possibility of it to being used against the person in question. This lack of trust becomes critical at times when migrants' need to express and vent their emotions to others.

Marianela knows this very well. When support was most needed she was targeted by gossips who circulated rumours in her compound.

> I have now chosen to (just) greet everybody and that is all. (I have had it) up to there! No more. No, I don't get involved. I don't talk. I prefer to go out to the street. I prefer (to be out) over there, and not here, because I had bad experiences (here). They (migrants in her compound) made me feel bad. On top of the problem I had at work, they made me feel bad because they say my boyfriend was using me sexually. That he was coming only to take advantage of me sexually and then *ciao* (bye)… I was feeling extremely bad, super bad, because I said, *I am in total crisis in my work and I come here to relax and what is the use of it? This world here is (even) worse… They harass me*, then I was lost. From then, I became harsh, *cara de palo* (hard face). Now, they talk about me and I am indifferent. They taught me to be like that... I used to come here (to her room), and I would start crying. I said: *why do they talk that way?* And then I would get doubts. Can this be true? Am I being silly? Where is my dignity? To which extreme have I got? (What) if my family knows? What would they say? Oh, (it) was like that.

In situations where migrants cannot speak about their problems, venting alternatives should be sought. In the next section I will discuss other methods used by migrants in the community in dealing with emotional distress.

9.3 Coping with emotional distress in the migrant community; killing the stress by dancing and drinking

Stress, in the new life context, provides the possibility to *forget oneself;* to be liberated from distress. This new language allows migrants to react in new ways to physical strain as well as emotional burdens. Therefore, these migrants party and engage in a myriad of social activities, rather than just going to bed, taking rest or spending time with family for support.

New forms of managing stress are all relevant aspects which appear in Gladys' experiences of distress. In this new language of distress, *tiredness* becomes *pressure* – something needing to be actively released. The new context also provides for resources – economic, cultural, and social – to manage current *productive distress* in a different manner. Individuals are now entitled – because they are stressed – and given more freedom to *release* such *pressures*. Now new resources are available to cope with – her previously *un*-productive distress. Gladys expresses it as follows.

L: Is there any way to relieve that?
G: Well, it is to go out to dance and relax, drink something, share with people a happy moment.
L: And, it is done the same as in Peru?
G: Well yes it is done, but not everybody does it. I, myself almost never… Sometimes people came to invite me; *mommy, go!* (her children said to her). No, I said. I am tired; I did not feel with energy, no, no, I cannot.
L: And here; what do people do about it?
G: Here, is a little bit more liberal. Let's say there is more freedom to go out. Here, I don't have to pay attention to… or depend on anything. If I want to I go out I go, if I don't, I don't (she laughs). There instead (in Peru), I used to say; *no if I go there, what people would say?* Here it is different. The lifestyle is very different. …There (in Peru) people are a little bit more conservative than here. There, one fears to go out partying because (people) would say: *oh look!,* already they are gossiping. Here, instead nobody says anything. Nobody has anything to say because you go out or anything... (To go out) is a way to dissipate, to forget oneself for a moment. To think only in that moment that one is living, isn't it? That one can dance, can laugh, and can enjoy a moment of happiness. There instead (in Peru), one feels more dull. Noooo! They say *I can't because the children are here or the husband (is here).* But here (in Chile) instead, is the same with or without husband. They go out the same way, they just go out.

The association between the social context and the various forms to manage distress is visible in Gladys' account. Unlike in her home environment, the current social context provides both: a more satisfying outcome for her productive efforts and a new language of distress. The bodily efforts invested in work are now productive. From this new position, body exhaustion – now body under stress – is reworked within the broader space the new society provides.

L: In which way is this distress relieved in Peru? Is there any way?
G: Well, it remains there because...Unless one… is too much... One could say "OK, I go out*"* one leaves and that is it. But that is rare. It is not very common. Here not. People say; "I have a problem, ah I'll go out". And even they go out to smoke a cigarette around the block, at least to breathe some air... Over there (in Peru), that cannot be done. Sometimes there was nothing to do. One is very tight (there) has (money) only enough to pay the tickets (transport) to work, to go and come back. At least here there is some liberation.

Music, dancing and engaging in heavy drinking are core activities at any social event among the migrant community. The perspective of going out to dancing is widely infused within the Peruvian migrant community. Felix describes the way other migrants deal with stress in Chile.

L: And, how should one relieve the stress?

F: Stress can be relieved by relaxing oneself, playing a baby football match, going to practice any sport. But this is almost not done here. It is done very little, and besides this, you know what my problem…is? I don't have any vices, other people let's say, would go out to dance. …There (at the ballrooms), they kill the *stress*. I kill the *stress* dancing, but my problem is that I don't know how to drink. I wasn't born to drink, or to smoke either. That is what other people do. They kill it (the *stress*) dancing and drinking.
L: Here?
F: Dancing and drinking that's all I can't do because all that makes me feel bad.

Elena also has critical views on what going out to dance and meeting other Peruvians leads to.

> They (migrant women) left their husbands there (in Peru). Here they get another husband. They (migrant men) left their wife there (in Peru), and here they find another wife. They go to some places downtown where they say they dance. So far, I don't know (those places)… They dance, get drunk, and I know it is true because here are hundreds of people living (Peruvian migrants). They come back drunk. They forget their families. They go their own way, speak rudely… A very *uncoordinated* life… In Peru, this does not happen.

To face difficult emotional experiences, men drink. Drinking is a culturally legitimised practice among men in order to cope with troubled feelings, solitude or disillusionment. Dancing is integral with drinking. Although women may also drink, in general, drinking is more predominantly a male form of coping with emotional suffering. An ambience of celebration, in public places such a party often leads to instances where men drink heavily and allow themselves to cry, vent their grief, or openly state their disappointments.

Very frequently, alcohol consumption leads to physically violent fights in which men and women equally participate. Women drink as well, but not with the frequency and in quantity that men do. Irma sees clear reasons of why women don't drink as much as men do.

I: I say maybe they (men) start to drink also because they feel sad. They feel lonely…women instead are different…
L: Why?
I: Because women cannot just begin to drink. (She laughs) It looks ugly if she does it, but some people vent in that way.

Moreover, culturally, women do not have the autonomy to drink as men do, as it is regarded not proper behaviour for women to drink on their own. As described in the ethnographic chapters (chapters V and VI), women should wait to be offered a glass of alcohol by a man. She must be served; only then can she drink. A woman would never take a bottle of alcohol and pour a drink for herself.

Lyrics of songs being played at migrants' collective houses, or in ballrooms and bars where they gather, repeatedly recount stories of love, betrayal and disillusionment. The culturally sanctioned practice of "drowning one's grieves" in alcohol is often expressed in the lyrics of popular songs. A good example is the very popular song *Mozo una*

cerveza, una y otra mas, (Waiter, a beer, another and another one')[129]. Music seems to convey and channel those emotions men find difficult to express in words – and in sobriety. Unlike men, women do not use alcohol to vent their emotions. More often, the use of alcohol is a "courage-builder," to confront festering conflicts. However as said previously, women's use of alcohol would always be mediated by a man who provides it for her.

Thus, for migrants, listening to and singing song-lyrics, drinking and dancing becomes not only a social event but also an emotional cathartic experience. It is in this situation where migrant men most often recall past hurts and feel free to *desfogar* (to vent).[130]

Marlo feels lonely. He feels like crying all the time and he drinks in excess. He sees the source of his affliction as related to his loneliness and to the successive betrayals of his partners.

M: I sometimes drink a beer, I listen to some music and then I begin to cry
L: When does it happen to you?
M: When I am out of work.
L: Is it only when you are alone or also when you are with someone?
M: When I am with my friends, I also cry. …It happens from one moment to another, when I begin to think, to meditate, what my daughter is doing there (in Peru), and my sister… that they love me so much. (He is crying.)

When I asked Marlo about how friends support him emotionally, he says:

…It is very seldom that I tell my problems to somebody. No, no. It is seldom, seldom. Unless it is a friend that I have some trust in, but just like this, (openly, as we are talking right now) like this? No, no. When I drink, yes. When I am quite drunk, yes. Then, I tell them (his friends), and I cry. So, then I vent everything. Totally.

Javier remembers how he escaped his problems by drinking.

L: Tell me what did you feel, when you say you felt the pressure and depression. How did you experience that?
J: When I was weak, it was like I felt the pressure of my aunt. And, I would leave; go out to drink, to forget a little bit that I was under that pressure. (That I was) pressured (to put money together). To forget for a while, let's say to feel liberated for a while, relaxed.

Drinking has been, for Johnny, a strategy to cope with his emotional suffering. He has been 'illegal' in Chile since his arrival, several years ago. This situation prevented him from following his partner to Argentina, where she went in search for a better job. However, he never told his partner what his real legal situation was.

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[129] The title of theme related songs are *Vivo Tomando (I Live for Drinking*); *Me Emborracho por tu Amor, (I Get Drunk for Your Love);* sung by the Peruvian singer, Dina Paucar, who is very popular with the migrant community. Other titles conveying love-related themes in Dina Paucar's repertoire are: *Falso Amor (False Love), No Me Quisiste (You Didn't Love Me); Adios Amor Adios, (Good-bye Love Good-bye), Incomprensión (Incomprehension); and Lágrimas de Amor (Love Tears)*. Other popular family-related themes in song are: *Madre (Mother) and Niños Desamparados (Deserted Children)*.

[130] "Defogar": (dar salida al fuego) to make an opening or vent in (to allow fire to escape).

I begged her not leave. (I told her) that we were fine here, and… during the time that she… with my separation from her… I devoted myself to drink. I abandoned myself. If I wanted, I worked, if I didn't', (I did) not. It was a kind of deception that I had, but it was not a deception as if she had cheated on me. (It was) only that we had got separated, because I never told her the truth about my papers. She thought I had my papers… fine... (in order).

Although not directly, Johnny mentions the impact of having lost his partner, which allows us to visualise his troubled emotional state.

J: And I drank more. I began to drink stronger drinks, like *pisco* or whiskey
L: Do you think that it affected your stomach?
J: Of course, because I did not feed myself. I practically did not have defences in my body. Everything was drinking, drinking. I would drink. I believe almost one bottle of whiskey and I would not get drunk. I had to drink more and alternate the drinks in order to get drunk and to be able to sleep. I had a process like insomnia, where I could not sleep, I was thinking, I would tell her ...are six months already that...(he and his partner were separated). I liked her because she was a down-to-earth girl. She did not drink. She was 'a girl from her house', centred, and centred in everything, in everything.

Men often make use of alcohol to cope with emotional suffering. In addition they tend to read the physical strains caused by the demands of their work as more viable explanations for the origin of the somatic problems experienced by them in periods of emotional distress.

Although these cases cannot be used as conclusive proof, these narratives show that 'stomach aches' among men are used as an idiom of distress. And, in this way, men's emotional suffering becomes 'objectified' in physical symptoms. For Marlo and Johnny, affective related problems lead to alcohol abuse and altered eating patterns which, in turn, led to stomach aches. For others, as in the case of Felix – who at present does not drink –, his current work conditions affect his eating patterns, producing the same somatic effect. However, he describes the occurrence of these symptoms when he argues with his partner.

True cause and effect are often not recognised, especially among these migrant men. From the personal dimension which originally causes distress (broken love relationships), to the consequence of a culturally sanctioned practice (alcohol abuse), or a socially produced cause (bad work conditions), the actual problem is ignored. Instead, men believe the direct cause of their stomach problems should be found in their altered eating patterns. In this way, emotional and affective causes of suffering experienced by male migrants are transformed through their practices and interpretations into a somatic, 'objectified' reality. In Johnny's view:

L: Do you think that your stomach problem is related to what was going on in your life at that moment?
J: I believe so, because I felt like this… I didn't have… I ate irregularly also, only drinking, without having breakfast. This was affecting me in my stomach and moreover it was the painting (its noxious fumes).

Men's abuse of alcohol is thus a gender framed coping strategy, and stomach aches are the somatic, ultimate consequence. Interestingly, at some point in each of the men's

narratives, stomach problems are regarded as their main health concern and it justifies the search for medical help.

The masculine approach to emotional suffering is well illustrated in Nato's attitude towards his own troubled emotions.

> Ñato's stern sense of endurance is entangled with his ideas of how a man should behave. Showing worries, concerns and problems is, for him, a sign of weakness, and opposite to the idea of what an authentic man is about.
> Eligio would never show sadness, worries or fear, he would rather minimise or hide these feelings. Furthermore, to him, a real man should show his endurance through illness and would not "run to the doctor". This idea turned out to be even more extreme when Peruvian men deal with issues of mental health.
> According to Eligio, Peruvian men who are affected by depression are at risk of being seen as weak. This kind of "weakness" in men is somehow connected with homosexual tendencies. Depression is something that may happen to women but not to men.
> Generally, according to Eligio, depression as a mental disease is not as pervasive in Peru as it is in Chile. In fact, for him the first time he heard of it was in Chile, and he is still surprised by the number of men who are affected by depression in Chile.

As Ñato and other migrants also believe, ideas of masculinity are associated with being strong and capable – to be able to face and endure difficulties. Problems such as *nerves* or *depression* go against ideals of masculinity. To acknowledge them is to recognise before others that one is 'soft' or 'fragile' – not really a man.

9.4 Medicalisation of migrants' emotional distress

At the beginning of my fieldwork, my household survey conducted among Peruvian migrants, showed 75% of those affected by some form of emotional distress did not seek medical aid. Out of the total, only 9, (4%) consulted with the public or private system and 15% sought alternative aid. This included, firstly, the help of relatives or partners, and secondly, a boss was mentioned. Reasons for not seeking medical aid for emotional distress are many and varied. For 12% of these cases, the problem was solved outside the medical system and 6% considered it was not necessary to seek medical aid at all. Another 6% did not seek professional help because their problem disappeared by itself. And, a final 6% did not know where to seek aid.

None of the migrants interviewed – who sought medical aid for their distress – found a solution to their problems within the medical system. The medication they were prescribed was unsuitable. Instead of it being a help, many felt their medication was an impediment to performing their normal work duties. In the end, Felix, Elena and Irma refused the medical treatment offered to them in Chile. Felix sought medical help for his stomach aches and was prescribed tranquilisers.

> F: I went to the doctor and he told me that (those) were tensions. It is stress, so he gave me a pill. "Tensionet"
> L: Tensionet?
> F: Yes, that I cannot take even half. Because it leaves me like sleepy until 12:00 – 1: 00 in the afternoon.

This doctor prescribed Elena both Paracetamol for her headaches and a progressive dose of tranquilisers.

> (The doctor said to her) *when you have headaches take Paracetamol, and at night begin by taking 1 pill* (of a tranquilisers) *and end with 6 pills,* I had to finish (with 6 pills). The first one put me to sleep two days; I said with 6, I would never wake up! ...So my husband said to me: *Don't take that Elena, these are only tranquilisers and they are going to cause you more harm than anything else, so stop that.*

Elena is dissatisfied with the biomedical approach held by the Chilean doctor who treated her.

> Here, there is not much importance to (placed on) the sick person, only tranquilisers. Only that thing, it is not as if one goes to a private doctor. No, is not like that. He (a doctor in a Chilean public clinic) only asks you *how are you daughter? - Just like that, doctor, always with my problems, – Yes, I will give you a pill that will calm you down,* and that will be it. So I gave them back (the pills) to the doctor and I told him that I did not feel well with that pill. He then gave me other ones, but it was the same thing. So it does not (help her).

Irma also refused to take the tranquilisers given to her by her doctor:

> I: The doctor prescribed me pills and so many things to be tranquil, but I did not take even one. …He told me: *You have problems in your work ...You don't get help, and moreover you now have this loss.* (Irma's father had passed away) *...Where do you find support? ...You don't have much support,* he told me
> L: And why you did not take them (the tranquilisers)?
> I: Because I said if… they (the medicines) were to (be able to) sleep – I sleep perfectly, quietly, I don't need those drugs to… to (be able to) sleep, and I did not take them.
> L: What was the name? Do you remember?
> I: *Neuronan* and other ones. … (They) were tiny little ones.
> L: Did the doctor ask you if you had sleeping problems?
> I: No he did not ask me. He told me: *With this, you are going to feel better. You are going to take this and you are going to feel more calm, more relaxed.* And on the other hand I said (to myself), if I am going to take this medicine, I am going to be blocked in my work. …No (I will no take them).

Rocio has not yet sought medical help for her distress. However, as she contemplates the possibility, she thinks she would not talk about her *depression.* Rather, she will talk about her physical distress.

> L: How would you present your health problem to the doctor?
> R: Ah, that I suffer from an initial form of tachycardia and I would then start explaining to the doctor that when I am sad, I get something... I start to feel a pain in my chest
> L: When do you have what?
> R: Ah, when I worry about my family. I start to feel pain in my chest. I feel lack of air. I can't… What can I do? Who I can go to?
> L: Would you say to the doctor that you feel *depressed?*
> R: I don't know. With other people, I cannot comment. I don't feel… I am not used to talk about that

Cesar consulted a doctor for his chest pains. The doctor discussed his drinking habits with him, suggesting he quit drinking, but Cesar had already stopped.

For many migrants, depression continues to be inscribed into a medical realm and as such, its use provokes resistance. It is being defined as suffering from some sort of pathology. This is precisely the reason why Irma rejects seeing herself as depressed. She resisted the diagnosis of *depression* given by Chilean friends at work and later by a doctor. This resistance is linked to conflicting explanations – between her Chilean colleague and her own views – about the causes of her distress. In Irma's view her distress was not 'pathological' but the logic consequence of the difficult circumstances in which she was living in Chile.

L: You told me that you got to know *depression* here. What does it mean that you got to know it here?
I: Because, I felt sad. Crying and crying and crying; nothing else. And, the people whom I worked for, they shouted so much and all that… And the children! …I had never seen that, for me it was crying and crying, day and night. So then, I began to lose weight. …Skinny, skinny! My friends became worried and my family too, when they saw me in pictures. It was due to the sadness, but I was told that it was *depression*. That it was all *stress* from so much work… But I said what I feel is *sadness.* That's the only thing I feel. I wanted to leave everything and leave.
L: Who told you that you had *depression*?
I: Long ago, when I just arrived there in Champa, (a Chilean friend told her) *Irma you are going to get ill, from depression,* she told me. *If you continue here, you will fall into a depression… You are going to get ill.*
L: And, you thought it would be that way?
I: No! Then I thought what should I said to her? It is all about this crying. *What happens is that I am very sensitive* (she told her Chilean friend) *and I am not used to this* (that work environment). *So that is why… To see these things, all of a sudden, is shocking. You have to be strong Irma that is all. Because you still have a lot to go* (said her Chilean friend to her).
L: So, when she said that, you felt that you would fall into a *depression*?
I: No.

Irma is an active interpreter of her own suffering. In this process, agency is localised in her search for explanations of the causes of their own suffering. Irma challenged the commonly used medical diagnosis used in the new environment.

L: Did you ever believe this was (depression) what happened to you?
I: No. I never assumed that it was *depression* or those things. Because the only thing I feel is *sadness*. And that is what I am always going to feel – *nostalgia*.

The possibility of attending psychological consultations to deal with depression appeals to women more than it does to men. Women see in counselling an opportunity to confide their personal matters to a neutral and discrete third person. Marianela and Mary have tried to access psychological consultations. At the public primary health clinic, Mary was given an appointment but it would not occur until several months. She thinks when it is time to go; she will not need it anymore.

However marginal migrants' access to healthcare system may be; it has not protected them from being misrepresented in their illness experiences within the medical system. Particularly, this happens with regards to the economic and social conditions from

which migrants' suffering and distress emerges. Indeed, societal determinations of migrants' illness experiences become obliterated by the moral discourse of the healthcare providers. Caregivers may often judge them as irresponsible and view their living conditions as morally deplorable forms of human degradation. Mary experienced misrepresentation of the medical system. Her own son was to be taken away from her. The child was being looked after at the compound by Mary's sister while she was out working.

M: They even told me they would take my son away from me. "If the boy does not gain weight we are going to take him away from you.
L Who told you that?
M: Here, at the primary health clinic. They told me that I had to see the social worker... They told me: can't you have the boy? (Can she look after the boy?) I told her (the healthcare provider) that I can, that I worked and my husband too. And then she told me that the majority of the children of the Peruvians are always malnourished and that he (Mary's son) was Chilean. So that (therefore) he was part of here (was Chilean) that they had to look after the child. They went on to accuse me that maybe I sometimes did not feed him on time, or I left him alone, all that they told me… but it was not like that. It was my need of going out to work that prevented me to stay here (in her room in the house) to look after him. But the social worker would not understand that; not at all.

This discourse also becomes compassionate seeing migrants as poor victims which in turn, become another form of misrepresentation. Thus the critical approach will highlight the extent in which the social origin of migrants' illnesses is misrepresented by the practitioners in the medical consultations.

When Marianela visited the doctor, she expressed what she felt in terms of *nerves* and he diagnosed her as depressed. She expresses the reason for her distress in terms of her work conditions. The doctor suggested she quit her job.

I told him that I felt so… Sometimes, I did not sleep, and those things that were happening in my work and that I felt nervous. And he told me (the doctor), *I know you are depressed and I understand you. But if you don't feel comfortable there, Marianela* (in her job)*, you should quit, because a person that doesn't feel easy does not work well and you are damaging more your health. So, you must take a decision. It is either your health or you continue working* (in the same place).

The micro level of analysis proposed by the critical medical anthropology highlights a relevant dimension of the problem of this study. This is the actual process taking place in the relationship between migrants and the healthcare system. Even though the interactions of migrants with the Chilean medical institution are limited an incipient process of medicalisation of their emotional distress can be observed as already taking place.

The medicalised approach to migrant's distress, as it will be discussed in the next section, is not exclusive to healthcare providers and certainly not to the Chilean public healthcare system. The public healthcare should not be seen as leading this process, as the system itself is quite marginal in the context of a highly privatised medical system. Furthermore, as we have seen, migrants' only access to the public health system is through scattered medical consultations. On the contrary, a medicalised discourse and

approach to migrants' distress seems to be present in various spaces where migrants interact with the host society.

It is precisely, the power relations involved in the discourses constructed around illness which are of interest for the critical approach in medial anthropology. These are discourses particularly constructed by biomedicine and its practitioners. And, as in this case, the medicalised discourse is taken up by other agents, such as the migrant's employer and other local agents, people with whom migrants interact in various spaces. As pointed out by Good (1994), an analysis of illness representation from this perspective requires a critical unmasking of the dominant interest, an exposing of the mechanisms by which these representations are supported by authorised discourse, making clear what is misrepresented, not told or hidden in illness such as the power relations surrounding and embedded in illness.

In the context of this analysis, one can also observe migrants' agency and resistance as often they tend to disagree with the biomedical approach to their distress. In fact, the causes of various forms of emotional distress tend to be understood by migrants as embedded in their own socio-economic context. The logical consequence of this understanding is then the belief that individual the therapeutic approach as well as medicalisation will not resolve the causes of the problem.[131]

9.5 Managing emotional distress at the workplace

Women working as domestic workers often have to deal with their own distress at work. Employers – often other women – play a role in managing women's physical and emotional discomfort. Often, not only do domestic workers not have a proper medical insurance but their movements are also restricted by their employers. Therefore, their availability to attend medical consultations is also limited. However, employers may also play a role in facilitating women with access to healthcare. The ways women's distress is managed at their employer's household is discussed here, as well as the extent women have room to manoeuvre within the limits imposed.

Gladys describes how she must carry on working in spite of her symptoms. Her distress is managed at work where her employer who is a medical doctor prescribes her with medicines.

L: And do you have to carry on working anyway?

G: The same. I have to go to work and sometimes tired like that. My eyes are swollen. You can tell by my face; my face disfigures. The tiredness, the tension and preoccupation that I have, shows. I try to hide it, but I can't hide it. The more I try *... ah Señora, that is OK*. *How are you?* She looks at me and asks me *have you measured your blood pressure? You have something*, because they know already; she is a medical doctor.

[131] One of the contributing factors prompting migrants to avoid medical consultation is an obvious stigma associated with psychological care. There is a close association between the need of psychological therapy and *madness* (locura). The label of *madness* holds very negative connotations among the studied group. The acknowledgement of the need of psychological therapy implies a self-recognition of insanity. There is a large risk in being seen by the social environment as having any degree of disability, in which migrants are not willing to put themselves.

To avoid the cost and the trouble of having to go to a medical consultation, Gladys medicated herself with medicines she requested from Peru.

L: What do you bring from Peru?

G: I ask for more *Aldomed*, or this *Naproseno Sodico*, that is also there. But the *Alocodran,* the *Omitrin* that is an anti-inflammatory, that is because I have bad joints. And, the *Amonpicilina* or *Magacilina*, and the antibiotics that cannot be sold here without medical prescriptions. Well, there, (in Peru) you go and say: I got a pain here, I got a pain there. Ah, they say, take this *Megacilina*, that is all. Pa, pa, one gets that (injected). Well if that does not makes you feel better, then we go to the doctor but they give us the same medicine. (She laughs)

Other times, Gladys' employer provides her with medicines or arranges for her special appointments with relatives who are also medical doctors. These appointments are always placed after Gladys workday hours, making sure she would not leave the household unattended. Gladys feels the pressure exerted upon her and the restrictions imposed. She knows the ultimate cost of her illness can be to lose her job.

G: If I demand my rights, even if she does not want to, she (her employer) has to allow me to go to the doctor. But now it is (what Gladys has) not so much of an urgency and besides this, I am always buying (my own) medicine. So that *ah I feel pain, and pla, pla, pla*, I medicate myself. … Sometimes I ask (somebody in) Peru; *send me that medicine*, somebody that is coming (to Chile). They bring them (to me) and I get calmed. So I have not allowed (her employer) to see me (sick) (because I don't want) …them to say "leave!" Only this last time, that I was very sick, I got flu, I even got a fever... I came (to work). And, she told me (her employer): *but Gladys, you should not have come, it is only because you got a fever that I am allowing you to go back home. Because if you only had a bad cold, I would not have given you (sick) leave just like that.* ...I looked at her and I say: "*We will talk señora, it is ok. Thanks*". I left and came back here.

L: Is she a medical doctor?

G: She is a doctor, that is why I say, but if I get to do my way, I ask her and she can't... well she can't deny it. The only thing is, if she wants, she can deduct it (a day from her salary) but then when the time comes, when I will have to really go (to hospital). When my body cannot resist anymore, I will have to go to the doctor anyway.

Sickness is therefore an unaffordable disruption of the possibility to continue working. The value of health is visible in the fear provoked by it's opposite – illness. Falling ill is seen primarily, as an impediment to carrying on productive work. Fears are aggravated by the reality of not having a social safety net to rely on for care.

For Gladys, there is a basic understanding of mutual cooperation between her and her employer. However, in this understanding she unfortunately is not reciprocated.

She (Gladys' employer) says that she needs somebody that (would not get sick). She told me that she can't give me permission every time in case of a,b,c. If I get sick or something happens to me, she would fire me. I say to her *señora Maria Elena, for a,b,c reason – God would not allow it. – I have a problem you would not be able to help me to solve it? Then I don't know what is*… I say the harmony that should exist between the boss and the employee. Because (Gladys says to her employer) *If I work for you I am solving your more basic priorities that are to look after your children, caring, cooking for them and*

looking after the whole household, and due to a, b or c (reasons) *I need you. You are going to tell me you can't? Well that is* (something) *to have present* (in mind).

Mary finds her discomfort is not acknowledged in her workplace:

But whether the lady would tell me: *OK Mary, you got the flu. ...Look go to the hospital. No, no.* (Mary said to her employer) – *You know Sra., I can't work, because of my bronchitis. I suffer from bronchitis. ...Sra. can I work half a day?* (Sra. replies) *Get everything done, the supper, beds and you can leave.* I left everything done and she paid me less anyway.

When Irma is in distress, her employer provides her with medicines which for Irma are just palliatives. In a way what is happening here is a process of medicalisation of the labour relations.

I: She would say to me, when she sees me bad. The other day, for example, I was feeling bad. She did not give me anything, but some other times, when she sees me bad, then she says *bring her something for her to take*
L: Who?
I: The lady. But (her employer gives her) sedatives, nothing more.

However in a context where domestic work is in high demand, migrant women may quit their jobs to find another household where she is treated better. In that sense, women have some degree of manoeuvrability to escape an oppressive work environment that has been the source of emotional distress.

Stress is associated with oppressive working conditions migrants must endure. Mary, working as domestic says: *I was too stressed in my work.* She experiences the pressure of working long hours without rest during the week.

From 8:00 in the morning to nine in the evening… It was too much. I lost my job because the lady realised that I was stressed. I was about to collapse... So she (her boss) demanded more from me. My children demanded more from me and my husband demanded more.

Experiencing stress opens up the possibility to escape from current oppressive circumstances. An outburst creates opportunities for change in the present scenario. Mary recalls: "I exploded at home and in my job too". She lost her job but at the same time, she transmitted a clear message to her milieu. The message was: she could no longer cope with all the demands that had been placed upon her. Stress leads to unpredictable outbursts, as in Mary's case, to challenge an oppressive boss.

As in the case described above, stress can be interpreted as a cultural performance similar to *nerves*. Some authors have pointed to the relationship between nerves, nerves attack and structural inequalities in society (Dunk 1988; Guarnaccia 2006). Lock suggests that nerves can be interpreted as "part of the repertoire whereby those who lack overt power flex their muscles" (Lock 1993:143).

In Chile, Marianela doesn't have the social network that can support her; however, she does have greater mobility to leave difficult situations when they arise. It seems she copes with the same feeling of impotence, by continuously changing jobs. This way of dealing with problems actually decreases the illness-causing impact difficult situations

have upon her. In Chile, she has not experienced any convulsions, as she can escape the situation that causes her distress.

L: Have you had the same kind of *depression* here that you had there?
M: In Peru, yes I have had *depressions* where I have ended up in hospital because of my partner. Yes I have got into Hospital. I have been hospitalised. They've put me on sedatives. They calmed me down, but these (experiences) are very different, as I say it to you, very different.
L: Why is this one so different from your previous experiences in Peru?
M: (Because there) I was collapsing, shaking all over. I could not control myself. I was with convulsions.

In Chile, Marianela is able to leave the environment that produces her distress:

> But here not (in Chile)...Here, the good thing is that if I have a problem, I leave my job and that's it! I leave that problem behind and it is as if I free myself. …Ahhh, I can breathe calmly and say to myself: *Finally I will not have any more problems. I won't see her* (her employer) *anymore. I will not have to listen to her anymore.* I feel relieved for a while, and feel calmer that is why I say that they (both illness experiences) are different; very different.

In Chile, she cannot count on social support but instead, has other means to cope with her distress such as changing jobs. Her current productive engagement has provided new resources to manage her distress as the availability of jobs gives her the option to move on when she chooses. In Peru, she felt trapped, where she was permanently confronted with what she identified as the source of her problems – her husband.

Most women find at the end of the day, that they must confront their suffering on their own, as Gladys puts it.

> If I let my problems overpower me, let myself to be drowned, I will not be able to get up. That is why I try… well… if I think that… I cry, I vent on my own. I think: OK that it is over now (the worrying for her problem) and I carry on, because otherwise, I don't know where (would she find help).

9.6 Conclusions

Changes and continuities can be observed in migrants' narratives of their previous experiences when compared with their current experiences of emotional distress. As in Chile, migrants have also previously confronted various experiences of emotional distress in Peru. While in Peru, migrants' distress was often linked to the hardships of their poverty-stricken lives. In Chile, their experiences of emotional distress emerged with circumstances of personal displacement as well as societal exclusion and discrimination.

In Peru, the various life events triggering migrant's emotional distress appear to be compounded by the lack of material resources and alternatives to face the adversity of life. Yet, vital resources are available there to help them cope with distress, such as family emotional support. Migrants in Peru experienced distress in the form of

exhaustion, sadness, convulsions, or stroke. These idioms are commonly heard and recognised.

In Chile, forms of emotional distress such as *depression* are experienced in solitude. The absence of emotional support makes coping difficult. In other cases, *stress* opens up a myriad of new practices to engage in, socialise and *feel liberated*. With more material resources available but lacking social support, migrants learn to use other alternatives to handle their distress. One crucial question to be asked in the face of these developments is: Are the coping mechanisms migrants use in Chile harmful to their well-being in the long term?

Culturally authorised methods to relieve emotional problems among Peruvians in their communities are dancing and drinking alcohol. Stress in migrants' narratives is experienced as *tiredness* or *being tired* and *exhausted*. It describes a physical and mental state. In Peru, this sign is read as the person needing to rest. However, in Chile, stress involves the need to release pressure, to free oneself from sources of tension – *one goes out to bars, for dancing, drinking and getting distracted*. The need to release stress leads migrants to socialise among themselves and opens up the possibility for more liberal behaviour. This is especially true for women who are often alone in Chile and find themselves in a far more liberal environment.

Alcohol consumption is a common and culturally legitimised way for men to deal with their emotional problems. Various factors should be attended to when appraising the importance of drinking as a coping mechanism among men. The lack of social support which affects migrants in general, is an important factor, but also the gender dimension which influences men's behaviour. In fact, among the men studied, both the causes of emotional distress and the escape from it are framed within the prevalent gender ideology. Maleness is associated with the capacity to endure and resist. Men do not share or easily show their emotional suffering to other men, as this may be read as a sign of weakness. Therefore it should be avoided at all costs. Alcohol consumption proves to be an emotional catalyst for men as maleness is also associated with the capacity to drink.

As seen, gender constructions are prime factors explaining the particularly strong male resistance to openly acknowledging the affective dimension of their distress. Gender differences are clearly manifest in the means and use of language to express emotion. I have also explored how the interpretation of the causes of somatic symptoms experienced by men is constructed by them around drinking and not around their experiences of emotional distress.

The nature of domestic work performed by women migrants leads not only to an increase in women's emotional distress but also determines mechanisms through which this distress is dealt with. In this process, not only is the prognosis of distress altered but also the individuals themselves. Their bodies, their self and subjectivities are transformed. The dynamics involved in the production and management of women's distress can be better understood by means of an analogy. That is the metaphor of a 'metabolic' relationship between nature – in this case the physical body – and the social realm. Women's distress can be seen as the 'metabolised' outcome of social relations which characterise domestic work as a particularly oppressive mode of production.

Framed within the social space of the employers' household, medicalisation of emotional distress is often the favoured means promoted by employers to manage women's emotional distress. This is particularly useful to the employer since medical categories of distress erase the social context where this same emotional distress emerges. Therefore, it is functional in diverting the responsibility of the employers and their families from women's distress. However, medicalisation is not exclusive to that space as migrant women and men are also encouraged to use medical alternatives to treat their emotional distress outside their work environments

Even though migrants have incorporated these medical constructions – *depression* and *stress* are primary medical terms – into their narratives, they are at the same time resisting the medical approach to their distress. Migrants often mistrust healthcare providers and fear treatments. In particular, migrants resist the medicalised approach to their emotional distress. Migrants often view their bodies chiefly for work and production. This last dimension becomes a narrow focus as their bodies are seen and used as means of survival. Migrants in turn have experienced medical treatment as a loss of control over their bodies and themselves. Often, treatment received limits their capacity to perform as workers, which is central to their material subsistence and main reason for their migration.

I have discussed here the extent to which the use of language(s) empowers or disempowers migrants by providing or depriving them of their agency to manage their own distress. This discussion was centred on how these new idioms of distress, have been learned through interaction with the host society. Medical categories of *depression* and *stress* are used by migrants to make sense of their experiences of personal suffering and to communicate similar experiences to each other.

Part IV

Migrants' Reproductive Health and the Chilean Healthcare System

The Program of Action of the Population Conference in Cairo (1994) and the Platform of Action of the IV United Nations Women's Conference in Beijing (1995) have committed in their principles of action, to the promotion of reproductive health. Reproductive health is understood as a general state of physical and mental well-being and not the mere absence of disease and illness in all the aspects related to the reproductive systems and its functions and processes. Reproductive health therefore involves the capacity to enjoy a satisfying sexual life without risks of procreating, and the freedom to decide to when and on what frequency to engage in or not to engage in sexual activities. Implicit in the above statement is the right of men and women to obtain information and means for family planning according to their choice. It involves access to secure contraceptive methods, which are efficient, accessible and acceptable. In addition, it involves the right to adequate healthcare services which allow pregnancy and birth to be free of risk and gives couples the maximum of possibilities in bearing healthy children. The realisation of reproductive health involves the recognition of the basic rights "of all couples and individuals to decide in freedom and responsibility the number of children they want to have, their spacing and interval among them and to dispose of information and means for that". (Cairo 1994, Beijing 1995)

The area of reproductive health seems to be a central aspect which has been subject to some regulation by the Chilean state in its aim to protect the integrity and well-being of pregnant migrant women and migrant children. However the approach of the Chilean State as concerns migrants emphasises not so much their reproductive health and rights, but the protection of children, particularly of those being born in the national territory since they are considered to be Chileans. Indeed, based on what is written in the Chilean Constitution regarding the 'protection to one that has not yet been born', the Government, since 2002, assures access to basic healthcare to pregnant migrant women no matter their legal status or income. This regulation also includes the right to 'regularise' their legal situation and to facilitate their access to healthcare during their pregnancy. Pregnancy is so far the only health condition which has involved particular treatment from the Chilean authorities towards migrant women.

The existent normative and high incidence of pregnancies among migrant women – legal and illegal- have led to Peruvian authorities as well as Chilean officials and healthcare providers to interpret it as a deliberate strategy of

migrant women to obtain their visas in Chile, in this debate questions about women's reproductive health needs have been largely ignored.

Part four addresses the issue of migrants of reproductive health in the light of their reproductive rights and is composed of chapters ten and eleven. Specifically it examines existent barriers of access to reproductive healthcare and explores the extent to which these barriers are affecting migrants' health, leading to unwanted pregnancies. It also explores the role of medical practitioners in disciplining and attempting to assimilate migrants. This is displayed through their interactions with migrants when healthcare is provided.

Chapter ten explores women's conceptions, needs and barriers in the use of effective contraception by looking at women in their community. This is so, given that Peruvian migrant women interact with the public health system in varying degrees and many of them attend to their reproductive healthcare needs outside the public health system. The chapter begins by characterising the use and knowledge migrant women have about contraceptives. It also identifies existent barriers to accessing healthcare, specifically to family planning services.

Chapter eleven begins by characterising services available to migrant women and examines whether – and in what form – discrimination takes place in the public healthcare system. It looks at the perception healthcare providers have of migrant women and their attitudes towards them. It discusses assumptions that are made regarding women's identities and sexuality and debates the extent to which these assumptions are shaping the services provided to them. It also discusses the perception women have of their own reproductive health needs, and of their experiences of being discriminated against in the healthcare system. Finally it looks at the strategies women implement in response to the inadequacy of the services and methods available to them.

Chapter X

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

10.1 Introduction

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

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

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

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

The third section delves into cultural dimensions which have an influence in women's use of contraceptives and more generally influence women's decision-making in the reproductive sphere. The analysis pays special attention to women's embodied cognitions and practices regarding their own sexuality and reproduction and explores the extent to which these dimensions interfere with their use of these contraceptive methods. Secondly it discuses prevalent gender and power relations involving the control over women's own sexuality and reproduction relevant to understanding women's reproductive decisions and use of contraceptives while living as migrants in Chile.

Lastly, this chapter presents the strategies women use to avoid pregnancy in the context of the existent barriers of access to healthcare and to modern contraceptive methods.

10.2 Gender, migration and reproductive health

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

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

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

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

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

Quitting their jobs and staying on in Chile may be one viable alternative when women have a supportive partner. Without such a support system, women are forced to return to Peru with the newborn baby. Moreover, pregnancy may cause serious conflict with the women's families in Peru. This is particularly true in circumstances where a baby has been conceived in a non-socially legitimate relationship, such as the cases of single women or married women who already have other children and a partner living in Peru.

The information presented in this chapter aims at shedding light on the factors that can lead women into an unwanted pregnancy, and particularly on those related to the condition of being migrants. The next section provides an overview of women's actual use of contraceptives in Chile. It identifies existent barriers to contraception as well as more generally, barriers to reproductive healthcare. While these barriers may be similar to what women experience in Peru, additional factors which respond to the condition of being migrants are specifically addressed here.

10.3 Use of contraceptive methods among migrant women

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

The information presented here is based on a survey that concentrated on the use of contraceptive methods conducted among migrant women in their community.[132] The goals of the survey were to gather the biological and social profile of a group of Peruvian migrants in their fertile age and to determine their mode of use of contraceptive methods. This information offers an initial picture of the factors which may lead to an unwanted pregnancy among migrant women, including the nature of the barriers affecting efficient contraceptive use.

10.3.1 Demographic profile of respondents

The sample in this survey was composed of 64 women in their reproductive age (15-45 years old); who were sexually active and users of contraceptive methods. The average age of these women is 31 years; 95% of them have partners and an active sexual life. On average, migrant women have 1, 52 children, which is actually lower than the average of children per woman in Peru. This confirms that migration reduces the possibility of larger families.

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

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

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

10.3.2 Contraceptive methods used

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

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

Methods Used	**Percentage**
Oral contraceptives	33%
Calendar	20%
IUD	17%
Condom	14%
Injection	8%
Other (*Coitus interruptus*, Lactational amenorrhea method LAM)	8%

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

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

Table X-3 Use of contraceptive methods in Peru in 2006[134]

Methods Used	**Percentage**
Coitus interruptus	4,3%
Periodical abstinence or *calendar*	17.6%
Condoms	8.7%
Injections	13 %
Female sterilisation	10, 6 %
Male sterilisation	0,4%
IUD	6,1%
Pills	7,1%
Other	2,8 %

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

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

[134] According to a latest survey conducted by Endes -contínua 2006.The study sample was composed of urban and rural sexually active women between 15 and 49 years old.
http://www.mesadeconcertacion.org.pe/documentos/documentos/doc_00529.pdf

as its use replaces the three months injection, not available in the country.[135] However 8% of women in the migrant sample were users of the one-month injection available in pharmacies and some primary health clinics in Chile. Also, as described in interviews further on, some women had received the tri-monthly injection during a recent trip to Peru.

10.3.3 Preferred method

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

Table X-4 Preferred Method

Preferred method	**Percentage**
OC	30%
IUD	20%
Tri-monthly injection	19%
Calendar	11%
Others	11%
Unsure	9%
Total	100%

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

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

[135] In Chile, the tri-monthly injection was not available to the public within primary healthcare until recently. The reason for its non-availability in Chile was not clear. Even the healthcare providers interviewed had no definite answers. Some postulated that this method caused undesirable health side effects as it caused the suspension of periods in some users. As part of the new official Ministry of Health policy regulating reproductive healthcare in Chile and launched in 2007, there is now a larger availability of contraceptive methods in primary health clinics, including the 3-month injection (AMPD, Depoprodasone 15).

methods offered to them in Chile. These perceptions are often not addressed or considered by healthcare providers, during medical consultations. Female users of traditional methods (calendar, *coitus interruptus,* and condoms) in our survey choose not to use modern contraceptive methods for various reasons which include negative side effects on their health; a negative social connotation associated with the use of these methods and beliefs that these methods are not suitable for younger women. As can be asserted from the survey findings, these perceptions seem to be shared by migrant women independently of variables such as age, educational level and the length of time living in Chile. These factors showed to not have any influence on the kind of contraceptive method chosen (modern or traditional).

10.3.4 Actual use of contraceptive methods

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

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

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

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

agents. This occurs regardless of the length of time these women have lived in Chile. As will be discussed in the next chapter, problems in the transference of information are issues at stake. Women complain that they often don't understand the explanations given to them by the Chilean healthcare providers.

10.3.5 Attendance to medical check-ups

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

The survey also determined that women obtained their contraceptives mostly from pharmacies (51%).[137] They can also obtain them from healthcare institutions (49%). In most cases (56%), the person who recommended the contraceptive method was somebody who was not a healthcare professional. These findings render it possible to assert that the majority of migrant women are not resolving their contraceptive needs in the Chilean healthcare system. Unfortunately we don't have comparable information of Peru, however this information poses questions regarding the nature of the barriers of access migrant women are facing in Chile. Indeed, a healthcare practitioner was involved in only 44% of cases in selecting the contraceptive method. Women's reliance on people other than healthcare practitioners reveals the particular dynamic involved in their decision making process.

10.4 Discrimination, exclusion and barriers to access of medical care

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

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

[137] In Chile, as well as in Peru, it is possible to buy the pill over the counter without a medical prescription.

10.4.1 Economic and legal barriers

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

However, unemployed and uninsured legal migrants are entitled to receive free primary healthcare in any public clinic if they can demonstrate their state of indigence to the social worker.[138] Typically, indigent cards are given to migrants for a one-month period, after which, they must apply for it again. Many times, this right to healthcare is denied to uninsured migrants even when they are in the country legally. Often, migrants' lack of information about their rights leads them to not exert these rights when they are rejected at public healthcare institutions. Many migrants would merely accept such rejection and would not assert their rights.

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

> I: The social worker told me that it (her right to free healthcare as an indigent person) is only for one month, that it does not cover birth. You see? Even that is very expensive, so I was also considering going to Peru to have my baby. Because I asked in San Borja (local Hospital), as supposedly mine is a caesarean section birth and they told me that is more than 640.000 Chilean pesos (more than 1000 USD). So, for me, that is too expensive.
> L: Did you discuss this with the social worker?
> I: Yes I told her. And, she said "*no*, *we will have to see you, after this month and that…* (the social worker said) *we would see*, *we would talk later about it*," because they had given me (right to free healthcare) only for pregnancy controls, not for the birth care.

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

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

10.4.2 Fear and mistrust

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

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

RM: I was afraid. I said maybe they will ask me for my papers, I did not know that they could give one care, just like that. (She becomes nervous, fearful.) …I don't know, I thought for my papers... I said maybe they would reprimand me. They would ask me *why did you get pregnant?*
L: Have you heard of anyone who had been told that?
RM: Well, sometimes the girls would tell me uyyy no. Let's say the girls tell me. They would tell me that when they gave birth, they scream at them, and this and that. So that is why I was scared.
L: They scream at them? And what do they tell them?
RM: Yes, that is why they scream out! That you should not have your child. No, but I have never, never gone to a hospital, I have always been afraid of hospitals. I have always been scared. When I was about to go for a check-up, the nerves would attack me.

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

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

10.4.3 Practical barriers and the lack of workers' rights

Provision of family planning care in public healthcare is based on the need to optimise use of professional resources. With that purpose, the regular procedure is that women with an appointment must be at the clinics as early as 7:00 or 8:00 in the morning to receive a "waiting list" number.[139] On average, women can spend 4 hours, an entire morning, sitting in waiting rooms to be called upon. Furthermore, the provision of contraceptive pills is structured so that women have to be present at primary health clinics on a certain day every month, to collect their contraceptive supply for the coming month[140]. For women who work, to have to go to consultation rooms on specific dates is not always feasible. To do so, means their employers would have to allow them half a working day each month so that they could collect their contraceptives.

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

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

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

As seen in the interviews conducted among women in the community and at the primary health clinics, various barriers to accessing healthcare were detected.[141] While some relate to migrants' general situation of exclusion, others are linked to previous experiences of discrimination in the Chilean healthcare system. Such incidents had caused fear and mistrust towards healthcare providers. Healthcare providers act as gatekeepers, restricting migrants in their access to healthcare. This is done by not providing the necessary information to migrants to make use of their rights to

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

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

[141] Some of these barriers have also been found in a small scale study conducted by Instituto de la Mujer (2007) in Santiago where evidence was found that undocumented pregnant women did not attend to primary healthcare clinics for fear of being reported and deported or because they are unaware of the existing norm that states that care should be provided to them irrespective of their legal status. While the current amnesty erases –at least temporarily – illegality as a barrier for accessing healthcare, other barriers still remain.

healthcare. For migrant women especially, these various kinds of barriers mount up. Often while working as domestic workers, they are more limited and restricted in accessing health-care when compared to their male counterparts.

10.5 Cultural barriers to contraception

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

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

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

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

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

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

The cultural legitimacy of women's lack of sexual experience is manifested, for example, in the expression women use: *he made me pregnant!* This is specific language used by women to describe the course of events that led them to an unwanted pregnancy at a young age. Underlying is the idea that men are experienced; the ones who know and decide. Nevertheless this expression may also be interpreted as women's desire to exempt themselves from responsibility for their own pregnancy, which in fact is the other side of assigning the legitimacy of knowledge and decision exclusively to men. The meaning of the notion can be confirmed in the fact that the first pregnancy of the majority of the 30 women interviewed was unplanned.

The majority of women interviewed began to use contraceptives or *cuidarse,* literally *to look after oneself* as they express it, only after their first baby or after subsequent pregnancies when no more children were wanted. As the survey conducted showed, single women with no children who use contraceptives accounted for only 13%. Not only are they in the minority, but also as the case presented next illustrates, these women do not openly exert control over their own reproduction and bodies.

> Vilma is a 23-year-old woman. She lives with her boyfriend, Marco. I met both of them in the building on Bandera Street. One day while we were taking about her health issues, I asked Vilma about the contraceptive method she was using. She responded that she did not use any method. After I had shown my surprise, she confessed she actually was using a method and asked me to switch off the recording machine so she could talk about this[142].
> She then told me she initially used the tri-monthly injection. She got this medication from her sister, who also lived in Santiago. The sister had injected it into her, as she had some nursing training. Vilma then travelled to Peru where a friend advised her to use an IUD. This is a birth control method she believed only to be used by women who had already given birth. Finally, she was convinced she could use it and this is the method she uses now. Vilma did not want Marco to know about the IUD because if he found out, he would think that by having the 'T,' she could more easily be unfaithful.

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

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

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

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

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

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

[142] I knew the couple so it was easy for me to have access to an interview and to Vilma's personal experience. There was, however, also the fear that I could talk to anyone else and maybe share the information given to me. Vilma feared that I would disclose this information to her mother-in-law whom I also knew and this would damage her partner relationship. The time that I spent among the community of migrants convinced them that they could trust me. However their fear to be exposed to other members of the community remained. It was not possible for me to record on tape their experiences about sexuality or other sensitive issues when these cropped up in casual conversation. This was contrary to what happened with the women interviewed in the clinics, who felt more protected by the fact that I did not know them and felt freer to talk about private matters.

chastity and of her moral quality. This protects the woman's reputation throughout her life. Ana, for example recalls an argument she had with her husband who migrated to Chile and left her in Peru. He heard rumours about her being unfaithful but Ana made it clear to him that he did not have the right to doubt her fidelity. She said to him: Y*ou did not meet me in the street* (Family planning).

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

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

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

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

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

He talked to me like an experienced man (the role of men in women's reproductive decision- making)

Men play a pivotal role in the use of traditional contraceptive methods. This is particularly true when women are initiating their sexual lives or when they are experiencing difficulties in the use of modern methods, such as undesired side effects. Aspects of this will be examined in detail in a following section.

Several of the women interviewed reported that the use of traditional contraceptive methods such as the *calendar* had either been taught to them by their partners or monitored by them. Men are often the ones who keep account of women's fertile days.

When asked to explain the way the calendar method works, as they remember it was taught to them, all its users described it incorrectly; information was supported by the survey results**.** This was evident in Aurora's case. Aurora went to family planning services in Peru, accompanied by her husband. After having tried numerous contraceptive methods and having experienced problems with all of them, they both were taught to use the rhythm or calendar method by the midwife. It was her husband's job to keep the record. She describes how they went about it:

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

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

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

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

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

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

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

[143] Further on in the interview she says she does not want to go to a health centre because she does not know where it is or how to consult. Also, further on, she says she fears she will not be treated well.

She once tried to buy (contraceptive) pills in the pharmacy. But she did not dare do it as she feared she could get the wrong pills and they would make her sick. Only in a few cases – the minority – it was found that men were using condoms. Men seem to associate the use of condoms with promiscuous behaviour:

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

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

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

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

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

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

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

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

> He (her husband) talked to my mother and said to her: *…Ah, no, señora, I want to have more* (children)... And, my mother got very upset. *No*, she said, *My daughter has already four! - Two children here* (in Peru) *and two there* (in Chile)!

Maria, 28 years old, has pressing economic reasons for not wanting more children:

> One gets too impoverished with so many children. A baby is a God's blessing, but also, one has to put out so much more effort. Sometimes one does not have enough to get them out (of poverty).

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

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

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

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

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

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

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

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

As migration alters the direct control exerted by the family on women's sexuality, women see themselves with greater spaces of freedom in the host country. Theoretically

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

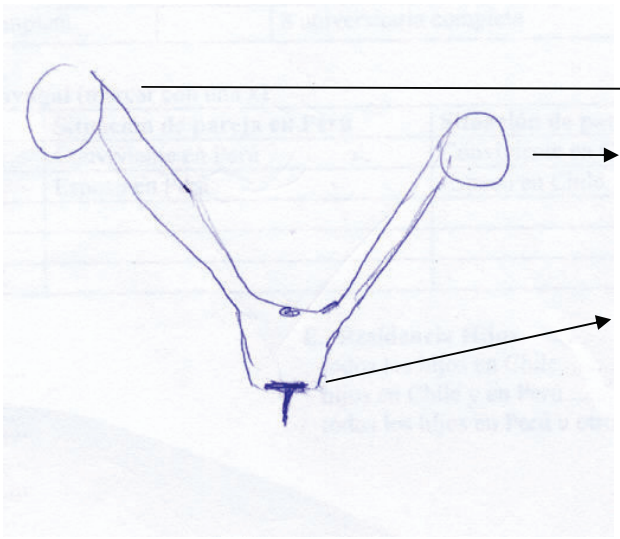
10.5.1 Women's embodied perceptions of their anatomy influencing their (non) use of modern contraception

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

The 'copper T' and its effect on the body

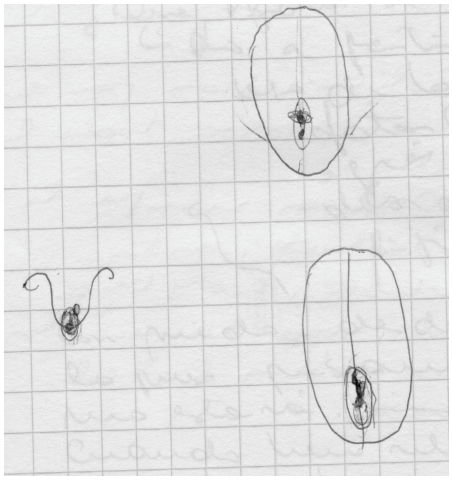
Women interviewed were asked to draw a picture of their reproductive system; to explain the way in which contraceptive methods act in their bodies, preventing pregnancy. This graphical representation of the reproductive system, and where the IUD is placed in their bodies, shows a mechanical perception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

L: Could you draw for me please, the way you see it, where do you think the T is inserted in your body?
X: Where do I think it is?
L: Yes.



X: I think it must be around here. I don't know whether it would be like this, here there is...
L: One tube?
X: One tube… Is that one?
L: And, these are the two tubes... (She draws the second tube)
X: Yes. (the T is) around here
L: Ah! around here… Would be it at the entrance of the. (vagina)?
X: I think so. Let's say I figure it out. Because I believe it must cover it so any sperm would not get into the ovaries.
L: OK.
X: Isn't it?

The above drawing was made by Hilda, 25 years old. She has a secondary education and was attending a family planning program. Hilda holds a mechanical conception of the action of the IUD in her body. Under this conception, 'protection' against conception offered by this method, is often linked to an uncomfortable physical experience. She does not visualise the systemic action of the IUD in her body.



In Vilma's perception, the copperT *must be located at the entrance of the vagina.*

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

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

There also is a strong association between the use of the *copper T* and infections as well as cancer. There was a suspicion that the use of the *copper T* could cause cancer. Women often referred to rumours about babies that were born with the T protruding from their foreheads. However, nobody ever confirmed having actually seen such a

case. But always, according to them, these stories came from a trustful and reliable source.

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

Oral contraceptives and its effects on the body

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

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

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

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

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

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

Rosita explains her emotional distress as connected with the fact that she began to use oral contraceptives in Chile. She quit her job as live-in nanny, which she thought

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

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

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

Tri-monthly injection and its effect on the body

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

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

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

Aurora Paredes used the tri-monthly injections in Peru:

L: Why did you stop using the pill?

A: Because the pills were like too many hormones. I gained weight. It was like eating and eating and I put on more weight. My husband told me that we better stop with the pills and thus I began to use the injection every three months but I did not have my period.
L: And was it uncomfortable for you?
A: Yes because it could cause nerve attacks. They said it is bad, so I also stopped the injections.
L: And is that bad?
A: Let's say it is as if one would have… As we say over there (in Peru), if we don't have our period it upsets the nervous system. …For any little thing, in a minute, I would explode.

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

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

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

10.6.1 Resorting to traditional contraceptive methods

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

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

Interviews showed that the chances of women resorting to traditional and ineffective contraceptive methods after suspending the use of a modern method increased when they did not have access to healthcare. This is because, in Chile, some methods can be

obtained outside the healthcare system as is the case with birth control pills. Oral contraceptives can be purchased without a medical prescription.

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

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

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

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

10.6.2 Changing to another modern contraceptive method

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

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

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

Indira (25), like Karin, changed from the *copper T* to the pill. Indira initially decided to use the *copper T,* as friends told her that was the most secure method of contraception. After two years with the *T,* she continued feeling physically bad. She switched to pills, but is not satisfied with this method either. Indeed, she never really wanted to use the pill since she knew what happened to her sister while she was using it.

> I have doubts about the pill because I sometimes argue a lot with my husband. Sometimes, I get disturbed and I have headaches. I remember my sister and what happened to her. (Indira's sister, who was on the pill, died of a cerebral stroke while arguing with her husband.) So I begin to calm myself down, to drink water. But I fear. Sometimes I think I would like to have an operation.

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

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

10.6.3 Obtaining contraception in Peru

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

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

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

10.7 Conclusions

The lack of access to preventative care in Chile together with the discontinuity of medical check-ups is notably evident. Although there is not enough evidence to assert it, these facts may be indicative of some degree of deterioration in migrant women's reproductive health in Chile.

Several detected barriers are contributing factors that affect migrant women's reproductive health. Economic and practical barriers as well as disinformation and mistrust of Chilean healthcare practitioners are important factors discouraging women from consulting family planning services. As a consequence, self-prescription of oral contraceptives is observed. Furthermore, incorrect use of traditional methods, such as *coitus interruptus* and the *calendar* method is also practiced. Silences around sexuality and women's culturally legitimised disinformation around reproduction also contribute to women incorrectly using contraceptives methods.

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

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

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

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

> I needed affection that was all I needed. That nobody would complain to me. That nobody would tell me… I used to call Peru and all there was – only screaming at me. That was all. They were upset because I was pregnant. All disappointed. My aunt used to tell me how were you able to do this? It is a sin what you have committed. They treated me bad, bad my family. So, I did not call… Nothing. And my boss told me about a shelter for pregnant women, here in Maipu.

Despite the multiple factors at play, pregnancies are interpreted by healthcare providers as a deliberate strategy of migrant women to obtain visas and remain in the country. This last aspect will be discussed in the next chapter.

Chapter XI

Migrant Women in Interaction with Chilean Health Practitioners: The Construction of a New Category of Patient

11.1 Introduction

This chapter examines the situation of migrant women as patients within the Chilean public healthcare system. It discusses the mismatch between the reproductive healthcare needs of Peruvian women and the family planning and antenatal care services offered in Chilean clinics. It explores various dimensions of the interaction between migrant female patients and Chilean healthcare providers. In this context, 'interactions' refer not just to the sphere of verbal communication, but also to "a broader and complex process involving the healthcare system as a whole (from healthcare medical and paramedical professionals, down to registration desk personnel), and migrant patients (both as individuals and communities)".[144] Thus, the analysis looks at these encounters and interactions from the perspective of both these groups.

From the perspective of the healthcare providers, this chapter explores the perceptions they have of migrant women as patients as well as the assumptions they make about migrant women's identities and sexuality. It also examines the effects these perceptions have in shaping the services provided to migrant women. Lastly, problems in communication with migrant women are also explored from the perspective of the healthcare providers.

From the perspective of migrant women, this chapter explores the perceptions they have about their own reproductive healthcare needs as well as the difficulties they encounter when communicating with Chilean healthcare providers. The existence of cultural beliefs and practices among migrant women which are not shared with Chilean healthcare providers during consultations are here discussed.

Lastly and also from the perspective of women, this chapter looks at experiences of discrimination which contribute to women's mistrust of healthcare providers and the Chilean healthcare system in general. This discrimination is analysed through the gossip and stories that circulate amongst migrant women that transmit messages of what happens during the course of their interaction within Chilean healthcare systems.

Throughout this discussion, the tensions emerging from the ongoing process of constructing migrant women as a new category of patients are highlighted. A central aspect of this tension is the ways the 'other' and her difference are approached and dealt

[144] This perspective has been developed by Partners for Health, a European project investigating discrimination against immigrants in healthcare services in various countries of the European Union. (www.salutpertutti.com)

with by healthcare providers. However, as will be discussed, migrant women are not passive in this process.

11.2 Migrant women as patients in reproductive healthcare

As users of the Chilean public health system, foreign women began to be noticeably apparent in the year 2000. In 2002, the Ministry of Health issued instructions to the various health institutions under its administration stating that care should be provided to everybody, including foreign citizens. Furthermore, it stated that if they are in possession of a Chilean health insurance – public or private – Peruvians are entitled to demand care from any health institution. However, their access to public care is restricted in situations when they do not have such insurance or when they do not hold the proper documentation to live or work in Chile.

An exception to this is the provision of care during pregnancy and birth, to which all women are entitled, as well as care for children up to 6 years of age. This right is granted independently of a woman's nationality, economic means or legal status in the country. Furthermore "illegal" pregnant women are entitled to legalise their status in the country to facilitate their access to healthcare. This norm is based on a constitutional principle according to which the State must protect those who will be born in the territory of the country, as they are entitled to Chilean citizenship. However, despite this legal provision, pregnant women with irregular legal status often are not properly informed of their rights, and therefore often do not visit primary health clinics fearing that they may be deported.

There are a few clinics which remain under the administration of the Ministry of Health and which provide primary healthcare to migrants regardless of their legal status, health condition or whether they are or not in possession of health insurance[145]. Although these facilities are not openly advertised within the migrant community, migrants eventually are informed by fellow migrants or are referred from other healthcare institutions to these particular health clinics. Information presented in this chapter was gathered at two of the healthcare clinics which provided family planning and antenatal care to migrant women in Santiago.

In spite of the growing number of migrant users, the registration system used in public health institutions does not differentiate patients according to nationality. This makes it impossible to draw statistical information about the size of this population among users of the public healthcare system. Yet there is a perception among healthcare providers at the two clinics in question that foreign users outnumber Chilean users. They also observed that Peruvian women consult with the Maternal Health Unit only when they are already pregnant. In the previous chapter we have explored the various reasons which can explain why migrant women do not take advantage of family planning services which are also offered. However, after delivery, as they are now

[145] These clinics are under the administration of the Ministry of Health which provides them with funding and does not restrict the care given to foreigners. Yet, most primary healthcare clinics in Chile have been transferred under the authority of Municipal administration. This funding is allocated according to the number of consultations each clinic provides which restrict the clinics in providing care to those migrants who are not legally entitled to receive it.

incorporated into the public healthcare system, most of these women consult on family planning issues.

11.3 Migrant patients in interaction with Chilean healthcare providers

The previous chapter discussed some of women's reproductive healthcare needs, as well as the expectations they have of the healthcare provided to them. This section explores the perceptions and assumptions which are present in the encounters between migrant patients and healthcare providers.

Migrants are generally mistrustful of state agents who seem not to understand their customs or to respect their immediate needs, such as basic economic survival. State agents on the other hand encounter difficulties communicating with migrants. As one public official noted, *it is difficult to make them* (Peruvians) *understand the health risk they are in*. Clearly, the existing dialogue and negotiation between healthcare providers and clients is problematic. As one midwife and key informant expressed, the nature of the public health system in Peru has conditioned the relationship that women have with their own health and, as a consequence, the way they relate to the Chilean healthcare system.

> They do not have a health system, they consult when they are sick, they don't understand the concept of the health check up, because *if they are healthy why would I go?* Here (Chilean women) know they come to the pills control, to the IUD control, antenatal control, they (Peruvian women) consult only when they have some illness.

This absence of the concept of preventive healthcare, as the midwife describes, leads to women consulting when they are seriously sick – circumstances under which they demand immediate care and do not accept being placed in a waiting list. These demands are perceived by healthcare providers as the result of women's lack of concern for their own health and an absence of preventive healthcare behaviours. Furthermore, they see women's demands for immediate care as attempts to transfer responsibility for their health onto the healthcare providers. Migrants, in turn, interpret delays in the provision of care as deliberate and as being motivated by the fact that they are Peruvian. Thus, to a large extent, the conflicts which arise when Peruvian migrants and Chilean caregivers meet and interact are explained by differing perceptions of remedial and preventive behaviour, together with differing expectations regarding the nature and reach of healthcare. Healthcare providers' perceptions of migrant women as patients are discussed next.

11.3.1 Constructing migrant women as a new category of patients

As users of the Chilean healthcare system, Peruvian women put demands upon it that have not been planned for. Several conflicting elements are mentioned by healthcare providers when discussing what characterises Peruvian women as users of the public healthcare system. Underlying these perceptions is the prevailing idea of a particular type of patient – a Chilean woman – upon which family planning and antenatal programs are based.

In the view of healthcare providers today, Chilean women are gravitating towards conceptions of reproduction, their bodies and health more in line with biomedical conceptions and less influenced by traditions or culturally specific notions characteristic of past generations.. Chilean women are conscious of the need for preventive healthcare and are also active in gaining an understanding of reproductive processes and of particular health conditions. As younger single women, they are reaching greater degrees of autonomy in decision-making regarding their own contraception practices, independently of men. Healthcare providers welcome the changes observed among Chilean women over recent years. However in some aspects the provision of care has not attended sufficiently to the changing needs of women. Indeed, in spite of the growing number of Chilean women entering into the labour force, the provision of reproductive care in public healthcare clinics is designed for a woman who does not have the pressure of work-related activities. This is because the length of time involved in the consultations is not compatible with a fulltime job

The elements outlined above play a role in the interaction between migrant women and their healthcare providers. For the most part, healthcare providers view migrant women as different from the type of people for whom the healthcare system was designed. This difference is seen by healthcare providers as problematic.

The impatient patients

It is a widely held opinion among healthcare providers at both clinics that one of the more pressing demands of Peruvian women is to get quicker attention. This demand often leads to confrontations with administrative staff. Midwives view Peruvian women who request faster delivery of care as being demanding. They are also believed to have a violent attitude which often leads to confrontations with healthcare providers.

Paramedics and administrative staff express their annoyance with the pressure exerted on them by migrant women to be given care quickly. One clinic staff member describes how they often express this demand:

> I arrived early! When am I going to be seen? I need to be seen soon otherwise I will be kicked out of my job!

Healthcare workers recognise that waiting a long time is what makes the Peruvian women so impatient, tense, nervous and anguished. Most of them are aware that the pressure exerted by these women is due to the duties they have as working women. However, in general the midwives, paramedics and administrative staff believe foreign women should adapt to the system as it exists. Furthermore, they see women's involvement in the labour market and lack of rights in that sphere as a problem that migrant women have to solve themselves. A paramedic expressed what she thought the differences between Chilean and Peruvian women were in a focus group of paramedics and registration desk personnel:

> They are very aggressive as opposed to the Ecuadorians. The Ecuadorians are much more humble, but the Peruvians are quite aggressive. …Every second (they come and ask) *What time will they call me? What time am I going to be attended to?* Let's say it is as if they are not yet accustomed to the system here, that we are very slow regarding the attention given. That one can spend the whole morning sitting there. And furthermore,

when they come here to enrol, they don't bring any document. But they demand to be given care immediately (and enrol) without any papers.

When discussing migrant women as patients, healthcare providers from both clinics agree there have been changes in migrants' behaviour since they first started to be noticed in these clinics. They see migrant women as having become more aggressive over time: they are now claiming to have rights which contrast sharply with their initial humble attitude (which healthcare providers seem to prefer). When they first arrived in Chile, healthcare providers saw them as more humble, more obedient and grateful for being given care. As they have become more aggressive in seeking care, demands upon the healthcare system have intensified.

Demanding, illegal and pregnant

Even though the population of foreigners has diversified over the last several years to include many Latin American nationalities (Ecuadorians, Bolivians, Venezuelans, Uruguayans), Peruvian women are perceived to be the larger, most problematic and demanding group, with whom conflicts often arise. As the process of migration has continued over the last number of years, and as more members of migrant families have began to arrive in Chile, more foreign patients are being brought into the clinics. Healthcare providers observe that now Peruvian women are not only demanding free care for themselves but also for their newly arrived relatives. They also observe that the majority of Peruvian women who ask for free care are pregnant and illegal.

L: What kinds of health problems do foreigner users come here with?
V: Generally, what we most see here are unwanted pregnancies, and women who are single mothers. That is the majority that comes here. …They come pregnant. They arrive (into the country) and get pregnant in the short term.
L: How do you know these are unwanted pregnancies?
V: Well, according to the files we keep and all, they became pregnant by chance. That their husbands are not the fathers of their babies. They (the fathers) are generally Chileans or some Peruvian they have encountered here. *(Veronica, paramedic)*

The recurring situation of illegality and pregnancy among migrant patients has led healthcare providers to believe that Peruvian women use "getting pregnant" as a strategy to legalise their status in the country. There is the perception among healthcare providers that women, especially the younger ones, deliberately become impregnated by Chilean men in order to have a Chilean baby and to obtain their visas.

The youngsters, they come here. I don't know whether it is (in order) to have a room to stay, to have food or to have a place to live... *or is it because they look for sexual partners?* Very easily, because we used to say *uff!! So why?* We asked (them); *why did they get pregnant from Chileans?* And according to what they say, it is because they wanted to keep their visa. Because they (will) have a Chilean child. *(Veronica, paramedic)*

A woman working at the registration desk at one of the clinics perceives similar reasons that migrant women fall pregnant.

I in the beginning noticed it because, well, one girl told me. I asked her and she told me *I arrived two months ago and to stay in Chile I had to get pregnant*. Let's say it was a way to remain in Chile, *and many of my friends*, she told me, *are doing the same.* And in fact I

had (an increase in the) number of women, mostly pregnant, coming for consultations These were the younger ones that were coming and they wanted to stay in Chile, the only way was to fall pregnant.

Due to the nature of their work, social workers are the ones who have a more accurate picture of changes taking place within the migrant population. One of the clinic's social workers acknowledges that deliberate pregnancy may have been the case in the beginning as having a child with a Chilean man was a way for an 'illegal' woman to obtain a visa. She also affirms that it does not seem to be the case anymore.

Currently, very different mechanisms are in place to regularise legal status. She further observes that Peruvian women now tend to find partners inside the Peruvian community. As mentioned previously, current regulations indicate that having a child, regardless of the nationality of the father, entitles a foreign mother to regularise her own legal status in the country. Furthermore, as observed in interviews, most often this regulation becomes known to women only after they have fallen pregnant. However, it seems to be the case that an overwhelming majority of migrant women visit clinics for the first time when they are already pregnant. In addition, many of them express that it was not their intention to fall pregnant. The reasons why they don't come voluntarily to request contraception before having a baby have been debated in the previous chapters.

However, the notion regarding women's reasons to get pregnant by Chilean men is to obtain a visa has remained unchallenged. It continues to circulate among healthcare providers as a valid explanation for the high number of pregnancies among Peruvian women despite the knowledge that they only seek medical attention when they consider it to be necessary.

Lacking legal papers and faking legal identities

The problem of undocumented status in Peru is structural as it is estimated that currently there are almost 3.5 million undocumented people in Peru (RENIEC 1995). Undocumented status is always associated with poverty. This population consists mostly of women, the indigenous and the poor. Undocumented people do not have an identity; more important, they are not entitled to any legal rights. In Peru, access to the state is weak and differentiated by social class and by economic status. This differential access translates into a negative perception, a sense of absence of the state.

Historically, poor, marginal Peruvians have encountered many barriers to legal recognition, including poor valorisation of the right to identity and basic access to social, political, and economic life. Peru lacks a unified registry of births. Poor citizens face administrative, legislative, cultural, economic, and geographic barriers; gender discrimination; and poor healthcare coverage and quality of service. In many places, moreover, the civil registries of municipalities have been destroyed during periods of violence (RENIEC 1995). In this context, the state, individual legal identity, and its associated rights are, for most Peruvians, inaccessible.

In the new contexts and confronted with the limits of the binary opposition between legal and illegal that is imposed over their existence, migrants attempt to challenge and transgress legality. In De Genova's terms (2005) migrants' transgress the sovereign authority of the national state and in this way they aim to subvert and blur this order in response to their own interests and needs. Nevertheless, these strategies may be

ineffectual in the new context after immigrants encounter foreign legal frameworks in the receiving societies.

Legal identification of users of the Chilean public healthcare system is of paramount importance: it is seen as a basic requirement for the provision of care. It is in this realm where there is constant tension with illegal immigrants. The national office of civil registration demands that clinics provide a prompt registration of all newborn babies. Peruvian parents who have no legal documentation can register their children under the nebulous classification of 'being born in the national territory of transient foreign parents.' Although this status can be changed to Chilean nationality when the parents regularise their own status, migrants tend to reject this classification as they feel with such status their children do not belong anywhere. This, of course, causes a delay in the registration of their babies, and correspondingly delays parents in bringing their newborn children for health check ups – sometimes by several months.

The appropriation of somebody else's legal identity seems to be a more frequent practice among migrant women. A social worker describes this situation:

> Yes, we have even had cases of identity usurpation. Some months ago, I had a pregnant woman who came all innocent, to tell me: *Señorita, I have here my health card and here is my identity card…eeh, for you to change my information that is here in this file.* And I tell her: *What information?-The names,* she says, *because all this information is from my sister…* So she entered into antenatal care with her sister's identity card and health insurance. With (the sister's) FONASA card (Health National Fund). So she was (illegally) attending the antenatal care for about three months.

A woman working at the registration desk at one of the clinics assesses the situation regarding legal documentation of Peruvian patients as follows:

> They are very "zero documents" (without papers). Generally the babies come only with the birth certificate from Peru. That certificate of theirs is not valid here, so the baby becomes an NN (no name, without legal identity). Here they don't have an identity number, nothing.

The way in which these babies have entered the country without proper documentation is unknown to the respondent.[146] According to the registration desk staff Peruvian patients often lie and that is one of the reasons leading to stigmatisation.

> The Peruvian patient lies. (He/she) lies to the directors, brings false addresses, so due to that also they are stigmatised, because they don't tell the truth for fear. For example, sometimes we open a record - I don't know, but it is something cultural - one tells them "look this small *carne* (identification card), you have to look after it, because here is the number of your medical records… and it all starts there". Three days later the same person: "I have never come before" and scared as if one would beat them. And my colleague, who is very good at recognising faces, tells him: "You came the other day… - No -…and it is because you lost your carne and are scared to say it". So (she) takes the

[146] Migrants who do not have any documentation to prove their identities are requested to present a temporary document that can be obtained at the international police offices. When migrants have entered the country illegally, registration procedures at the clinics become problematic as migrants appearing in front of the police to obtain a temporary document may be deported. However, in these two clinics – unlike other public sector clinics which are part of the Municipal system – exceptions are made and emergency care is provided to migrants who have entered the country illegally.

passport goes to the computer, "but Sr. you came the day before yesterday!" Only then he says it and is scared as if one is going to scold him. Probably in other places they have been treated like that. Of course we are going to make you a new *carne*. I have noticed there is something about them –a fear to say I lost my *carne*– it is as if they think it is a crime.

Difficult to reach

Follow-up mechanisms in primary healthcare are intended to assure that patients are notified and treated once a disease is detected. According to public healthcare norms, patients should be notified if the Papanicolaou test shows anomalous results. The same also applies when sexually transmitted diseases are detected. If patients do not come to the healthcare institution in person, healthcare personnel will go to their homes to notify them. However, with the migrant population, it is difficult to notify them as they are highly mobile.

> When they don't attend their check-ups, we go and pay them a visit. So there (many times) we find cases where they have already left (that house). They have changed places or have left the country. It could be a VDRL (test), or any type of those tests (results). I once went searching for a person who had about three or four addresses. (That is) the problem we have with them. They move very quickly. *(Veronica, Paramedic)*

Migrants don't only move house frequently: those who live in the country without proper documentation move often in order to hide from the authorities or anyone else who might be looking for them. In general, fear and mistrust of Chileans runs high. As a protective mechanism within the migrant community, people will deny knowing the whereabouts of the person who is being sought, even when he or she is still living at that particular address. However, if the person in question has genuinely moved away, the message is passed along through the migrant "jungle telegraph" network. Usually, the intended recipient of the message receives it and goes to the clinic.

> For example two blocks away in Copiapo Street in the first house (…) you see the medical records - all of them have that address. I have gone there to look for more than one person and (that person) has never lived there. There are Peruvians living there, yes. *Do you know this person?* No, they have gone already. So then we don't know if that person has ever lived there or not … *Can you not locate her? Please call her* (and tell her) *that we need her to come to the clinic*. If there is a test with some worrisome results and we go there (we say), *Well, but if you ever see her, let her know.* After a week (the affected person) arrives (in the clinic), but he (the actual dweller) has not acknowledged that he knows (who the healthcare providers are looking for)… They are scared because many of them are illegal. *I am going to see if I can find her, but I am not quite sure*.

Also the registration system at clinics is challenged by the mobility of transient Peruvians. Personnel at the registration desk often complain about the duplication of medical records in the various sections of the clinics or in the various clinics where migrants seek help. They also complain about the duplication of medical prescriptions as migrants may consult with various medical doctors in the same clinic. This results in the duplication among the healthcare cards and patient numbers which are issued within the registration system.

11.3.2 Assumptions being made about migrant women's identity and sexuality

Healthcare providers are guided by perceptions and assumptions about migrant women's identity and sexuality. These assumptions are entrenched in the distance with which the 'other' is perceived. Furthermore, women's sexuality – migrant women's sexuality in particular – is often encapsulated into moral dichotomies of either order and purity or disorder and promiscuity. Do the perceptions of migrant women held by healthcare providers shape the services provided to migrants? I hypothesise that the image healthcare providers have of migrant subjects is present when they are relating to migrant women patients. It is my assertion that these perceptions are influencing providers' decision-making processes regarding the health and bodies of migrant women.

Various notions regarding migrant identity and sexuality have crystallised over time. This has largely been the result of an initial image constructed by healthcare providers about migrant women, and less the result of daily interactions between healthcare providers and migrant women. Indeed, the ideas healthcare providers have are based on observation and conversations they have had with migrant women when the women first arrived. After this initial interest in the other, the dialogue is suspended as healthcare providers managed to construct an image of the new patient that became fixed in time, much as if each new patient would confirm what was already known.

Peruvian women as mothers

From the perspective of Chilean healthcare providers, women's physical distance from their children and their absence from home provokes negative connotations. There is a perception that Peruvian women are not good mothers. A social worker at one of the clinics expressed this negative perception of women who share responsibility for childrearing with others:

> Another situation that often happens is a little bit of 'maternal negligence.' (Like) in the case of the children. It is negligence, a bit indirect sometimes, because the mothers who work leave their children under the care of another person. But they leave them with all the responsibilities. Let's say that the other person brings them to the medical clinic for check ups. For us (it) is unthinkable that it is not the mother who takes (the children) to the doctor when they are sick or have a health problem. I have many references from the doctors, that (say) they need the mother to come. But nooooo! It is shocking, the unconcern of these mothers!"

Healthcare providers hold that, in delivering care, there are very clearly defined ideas of what is required to be a good mother. The absence of the mother is 'unthinkable' and 'shocking' in the view of Chilean healthcare providers. For them, the absence of the mother connotes 'maternal negligence' and 'unconcern' for the child's well-being. These ideas persist in spite of the fact that they know they are dealing with a working mother, who cannot possibly leave her job to bring her child in for medical check-ups.

Furthermore, when women who have left their children behind in Peru become pregnant in Chile the negative perception healthcare providers have of them increases. Healthcare providers perceive them as bad mothers and as selfish women who enjoy themselves by engaging in new relationships while their children are abandoned in Peru.

This judgement still holds even though the women may be economically supporting their children in Peru.

Conflicting ideas regarding marriage, fidelity, family and motherhood emerge in interactions with Chilean healthcare providers. As most Peruvian women leave their families behind in their home country, there is greater opportunity for them to initiate new or parallel partner relationships. Similarly, women's physical distance from their children challenges Chilean healthcare providers' ideas of what it means to be a *good mother*. Their concept of 'the ideal mother' is centred on a woman's presence at home raising her own children. Involvement in the labour force is not seen as women's primary responsibility, even when that involvement is critical for the survival of their children.

A: In fact, we had a case of a girl who was 2 years old and had obstructive bronchitis. I read her medical records - the girl was taken from paediatrician to paediatrician. I asked the father and he was the caretaker. He told me (that it was) because he did not give her the doses in time. Obviously if one does not give amoxicillin to a child at the right time, and the course is not completed, the effect is lost.
L: Was he in charge of the girl?
A: Yes, the mother was employed (as a live-in nanny) in Las Condes, so he would look after her until noon then he would take her to the crèche. So cases like that one, that one does not have any idea how they (children) are looked after. But in the level of caring for children there is carelessness on the part of the mothers. The mother brings the children when the diagnoses are not for primary healthcare (and the health problem should rather be dealt with in secondary healthcare). Let's say this is generally the case with these mothers that I am talking about. (Registration desk staff)

However, as the nutritionist expressed, when women are seen interacting with their children during the medical check ups, they are extremely caring, patient with their children and concerned about their well-being.

N: They are very sweet with the children - the relationship… I have not seen any mother...(treating children badly). On the contrary! So when this mother, Samuel's mother, says that she does not want to take him for an exam because she is scared they will inject (and it may hurt) him and that thing that mothers here don't do, let's say the (Chilean) mother holds the (child's) arm there, isn't it because she has a different consciousness. But this mother - it is not that she does not have consciousness, maybe she confuses the protection role, that they would not harm her *hijito* (little child) – all of them speak about their *hijito* with a diminutive; they never say my child or the (child's) name. They are all very affective mothers.

Midwives also have the opportunity to see these women interacting with their husbands or partners during consultations, where they observe the existing gender power relations.

Peruvian women as spouses

Midwives see migrant women as *machistas*[147] subjected to the authority of their husbands.

[147] Ideology that justifies men's authority over women based on gender attributes. Male supremacy is seen as an intrinsic attribute of men.

M: Women are *machistas.* They come with the husband to everything – many times even to get the *T* inserted or to decide if they (will) take contraceptives… They are with the husband.
M1: The husband is the one who decided yes or not.
M: The husband is the one that decides, the husband says yes or no.
M2: Yes, it is true. The husband decides a lot.

Midwives consider this situation to be questionable and criticise the absence of dialogue between the couple, as they observe that it is men who take decisions on women's reproductive matters. However midwives do not interfere in the existing power relations and, in fact, reaffirm them in the interactions.

L: What do you do in this situation?
M: Nothing. Explain to the husband (the contraceptive methods). That is all.

However a midwife also observed how Peruvian women liberate themselves by being away from the control and the constant surveillance exerted at home. They are now making some income which allows them a certain degree of autonomy.

Healthcare providers acknowledge the forms of control women were subjected to in Peru as unfair. However, the greater degrees of freedom migrant women enjoy in Chile is perceived by healthcare providers as leading to promiscuity, disorder, and illness – all of which is aggravated by the living conditions in which the women find themselves in Chile. So in midwives' perception Peruvian women are submissive in most cases when the husband is around. At the same time they enjoy their new freedom when he is absent.

Their living conditions and what these conditions say about them

For some paramedics there is a direct association between the living conditions of migrant women and their sexuality:

> The (fact) that they do not have a stable address, that they do not have privacy, the economic situation. They are (willing) to accept any type of job, for any salary. So that must have an influence on their sexuality. Many are working as waitresses in 'topless' coffee places. In addition, I think that, according to what I see, there are a lot of people that take advantage of this, so they offer them that sort of work. Regarding the pregnancy of the youngest ones, many young girls that are pregnant come here. But regarding venereal diseases, there has not been an increase. *(Veronica, paramedic)*

Midwives and professional clinical staff often believe the living conditions of migrant women facilitate promiscuity. They recount having been in migrant patients' rooms and having seen relatives or friends sharing the same bed. Such workers also seem to agree that their living conditions lead to infectious disease – especially sexually transmitted diseases and tuberculosis.

> We have noticed that they are more at risk for sexually transmitted diseases. I don't really know if that is - let's say ehhh… because of their behaviour, their orientation and all that, but I think that it is related to that… Their social conditions also. And yes, they come to a foreign country and maybe they are not very accepted, right? They live too overcrowded (in overcrowded conditions). *(Midwives focus group)*

According to their perceptions tuberculosis has increased, with new cases being added from within the Peruvian population. As medical institutions do not have a registration system which differentiates nationality, healthcare professionals rely on their empirical experiences. One event, told over and over again, becomes a collective perception and later an unchallenged truth. In one of the clinics, a reference to the increase in the number of tuberculosis cases is backed up by the medical and administrative staff interviewed.

Particularly strong perceptions are held by healthcare providers who work as administrative staff at the registration desk and who are at the front line when dealing with migrants' demands for care. Among these staff there is indeed an identity of 'the Peruvian patient'[148] in the making:

> The Peruvian (patient) is seen now as *the dirty one, the filthy one who wants everything. The one who wants to take the milk, the food* (from the clinics); *the one that wants the food and all the stuff* (from the clinics), *for the grandmother.* Let's say it became stigmatised in that way. (The one) *who came alone but later brings the father, the mother, the grandpa along.*

The negative images held by the administrative staff are, however, to some extent counterbalanced by a receptive attitude on the part of the clinic management. Aware of patients' rights, when confronted with complaints from Peruvian patients the clinics' directors often try to work around bureaucratic procedures in order to provide them with care. However, in general there is no acknowledgement of the specific vulnerabilities of the migrants and the extra stress and difficulties they face when care is provided to them.

Their differences from Chilean women

Midwives at one of the clinics referred to a study conducted by one of them where differences between Chilean and Peruvian pregnant women were – although in small scale – more systematically registered. This study showed that pregnant Peruvian women seek care more frequently than Chilean women. Patients who consult more often than average patients are given the name of *policonsultante*. Typically these patients are placed in a separate category as it is thought that they are abusing the consultation system without a 'real reason.' In the search for reasons for the higher number of consultations among Peruvian women, the midwife who conducted the study asserted it may be because they are welcomed in the clinics.

> They are welcomed by the clinic to solve their health problems … so that is why they consulted more than the Chileans.

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[148] The construction of 'typologies' of patients among administrative staff is not exclusive to Peruvian migrants. Some Chilean patients are also constructed in a particular way and treated accordingly. Such is the case of those patients belonging to the program PRAIS, these are people who were exiled during the dictatorship of Augusto Pinochet and now have access to free healthcare as part of a compensation package. They are seen by administrative staff as 'being socially resentful" and problematic. Also, patients who are entitled to free care as part of a poverty alleviation program "Chilean Solidarity" have been labelled as aggressive, if possible to be avoided. Administrative staff members feel displeasure in dealing with these patients and often treat them with distance and mistrust.

The same study conducted by this midwife showed that Peruvian women tend to live in common union, while Chilean women are more often in a legal marriage. The midwife also added that Peruvian women tend to be concentrated in the middle ranks of the fertility ages, unlike Chileans who tend to concentrate more in the extremes – around 20 years old and to above 35 years. The midwife sees this as a reflection of the common ages of migrant women. The study conducted by this midwife also showed more anaemia among Peruvian women than among Chileans. Apart from this information, there has not been any other systematic collection of data in the clinics. Midwives in the focus group, however, expressed their views of the differences between Peruvian and Chilean women on the basis of their subjective perceptions.

M1: Peruvian pregnant women in general are more whinging (than Chileans), everything hurts (them), they complain about everything… but the ones in 'plani' (family planning programs) eeh, generally for example, (in relation to) the contraceptive methods, in relation to… the IUD – they keep them for short time.
M: Let's say it bothers them…They have more discharge than the average Chilean.
L: Why is that? What do you think is the reason why they don't keep that method for long?
M: Mm… everything bothers them, any little things bother them. Let's say they don't put up with.
M1: I think it has to do with something socio-cultural.
M: Yes, that is why they are *policonsultantes*. They come more frequently to the check ups and all that.
M2: In Peru they are more used to the injection.
M1: I lived in Peru for a year and there the *copper T* is not used very much, so that is why it is a cultural thing, contrary to here in Chile (where) the injection method in relation to other methods is opted for by only a few women (in Chile). In Peru it is the opposite, they use much more the injection method for example…
M: Well, there is a government policy too.

When discussing reasons which may explain differences in epidemiological profiles, particularly the higher rates of anaemia and malnutrition among Peruvian women, midwives bring in racially based explanations. This notion, however, appears conflated with socio-cultural dimensions.

M1: …and the other thing that for example, eeh… (There are) things that are related to race, to the socio-cultural, the genetic. For example, I find that the scale of assessment (used) for (Peruvian) pregnant women is not (should not be) the same as the one (used) for Chilean (women)… For example, typically pregnant Peruvians are slimmer women, more *petit* … they are of other build and they are assessed with the same ratings as (Chilean women), so generally they show to be thin, with ranks at the limit (of the scale).

However, while different anthropometric measures are acknowledged, closely linked to this are ideas about different eating habits and notions of what constitutes quality food or poor food. This, in turn, leads to the different physical development of the two countries' population. There is a perception among midwives that, regardless of their socio-economic level, Peruvians tend to eat 'poor food' – a factor which ultimately defines their body size and ill health.

M1: I was so surprised, I had a friend (in Peru), from a high socioeconomic stratum, the equivalent to us (laughs). And do you know… she was raising her 'guaguita' (baby). The first meal was a broccoli puree, with a smashed carrot, half potato,

> something like that, it did not have any protein … and they added something they call *quinoa*[149]. I am not sure if that famous *quinoa* had any protein concentration, I have no idea… it was like very poor food when we are supposed to maintain a certain level of proteins.

Cultural constructions of race held by these healthcare providers seem to combine socio-cultural factors with phenotypic traits and different genetic pools. Implicit in these differences is an understanding that differences in anthropometric measures are exacerbated by the differences in eating patterns and the quality of food. The clinic nutritionist explains the differences she sees between Chilean and Peruvian children. She estimates that out of all the malnourished children she treats, 20% are Peruvian. Her assessment of the situation is based on her observations and interactions with these children.

> What calls my attention is the build of these children. The size of their faces is smaller – let's say all their bodies are smaller … These Peruvian kids, it seems as if they all look alike. Their faces look the same. It is a face with a fine nose, quite different to the (Chilean) kids… I can identify them (Peruvian children), even when the kids walk in here I can identify they are Peruvian because it is noticeable… But the most striking (characteristic) is their smaller anthropometric size. They go along different developmental paths. In fact, when I see (Peruvian children) in high risk, they are much smaller in size and weight than a Chilean kid. They are more nutritionally deteriorated, let's say.

Furthermore, she describes the eating habits of Peruvians as characteristic of Third World countries and as the ultimate explanation for physical differences.

> It is a very demeaning sentence; I think so, but ehh… It is not strange, for example, that the staple food in less developed countries is rich in carbohydrates with deficits in vitamins, with deficits in minerals, and they base their food more in carbohydrates because that is what is available. Things that draw my attention, so much, for example, (is) when we talked to pregnant women and they calculated the quantity of rice, for example, they buy in a month. Everyday they eat rice, they eat rice at breakfast, rice at lunch, but then if you ask for milk for example, a minimal consumption, the habit is not there. Or maybe there isn't the availability either. I don't know, I don't know Peru.

However in the perception of the nutritionist, these genetic characteristics will change as Peruvian children grow up in Chile and begin to eat differently.

> I don't know in how many more years this will be corrected (their smaller size), because these kids will live here and they will have a different feeding (pattern).

149 "Quinoa originated in the Andean region of South America, where it has been an important food for 6,000 years. Quinoa was of great nutritional importance in pre-Columbian Andean civilizations, being secondary only to the potato, and followed in third place by maize. In contemporary times this crop has come to be highly appreciated for its nutritional value, as its protein content (12%–18%) is very high. Unlike wheat or rice (which are low in lysine), quinoa contains a balanced set of essential amino acids for humans, making it an unusually complete foodstuff. This means that unlike wheat protein, one does not need to supplement it with complementary foods such as legumes containing the other essential amino acids. It is a good source of dietary fiber and phosphorus and is high in magnesium and iron. Quinoa is gluten free and considered easy to digest". (http://en.wikipedia.org/wiki/Quinoa)

When I raised the possibility of misclassification in terms of confusing smaller anthropometric size and malnourishment scales, this healthcare provider asserted that Peruvian children are bio-chemically more damaged than malnourished Chilean children.

> It is about the blood levels, of proteins, haematocrits, haemoglobin, those are the levels we measure and these malnourished kids are more complicated to recover, as they are anaemic, non-appetent. They have several manifestations, such as deteriorated skin and hair, whereas ours – let's say the Chilean (kids) when they get malnourished, it is because there is an acute pathology.

Perceptions about migrants in general and migrant women in particular tend to associate them with underdevelopment, with rural origins and traditionalism. A paramedic describes how she sees migrant women.

> L: Do you consider Peruvian women to be different from Chilean women?
> PM: Yes, in their way of speaking, their sayings. Their religious beliefs, they are like rural people. Regarding their religious beliefs, they are like our rural women. Things like witchcraft, that sort of thing. I see them as not so modern as the urban ones. Because generally, urban women do not come here. (The ones I see here) are from the rural areas.

As seen in a previous chapter, migrants do believe in the existence of *daño* – belief which belongs to the realm of the supernatural. However the healthcare providers who have inquired in a more systematic way about women's origins assert that they are urban, quite educated and articulate – even more than the average Chilean. Indeed, as contradictory it may appear – considering other observations of migrant women made by healthcare providers – one striking characteristic that attracts everyone's attention is the Peruvians' correct use of the Spanish language and their excellent pronunciation. Their precise use of terms contrasts sharply with the language used by the average Chilean. This characteristic is seen as incongruous by healthcare providers who cannot clearly classify Peruvian women, as they also observe and generally agree that most Peruvian migrants possess a high level of education. Indeed, although educated, these women are to different extents influenced by cultural traditions which, in spite of their schooling, are deeply engrained in their systems of knowledge and beliefs.

11.3.3 Women's silenced cultural conceptions of the body and its reproductive processes

In the previous chapter I explained existing cultural conceptions of the body and its relation with women's acceptance of contraceptive methods. In this section I will delve into conceptions around pregnancy and giving birth.

Often, the existence of two systems of knowledge – that of the healthcare providers and that of the patients – is more visible and problematic when the patient is a migrant. As 'Partners in Health' has pointed out: "medical doctors and migrant patients belong indeed to different cultural backgrounds and often do not have the means to reach a mutual understanding. Approaches to health, illness, treatment and the fruition of healthcare services differ deeply according to the specific culture" (Partners for Health 2005:17).

The conceptions described next prevail among migrant women of all ages and educational levels, although to different degrees. They can be considered as remnants – as 'mosaics'- of traditional Andean notions of the body and its processes. These are fragments of previously existing conceptions which have lost some of their coherence along with processes of acculturation to urban modern life which various generations of women have undergone. Most of these beliefs and practices are not shared with healthcare providers in the consultations because they are suppressed and censored by women themselves. This is a consequence of censorship previously exerted by healthcare practitioners in Peru; now these notions and practices are silenced in front of Chilean healthcare practitioners. One of the questions that emerge in light of the discussion to be presented hereafter is the extent to which the lack of acknowledgement of these traditional conceptions on behalf of healthcare providers interferes with women's adherence to treatments, as well as increasing the distance from biomedicine and its practitioners, reinforcing the gap existing between migrant women and the medical system.

The reproductive body: linkages between the mother, the baby and the social milieu

The series of notions and preventive behaviour around reproductive processes which migrant women observe highlight the underlying principles which articulate them. It is in the descriptions of women's notions and practices that such principles emerge. There is a widespread belief among migrant women, for example, that during menstruation, or at least during the first day of their periods, women should not take a bath or immerse their bodies in water. The reason is that water interrupts the flow of menstrual bleeding. It is believed this blood will then rise up to the head, causing serious long-term health problems. Long-term effects would be experienced after the age of 40, when women begin to suffer from headaches and the onset of an early menopause. In the short-term, the non-observation of this precaution will be experienced as a rise in blood pressure, temperature and painful menstruations.[150] The body is believed to be open during menstruations and pregnancies, therefore particularly vulnerable to various forms of influence. That is why women assert that another pregnancy often occurs quickly after a miscarriage because the uterus is open.

The notion of the body during pregnancy as an open body may explain why the symptoms of pregnancy are not restricted to women. During pregnancy couvade syndrome or "sympathetic pregnancy" is experienced by migrants – not only among women's spouses, but also among other women who are close to the pregnant women. Marta, a technical nurse by training, describes her personal experience with the pregnancy of her younger sister. She suffered the headaches that her pregnant sister experienced. She stayed with her sister when her sister's husband was working the nightshift. Her sister's physical closeness caused Marta, in her words, *to absorb the baby's humors* and the mother's headache was passed on to her. The baby's father experienced nausea. He vomited and had toothaches. This last symptom, according to

[150] One midwife perceived women's cultural habits as difficult to change: "After they have given birth they take a rest, right? Their hygiene is minimal. Yes, I don't know how long they stay in bed, and then their hygiene diminishes because they can't clean themselves. Something like that, it is like that, so infections increase because of that. Due to their habits, let's say, that they bring. Culturally it must be like that. I don't know OK? And it is very difficult to change". (Midwife Focus Group). Yet, all the other midwives interviewed did not report the existence of such restrictions or similar situations.

Marta, has to do with the fact that the baby was growing and absorbing not only the mother's calcium, but also the father's as well.

The existence of the baby as an independent life within the woman's body is identifiable in the very early stages of pregnancy. Indeed, soon after a baby is conceived, a second pulse can be identified in the woman's body and is perceptible to the touch. This second pulse can be felt in area of the wrists and also in the abdomen. It is believed that there is a connection between the baby and the social environment which can be observed, for example, in the properties attributed to the umbilical cord of a newborn baby. The umbilical cord of a newborn baby cooked in a man's meal is supposed to make him loyal and family oriented. It is believed this deters him from hanging out with other men drinking and squandering family money.

On giving birth and becoming a mother

Peruvian migrant women see giving birth as a natural process through which motherhood is constructed. Caesarean section is, on the contrary, a medical procedure which interferes dramatically with the natural course of events. It is viewed as an operation, an exogenous intervention into the nature of the birthing process. They believe it disrupts the emotional bonding between mother and child which is anchored in a (vaginal) birth. The experience of a vaginal birth and associated pain is seen as the paramount experience of motherhood. Furthermore, the physiological transit of the baby through the vaginal conduit and the pain associated is seen as fundamental and intrinsic to the physical, emotional and symbolic process of becoming a mother. Moreover, for these women, fatherhood can also be affected by birth. The presence of a man in the birthing room is seen as positive as he has the opportunity to witness how much effort and pain is involved in bringing a child into the world. Allowing men to witness the birth is believed to influence them in adopting a more considerate and respectful attitude with regard to motherhood in general.

Peruvian women say that in Chile *everything is seen as a cut.* This is in reference to the predisposition of medical doctors for Caesarean section births in anticipation of possible complications.

Peruvian women also see this as a predisposition on the part of Chilean women, who too easily agree to have Caesarean births. Chilean women are judged in this regard as selfish, desirous of comfort, and as being cowardly in wanting to avoid the physical pain of giving birth.

Indeed, in Peru, birth through a Caesarean section is seen as a misfortune for both women and their families. Women show pride on reporting that they and their female family members have all had vaginal births. This is part of a "collective reproductive identity" of the female members of a Peruvian family. Furthermore, a Caesarean section birth becomes a permanent trait in the reproductive identity of a woman who then is termed to be a *cesareada* – a woman who has become a mother through Caesarean section birth.

Behague (2002) observes a contrary trend in Brazil, where low-income women demand access to Caesarean sections as a claim of equity. While in these situations

women are expressing opposite demands, in both cases the demands women put on medical practices reflect the demands of other domains of life.

> Differences in medical practices and values are related to other domains of life, including domestic arrangements, marital relations and gender-based authority. While birth is made into a medical affair, having children is a widely diffused experience that, for the large majority of women in this setting, is a necessary and positive life-altering experience. As such, birthing shapes, or responds to, the patterning of experiences in various realms of life, including access to public authority, status definition, and ideologies of inequalities (Béhague 2002:481).

While women in Brazil feel that their access to technology empowers them, Peruvian migrant women in Chile feel that it deprives them of a central and embodied dimension of their motherhood – the natural birth. Furthermore, it positions them in a new identity of a *cesareada*. Being identified as such removes a portion of their experience as mother of the born child and limits their physiological capacity to give birth in the future. There are only a limited number of Caesarean births a woman can have, as it is major surgery. In the experience of women, there are fewer Caesarean sections performed in Peru due to the empirical role played by midwives. Called *matronas*, midwives come to see the woman in her own home. The midwife makes sure the baby is in the right position to make the birthing process as easy as possible.

After giving birth, women are susceptible to suffer from *sobreparto* or illness following childbirth. This refers to a group of symptoms – weakness, general malaise, headaches, and body aches – that may persist years after the last birth. Cultural beliefs and practices held that women are especially vulnerable during and after childbirth. It is believed there are multiple orifices through which cold and winds could enter the body causing illness (Leatherman, 2005). Hence, care should be taken to rest and refrain from exposure to environmental extremes and, although not referred to by migrant women, there are also dietary restrictions.

Sobreparto can manifest around the age of 40. Julia is a very energetic and thin woman, just over 50 years old. She describes her symptoms in this way: “the nerves ache. You feel pain in your bones. Pain in the waist and hips and medical doctors cannot identify this problem”. Julia has had 13 pregnancies and 10 live births. She is proud she has maintained her physical strength and health. She observed bathing restrictions after giving birth to each of her many children, thus preventing *sobreparto.*

> I looked after myself. Only after the twentieth day I would take water and now look at the way I am built! …

While these conceptions are not brought into the consultation by women, healthcare providers know that they exist but do not see the need to learn about them or to address them. These conceptions are a reflection on the one hand, of the cultural dimension present but ignored in the provision of care. At the same time they are a reflection of the existent gap between healthcare providers and migrant women, and the extent to which migrant women can experience alienation as recipients of healthcare.

11.3.4 Mismatches and miscommunication

Despite the fact that healthcare providers and Peruvian migrant women speak the same language – Spanish – there are various problems of communication which emerge in their encounters. One immediate aspect which surfaces when discussing issues of communication, is the specific terminology used in daily language in the two countries. Sometimes after interacting with Peruvian patients healthcare providers have learnt women's usage of specific terms and have incorporated them into their communication with these women.

> X1: We have not had a problem in communicating (with Peruvian women) because we understand what they say, in their terms.
> X2: Although sometimes we don't understand what they are asking us.
> X1: Yes, but for example sometimes for underwear they use the term *trusa.* So as there are many Peruvians here, we use the same term (and say to them) 'Take off your *trusa,'* instead of saying 'take off your *cuadros'* (the Chilean term for underwear). We don't use that term, as they don't understand.

Nevertheless, issues of communication between healthcare providers and migrant women run deeper than the simple use of different terms. This section discusses, from both the perspective of migrant women as well as the healthcare providers, the problems of communication that arise when they meet and interact.

Informing women about contraceptives

When I asked women to explain how the pill functions in their bodies, they always answered by referring to the explanations given to them by the midwife: "that it should be taken everyday at the same time and if one is missed, the next day two should be taken". Only after questioning further how the pill actually works in their bodies do they admit ignorance.

They often say they were informed, but now do not remember what it was about. Some did not bother to ask. "Ah, now there I am really bad. I don't really know. I have not asked myself that question before". The emphasis midwives put upon the schedule for taking the pill at the same time each day, many times leads to misunderstandings and adds complications to women's lives. Indira thought that with the oral contraceptive she could not have sex before it was time for that day's pill. If she did, she believed she would not be protected against pregnancy.

Healthcare providers are aware of the difficulties Peruvian women have in the use of the contraceptives offered by the clinic.

> With the IUD they have problems: they have discharge, it wounds, it stabs, it (makes them) swollen. They don't put up much with the method. Now and then when we change it to pills the problem is that they do not manage themselves well with that method, because they forget, they don't take it well. They come to check ups, and don't know when their period was. They don't bring the pills (and) don't know how many they have left.

Midwives, in turn, express their frustration about the number of times they explain to women how the contraceptives work, especially the *copper T* - information which does

not seem to resonate with women. Women, say midwives, listen more to each other than to the healthcare providers.

M: I believe as Peruvian (women), they live more *juntitas* (very close to each other). They communicate with each other more; they transmit to each other their aches. They all come here because 'it hurts' (the *copper T*), in spite of having received the same information as the Chileans (patients).

M1: For her (the Peruvian woman) what a friend tells her is truer. They tell you thousands of stories. *Who told you that? – My friend*. And it is very difficult to convince (them) that what the friend told her (is not true), in spite of one's explanations… A Chilean woman instead, they sometimes come with concepts that are wrong and you make a drawing. *It is because my friend taught me* –no poh! Your friend was wrong–… *You are right, miss* (says the Chilean woman).

Midwives are puzzled by the problems in making the migrant women understand, as they know that Peruvian women have a rather high level of education.

M1: In the study I conducted, let's say the educational level was good. For example, they had finished secondary school, and even more they even had tertiary education. So sometimes there is a contradiction.

M2: So we don't understand quite well, because the communication that is possible between us (the Chilean midwife and the Peruvian women) is not related to their educational level.

After midwives' attempts to understand the apparent paradox between the relatively high level of education of Peruvian women and their difficulties in understanding midwives' explanations, one midwife who had lived in Peru reflects on a possible cause.

M: No, what happens is that there is a super important factor at play - that is, one is far from your homeland, (you are) in another land, it is more difficult to understand, even the simplest (thing), because it happens to me.

In spite of this important insight from one participant in the focus group, these midwives continued to have difficulties in putting themselves in the place of these women.

What seems very strange to me is that I say to them (Peruvian women with unwanted pregnancies) *Ok, were you using the method?* Y*es. You were taking the pill, so then you fall pregnant taking the pill? No, it is that I did not come to the medical check up. So how is it you did not want to get pregnant? No,* (I did not) *because I was taking the pills. But in practical terms you were not taking them, you had abandoned them – Yes, because I was feeling bad. But why didn't you come? I was planning to come.* I don't quite get it. If they could not come, if they did not want - did they want to fall pregnant or did they not? I don't know.

Women expressing their concerns about cervical cancer

In Peru, campaigns to prevent cervical cancer began in the late 1990s. Media campaigns about the prevention of cervical-uterine cancer put an emphasis on women monitoring their own discharge. Colour and density were the main things to check. If changes in colour or smell were observed, women were urged to visit their clinics for a medical consultation and tests. However, campaigns implemented to educate the public in

prevention have been criticised for putting emphasis in the wrong place. Specifically, critics have pointed out the need to abandon teaching women the signs and symptoms of cancer and rather to encourage women to get regular Pap smears or other screening procedures (Hunter 2004). The reason is that such messages undermine the effectiveness of a real preventive health campaign.

Nevertheless, migrant women who have been targeted by those campaigns in Peru have learned to observe their vaginal discharge as a preventive behaviour. This may explain why even though all the women surveyed outside the healthcare system knew about the Papanicolaou test, the majority had not had one.

In interviews women expressed concern about vaginal discharge and said that they often voiced their concerns in consultations at clinics. However they generally received no explanation or answer from their local healthcare providers. It seems to be the case that women in Peru are informed about cervical-uterine cancer prevention through very different messages than are women in Chile.

> They ask a lot about their *descenso* (vaginal discharge). They always have too much *descenso* and many of them don't have an infectious discharge - it is the normal discharge of their cycle, but that bothers them very much. It has happened to me in several cases that you explain to them what it is about and after a week they come back. You ask the gynaecologist and the same thing – they all come because of their *descenso.* I have never investigated more. (Midwife Clinic 1)

Concerns which women express in their consultations do not seem to resonate with Chilean healthcare providers. Underlying this are seemingly discordant prevention messages in Chile and Peru.

In Chile national campaigns publicising cervical cancer prevention have been carried out by the Chilean Ministry of Health since 1993. Their aim for introducing the Papanicolaou test among women was to use it for early detection of cervical-uterine cancer. This campaign targeted sexually active women between the ages of 25 and 64. Women were expected to voluntarily comply and have a Pap smear done every year. Medical norms in reproductive healthcare also indicated that in all gynaecological consultations, women should agree to take Pap smear tests. Even though these campaigns did not specifically address migrant women – even the later campaigns when the migrant population in the country began to increase and became noticeable in primary health clinics - migrant women were also expected to voluntarily comply with the norms and have the test done regularly. Thus, miscommunication between healthcare provider and migrant female patient with regard to this issue is not much based on the fact that women have a more traditional approach to their health or that there are differences in the use of terms but largely due to differences in campaigns in the two countries.

Expressing doubts and asking questions in consultations

Many women say they express their doubts and direct questions to the midwife. However most often it is the most educated women and the ones who have a profession who ask direct questions. Other less educated women such as Elsa feel embarrassed and intimidated:

L: If you need more information about certain contraceptive methods or sex-related issues, or just issues related to your health, where do you go? With whom do you get clarification?
E: You see, I sometimes don't clarify my doubts with anyone. Sometimes I don't understand what the midwife says to me.
L: You don't understand her? You don't understand her vocabulary?
E: No, no, no.
L: So, you don't understand her words?
E: No. Let's say, I don't trust her.

Younger women prefer to ask older women rather than the midwives, as often they feel embarrassed to ask them questions. *I ask a person closer to me - let's say my mother. Older people, like my mother or mother-in-law.*

Nevertheless several women report no problems in communicating with the midwife and feel able to ask the questions they need to ask. For one of the midwives/key informants in a management position, the problem is that Peruvian migrant women don't really ask much, but instead tend to express more the inconveniences they experience.

> If they ask about the inconvenience experienced with the pregnancy, about the discomfort caused by having to take the pills, about the pain that the IUD can cause them, it is never from a positive side, from being interested in the issue. It is always the complaint that they have contractions, that it hurts them (the IUD), that the baby is moving too much, the vomit and nausea – always in terms of inconveniences, always. Not like the Chileans who sometimes bring their notes and ask about things that have happened over the last months.[151]

What also surprises this midwife is that sexuality is absent from the women's concerns.

> They do not manifest either their… that something intrigues them if they have or do not have sexual desire. For the Chilean who sometimes has a difficulty with their partners and they tell you, *Srta.* (miss) *you know that maybe I have something…* At least they

[151] In a study about migration and health in the Metropolitan Area of Buenos Aires in Argentina, Jelin, Grimson and Zamberlin found that among the professionals in the public healthcare system there is a belief that Bolivian patients "have more resistance to physical pain" (Jelin *et al.* 2006 in Caggiano 2007:4). This perception, according to Caggiano, not only confirms the existence of racial prejudices but also calls the attention on medical practices that eventually can be justified in such notions (ibid). Furthermore Caggiano also refers to the existence of what he calls 'cultural fundamentalism' in the Argenitinean society, which is corroborated in the findings of Jelin's study. Such cultural fundamentalism manifests itself for example, in doctors and nurses' beliefs regarding some cultural practices and behaviour of the Bolivian immigrants as being risky and unsafe, and as interfering negatively with the provision of healthcare. Examples given are women's resistence toward the caesarean section, the value given to the placenta, their rejection of blood extraction, their concern about the exposure of their bodies during the medical examination, their unsuitable dresses and hygiene habits. Similarly as found in the case of Peruvian migrants in Chile, among Bolivian immigrants in Argentina, Jelin *et al* (2006) describe how the provision of healthcare to these immigrants is loaded with tension which result from esentialistic 'cultural differences' the healthcare providers perceive that exist between them and these strange and different people. Furthermore the Argentinian healthcare providers insist that the difficulties in the interpersonal communication with the immigrants are a responsibility of the latter. The communication with Bolivian patients presents problems due to their language and expressions (but not due to the language and expression of the medical professionals) (in Caggiano 2007:6-7). The notion through which the 'other', migrant from neighbouring countries is constructed deserves further and detailed study.

question themselves that maybe organically something happens to them, that my husband says that I am lacking hormones. Never has a Peruvian woman asked me, *Srta, you know I don't have sexual desire, I don't feel like going to bed with my husband*. Never, out of all the Peruvians I have given care to. It seems that sexual life during pregnancy does not exist for them… because you sometimes tell them, you have to do your normal life, or you are not going to have sexual relations because you are with contractions or you are bleeding … *No Srta. I don't have sexual relations since some time*... They don't give importance to that issue… maybe because they have it super sorted out and they really don't have difficulties and can talk about it, I don't know. Or is it because they erase that during pregnancy?

Clearly communication problems between healthcare providers and migrant women do exist. Midwives are well aware of the difficulties of really understanding women's behaviour and are often intrigued about the reasons for this as they know it is not a problem of women's lack of education. Women in turn – with exceptions – do not feel comfortable asking questions or they do not provide full information about themselves unless specifically asked. Other problems arise when women express their concerns about vaginal discharge, which is not seen as a relevant concern by midwives but rather as an annoyance. Midwives tend to blame women for not understanding their explanations. Indeed, it seems that information regarding contraceptives, although provided to women, does not really reach them. Furthermore, sometimes the information provided creates misunderstandings with consequences for women's sexual life and reproductive health. So far healthcare providers have not found a way to reach these women successfully. What seems to be happening is the existence of mixed messages between healthcare providers and migrant patients. Peruvian women on the one hand insist, press, and articulate their specific worries when they relate to the possibility of falling seriously sick. On the other hand they are reluctant to be explicit about specific issues such as sexuality or contraception, maybe because culturally they don't feel these concerns are legitimate.

11.3.5 Migrants' perceptions of being discriminated against and what healthcare providers think about it

In this section, I discuss narratives of discrimination which take the form of stories about what has happened to migrant women as users of the public healthcare system in Chile. These are stories that narrate events and unsatisfactory outcomes for these women. Although healthcare providers are not aware of these stories, they would probably consider them as not true or as partial truths if they were to hear them. Indeed, establishing the 'true facts' in these cases is a close to impossible endeavour. In approaching this problem, the focus has been to attend to what is underlying these stories. My contention is that these stories are constructed because of the general discrimination that exists in Chilean society against migrants. They therefore are a reflection of the general inability of migrants to influence their own circumstances. Stories of discrimination may eventually assist those who tell them, in asserting their rights and voicing complaints, as well as in creating linkages of solidarity with others.

Rosa María Castañeda, a pregnant woman, considers mistreatment from healthcare providers to be especially directed at Peruvian women:

L: And where did you hear that (healthcare providers mistreat Peruvian women)?

RM: Well, sometimes they said '*uyyy no.*' Let's say the girls tell me that when they give birth they (the Chilean healthcare providers) hoot at them because they cry out (in pain). That is why I would get scared. Yes, (healthcare providers say to migrant women) *You should not have had a baby.* I have never, never gone to a hospital here.

These stories are typically told by women to each other in waiting rooms of clinics, or by a roommate, relative or friends at a social gathering in the community with the intention of warning female members of the community about mistreatment in the healthcare system. Such stories also detail the poor quality of healthcare in Chile, as well as negative outcomes that may affect Peruvian women as members of a distinct and marginal group.

Furthermore, through storytelling, migrants also attempt to position themselves within the healthcare setting and to exert their rights. What they demand is fair and equal treatment from the public healthcare system. Manderson (2003) analyses the use of storytelling in the healthcare setting among female immigrants from the Horn of Africa to Australia. The authors use the term *medical gossip* to refer "specifically to the transmission of information about health and illness, usually by a friend or relative with no medical training, in an attempt to provide assurance of, or, to express alarm" (Manderson 2003:5).

Gossip and story telling in this context also have an instructional value in that they explain an unfamiliar system to immigrants. Unlike the Australian case, storytelling and gossip are also shared in the waiting rooms with Chilean women, who in turn also have stories to tell about their own negative experiences in the local healthcare setting. As a result, through storytelling, Chilean and Peruvian women encounter and recognise each other as victims of the same battlefield. It serves to bridge the distance that had previously separated them. Equally important is the fact that through storytelling with Chilean women, Peruvian women reinterpret their earlier perceptions. They begin to realise they are not necessarily the victims of a nationally targeted campaign against Peruvians within the Chilean healthcare system.

Roxana Lopez is 27 years old, explain why she does not attend medical check ups; *I did not go to the doctor. One, because of fear, and two, because I was healthy, so why should I go?* She has had the experience of having been discriminated against.

L: When you went to the clinics did you feel you were treated differently than the Chilean patients?
R: Yes.
L: Have you felt discriminated against?
R: Yes.
L: How?
R: Let's say one's asked for a favour, let's say one thing and they start *but you don't understand*
L: So (you feel it) in the way you have been treated?
R: Yes they are evasive, it is like they don't provide care they don't give me (enough) time.

Examples of discrimination circulate among migrants in much the same way as gossip. The majority of Peruvian migrants explain these negative experiences as being

due to their nationality. However, there is also a group of women who consider this experience to be common to all users – including Chileans.

Giving birth is the experience most commonly described by women as being affected by discrimination. This seems to be particularly the case when women are having their first baby – they often feel they are being punished. This is heightened by the fact of being a foreigner and giving birth in an alien country. In many cases, women feel Chilean healthcare providers reprimand them for crying out in pain as they give birth. A woman in a focus group recalled her experience of giving birth in Chile:

M3: And the worst is that if you complain, they scold you inside the pre-birthing ward.
L: How do they scold you? Did they scold everyone in the same way? Did you feel that they reprimanded you more? Was this your first time giving birth?
M3: Yes, I was (there) for the first time, giving birth. (But, they scold) solely because you are foreigner. (So,) they treat you bad.
L: Did you feel it was really like that?
M3: Yes, because I arrived being at 6 cm dilated, but they shout at you. And they told me: "What do you complain about?"...That was all they said. "What do you complain about? What do you complain…!" That was all they said. But there would be a Chilean [woman] arriving and they would give her care immediately. She would be let in, but there, they leave you sitting with all the pain.
L: Was there any mention of the fact that you were foreigner? Or did you just feel that way?
M3: Well, as I see it, I felt it. It is like they look at you differently. That was what happened to me in my first and second (births). They do not treat you as it should be. It is not as if it was your own country.

The group brought into the discussion experiences of other Peruvian women who also felt mistreated while giving birth. Some other women in the group, however, have had good experiences with their births. One woman talked of her experience of being married to a Chilean and the difference in the way she was treated when her husband accompanied her to her consultations. This is the story of yet another woman who gave birth to two babies while living in Chile.

X6: My first birth was the same (as the other participant described). …Chilean healthcare workers said to her: "*Why do you come here, Peruvian?"* This was followed by an exasperated "Uff!"
L: I can't believe it!!
X6: Yes, and they sewed me bad too. For two months, I could not sit.
L: Was it also your first baby?
X6: Yes. And it was mostly the service personnel. The ones that sweep (the floors), those people. (They are the ones who said) that Peruvians were coming (to Chile) to take over their jobs
L: Was this before or after you gave birth?
X6: When I was giving birth! They would tell me right there. …But there are good people too. I was alone, so I felt bad. For the second baby, I was with my husband, so they could not do it to me. They treated me well then. But there are the cleaning people that always, when they see you there, they give you a bad (look) because you are Peruvian. *Ah, you are Peruanita?* They look down on you.

This seems to be a common experience for migrant women who are alone during their first birth. Being accompanied by one's husband makes an obvious difference in how the women are treated by hospital workers in general.

From the perspective of healthcare providers, and specifically in the midwives' perception, Peruvian women come with an attitude of resentment. Most midwives are of the opinion that Peruvian women believe they will be mistreated, or that are going to be rejected because they are Peruvians. Such midwives feel this negative attitude is visible in many Peruvian women who are about to give birth.

> It becomes evident in their attitude. …Eeehh! … You must give me care, now...! I am equal to all Chileans!

According to the midwives, Peruvian women generally – and particularly in the beginning – arrive with a predisposition that they will be rejected by the healthcare system because they are Peruvians. This is probably because they have been told stories and gossip about what has happened to others. They fear the same will happen to them. Over time some of them change – especially those who have higher education - while others (the less educated) maintain their defensive attitude. However, previous conflicting experiences can explain their defensiveness.

> Also (it happens) because (of bad) experiences they have had in other places, (in) the hospital sometimes. So they come here like that – defensive –with that [negative] attitude.

However, many midwives do not believe that Peruvians mistrust them with regards to medical procedures or treatments. In fact, midwives generally feel that Peruvians, like Chileans, have complete trust in them and follow their instructions without hesitation. Therefore, midwives rarely have to deal with conflicts. However, conflict occurs more often with the technical and administrative personnel. This is explained by a key informant midwife in one of the clinics.

> The paramedic and technical personnel are confronted by the patient all day long. They are the ones that shows the face, the one that says there is a midwife or there isn't (to provide care), that there are not more appointments – so their reach to patients is also different. I think they have some resistance towards these patients, due to their difficulties in understanding instructions and the difficulties in following the instructions given to them.

From the perspective of the healthcare practitioners, a related issue is the conflicts which emerge in the waiting rooms between Peruvian migrant patients and Chilean patients when care is given to a Peruvian patient and a Chilean patient is forced to wait.

> There have being fights here –yes, that *she is a foreigner and she is preferred. That is why we are left without care they come to take our jobs!!!*

11.4 Migrant women's specific reproductive needs

This section discusses the demands made on the Chilean healthcare system by migrant women as well as the extent to which the system has incorporated changes to address these demands. It also debates whether healthcare providers perceive a need to incorporate future changes to respond to migrant patients.

11.4.1 Unwanted pregnancies

When I asked healthcare providers about the existence of abortion among migrant women, they seem to agree that it is not something women would express in the consultations.

X: At least here we don't sympathise … *You are pregnant* (says the midwife to the woman). There are Chilean women that tell you *This pregnancy I will not continue. I will have an abortion, I am going to do anything*. But instead, they don't …. I don't know if they don't feel it, they don't think about it, but they don't show it openly as the Chileans do.

X1: There are Chilean women that ask you for help in terminating their pregnancies (Peruvian women facing unwanted pregnancies) instead, maybe they feel it, they prefer it, but they don't tell you.

However there have been occasions in which migrant women have demanded help from healthcare providers to prevent or terminate unwanted pregnancies.

> Sometimes women come to the services asking for help. (They want us) to interrupt an unwanted pregnancy through an abortion. …Many times they ask us, (they say) *No, no I can't be pregnant,* because their situation is such. When they arrive (in Chile) they rent rooms. (They are) alone or they do not have employment, so for them to become pregnant is quite catastrophic. *(Veronica, paramedic)*

Paramedics are often confronted with a woman's demand for help in a situation where a pregnancy can cause them big trouble.

PM1: Many times they come (and say) that the husband is going to arrive from Peru. Do you remember that *Señora*? (Laughs)

PM2: Yes, she had like three children already and had left them all with her family in Peru. She came here, worked, began a relationship and got pregnant with a Chilean, and her husband was about to arrive (in Chile). We believe that she had an abortion because she never came back. She did not come back because she was desperate.

PM3: Yes, because she had not been in Peru for so long and the husband would find her with a baby! (Laughs)

PM1 And she put pressure (on us). That she had to have (an abortion). …Let's say that she could not be pregnant. Of course, because she had her husband and he was to arrive in two or three more days (she could not be pregnant).

L: And what did you say?

PM1: Well, I am more like… (I say) "*Well, that is not our problem. That is your problem. You should have thought about it and have solved it before now. [You should] not come to pressure us here. We don't do abortions here"*.

11.4.2 Addressing women's cultural differences

L: In what ways have migrants' cultural differences been incorporated into the healthcare provided to them?

M: No, it has not been incorporated, not until now. I think what has been stressed is the fact that they are foreigners, nothing else. …But there is nothing special here for them. No. …In a way one says: *Peruvian, Ecuadorian, and Bolivian* – because we have them from different countries, but there are more Peruvians. So then we

> say: *Yes, they are more aggressive, more violent*, and in that regard, one looks at them as more… (different). *(Midwife, primary healthcare clinic)*

Even though healthcare providers showed an interest in getting to know this new population better, their curiosity was expressed mainly when migrant women first arrived in Chile and began to be noticed among the healthcare system users. Paramedics and then the midwife would engage in conversations with these women about their lives and their families in Peru, the reason why they had migrated and so forth.

This was the healthcare workers' attempt to understand what brought these Peruvian women to the country to live the way they do. These Chileans wanted to know how they could leave their families, and in these tenuous circumstances, why they had allowed themselves to get pregnant. Eventually, healthcare providers felt they had enough information and stopped asking women about the reasons for their migration. In this way many perceptions regarding migrant women remain fixed. Nevertheless, there are also healthcare providers who –to the extent of their possibilities and limited time – are opening spaces for Peruvian women, holding conversations with them to find out about their lives and concerns.

When I asked midwives and paramedics in both clinics whether issues related to care of migrant women patients are ever formally discussed, they agree that they are not. This is very much the way it was in the beginning. As midwives affirm, they were not prepared to deal with these new patients.

M: In a moment we all wondered, *what are they doing here?*
M1: *Why doesn't the government put a stop to this?*
M: Let's say in a moment we all wondered, *Why are they taking our milk? Why are they using the space of …* (Chilean patients)
M1: The Chilean user also asked *Why* (are Peruvians getting care) *if this is something that is ours? Why is there such a flow of Peruvian women or of foreigners (in general), and they are incorporated into all the health structures?* Nobody understood anything, nobody gave us explanations.
M2: We had to adapt ourselves to their language.
M: Now we have great friends among Peruvians.

A key informant who is a paramedic recounts what it was like for them to all of a sudden provide care to foreigners.

> Because we don't know anything about how the system is over there (in Peru) – the planning, the system of care provision – in that regard we don't know anything. They (Peruvian women) arrived all of a sudden and we received them based on what we knew. We kind of got used to their sayings. We learned the words they use, the expressions they have. Sometimes we could not understand them at all. Each one understood the other as best we could. *(Veronica: paramedic).*

A key informant who is a midwife at one of the clinics who has the responsibility of overseeing all the activities within the Maternal Unit affirms that the only time the issue of migrant patients emerges within the structure of the clinic is in connection with the provision of medicines by the clinic's chemist.

> One notices that the stock of remedies diminishes rapidly. For example, what I know about the pregnant women, many of them are anaemic, so if before we bought, let's say, 11,000 *Ferramed* doses, now the 11,000 do not even last 20 days. *(Pharmacologist)*

In general healthcare providers point out that the system of care has not been modified or adjusted to the characteristics of the migrant population in any way. They affirm that the migrants *are treated like any other Chilean patient*, for example, the contraceptive methods that are available are the same, despite the demand by Peruvian women for other types of methods. For the healthcare providers it is important to meet everybody's needs and the needs are seen to be the same for everyone. Chilean caregivers insist that Peruvian migrants have equal rights, which for them means giving identical treatment to everybody and not encouraging differences. To do so, in the healthcare providers' view implies discrimination. Implicit is the idea that, if migrant women demand something different, they should adapt themselves by changing their demands in response to what is offered.

> L: Do you think that the provision of care should incorporate the patients' cultural differences in anyway?
> M: I don't think so. At the most it could be more information about who is providing care, more knowledge…eeeh. To know more…How big is the population, what are their benefits, specifically…To tell you the truth here we give them (Peruvian women) care like anybody else, but I have always wondered, let's say if it is fine or is it not fine… Is that the way things should be or not?

A key informant who is a midwife and head of the Maternal Unit at the other clinic thinks that it is necessary to acknowledge the differences that distinguish the foreign patients, just as it should be done with indigenous Chileans. In order to improve the care provided to migrant patients, healthcare providers should be better informed about who the patients are. They should learn about their lives and why they behave in one or another way. She believes that this would have a positive effect on migrants themselves as well as on the healthcare providers.

Healthcare providers, however, point out that healthcare foreign patients have access to the same healthcare services as any Chilean patient, including antenatal care and consultations with the nutritionist. In addition, women have access to the complimentary feeding plan available for pregnant women who are found to be underweight, malnourished or anaemic.[152]

More important than a wider range of contraceptive methods, according to midwives in both clinics, is the need to educate migrant women for them to accept the existing methods, to give them more information about how they work, and to inform them about what they may feel or experience as a normal effect of using the method. They don't see the provision of more methods specifically for migrant women as justifiable, given that they also face problems with Chilean women who do not respond well to the intrauterine method and for whom no additional options are offered. Overall, the implicit idea which predominates among healthcare providers is that fair treatment is the provision of the same standard of care to everyone, regardless of their nationality or culture. In my view the approach to equity held by healthcare providers although in an unintended way, excludes migrant women. As long as their difference is not being

[152] The plan provides one kilogram of enriched powdered milk per month.

addressed, the care provided to them would perpetuate in their lack of control over their own reproduction, and will limit them in achieving full reproductive rights.

11.5 Conclusions

In this chapter I discussed various dimensions that emerge in the interaction between migrant patients and healthcare providers. This examination revealed various forms in which exclusion and discrimination against migrant women occur. I explored the perceptions of Peruvian women about the public healthcare system.

While migrants are given care, they are at the same time excluded as their specific needs are not acknowledged. One of the dimensions of exclusion can be characterised as the mono-cultural, mono-ethnic notions underlying practices in reproductive healthcare. There is, indeed, an ideal type of patient – namely, a Chilean woman. Migrant women challenge this ideal for various reasons. However these reasons are hardly considered by healthcare workers when providing them with care. First, migrant women are confronted with practical barriers to accessing healthcare linked to the very condition of being migrants and part of a rather mobile population. Migrant women face constraints in attending medical consultations as they work as live-in domestic workers where they lack the power to demand time off to attend healthcare consultations, which typically require several hours including waiting time. Secondly, as contradictory as it may be – bearing in mind the autonomy of these women in undertaking migration in the first place – is their restricted autonomy in decision-making regarding their own reproduction. The idea of the patient that underpins the provision of care is based on a woman who has ample time to attend consultations or who, if she is working, has sufficient power to negotiate time off from her job. The typical patient also has autonomy in decision-making about reproductive health matters. Based on this idea, migrant women are expected to relate to healthcare providers in the same way as other women, despite the fact that they lack the autonomy.

As detected, there are some forms of discrimination against migrants taking place as covert practices since healthcare providers seem not to be aware of the fact that they hold discriminatory attitudes. For example a contradictory element which is incomprehensible to healthcare providers is that while having had access to sufficient formal education in Peru, migrant women still hold on to traditional conceptions about their bodies. Instead of motivating healthcare providers to develop cultural competence and sensitivity to improve the effectiveness of their work, these contradictions reinforce their stereotypes of Peruvian women as being backward or “not very bright”.

Indeed, rather than regarding the above characteristics as part of migrant women’s different healthcare needs, women migrants are being constructed as demanding, complaining and abusive of the system. The stereotyping of migrant women has consequences in terms of the way women are treated and represents another form of discrimination against migrants in the healthcare system.

The approach to equality and fairness held by healthcare workers consists of the provision of one and the same type of care regardless of the individual characteristics of the patients. One of the consequences of this approach is that unwanted pregnancies are not successfully averted. In fact women become pregnant while attending family

planning programs, due in large part to the unsuitability of the contraceptive methods offered to them and the insistence of healthcare providers on women adapting to these methods. Unwanted pregnancies among Peruvian migrants are not seen as a public health problem or as an issue which the healthcare system can play a role in stopping, let alone as a situation that the healthcare system may have contributed to producing. Furthermore, rather than acknowledging the need to improve the contraceptive methods available to women, healthcare providers support explanations about women falling pregnant as a deliberate strategy for obtaining their legal papers.

However, rather than being passive, migrant women resist the attempts to discipline them by transgressing legality, by demanding prompter care, and also by storytelling. Stories of discrimination may assist the women who tell them in asserting their rights and voicing complaints, as well as in creating linkages of solidarity with others, including Chilean women.

Conclusions

To conclude this work, I would like to assess the extent to which the goals set in the beginning of this thesis were achieved. I will do so in the light of the findings of this study.

1. The first goal of my study has been to explore through the use of an ethnographic approach the linkages between social, economic and cultural determinations of migrant's health and their collective and personal experience of illness.

Ethnography and the linkages between social determinants and individuals' health

The ethnography of the community of migrants was conducted through participant observation. This strategy allowed me to obtain an 'inside view' of the community under study, thereby gaining access to information until now unknown. Indeed, and while this group lived on the margins of the heart of Santiago city, existent information on them, as well as more generally, on what it means to live as migrants in Chile, was until now non-existent.

Through ethnography and from a perspective of the collective lives of these migrants I could gather in depth information on their living and working conditions as well as on their social practices and the meanings they attach to these practices. This knowledge was central to gain an understanding of the structural limitations migrants face in Chile. In view of these limitations I could understand the logic of the migrants' decisions, for example, why migrants remain living in collective houses, and more generally the various decisions taken or not taken which respond to the logic of living as 'passing birds.' Through ethnography I could picture forms of structural discrimination and exclusion exerted upon migrants. I was able to view the effects on migrant's lives of the segmentation of the labour market, the impact of residential segregation as well as other forms of everyday discrimination upon them. In addition, the ethnography conducted allowed me to visualise migrants as active agents in dealing with their limited circumstances and developing strategies to circumvent these restrictions. I also gleaned an insight into the endeavours of migrants' in striving to attain their goals.

Through ethnography and the complementary techniques used (household survey) I detected the dynamics of migrants' movements in establishing the transnational character of their migration. I detected the kin-related nature relations that migrants maintain with Peru and how these relationships were maintained through the sending of remittances. In addition, such relationships were nurtured through various forms of communication (telephone calls, e-mails, packages) and through trips back to Peru. Conducting multi-sited ethnography in Peru allowed me to capture the other side of migration. In my visit to returned migrants and their families in Peru, I could explore health resources as well as gather information on the general economic situation, and gained better understanding of the migratory process.

In the context of the ethnographic knowledge I could visualise the main health problems migrants have in Chile. Specifically it allowed me to identify the point of articulation between the general structural conditions affecting migrants' lives and their individual health. I could grasp the core question of my research, namely the linkages between the constraints that the environment imposed on migrant's lives and the way in which those constraints affected their health and well-being. The household surveys conducted allowed me to detect the recurrence of these problems and to assess the extent in which migrants were accessing healthcare. Lastly, the ethnographic approach allowed me to use various other complementary methods such as a mental health test and in-depth interviews to gather illness narratives. Equally important, the ethnography allowed me to place the findings in the context of their cultural meanings.

Emotional distress as a manifestation of migrants' social suffering

The aim to capture the social production of suffering and its effects on individual migrants' health required an approach that would connect the meso and micro level of analysis. A medically validated mental health test, allowed the screening and capturing of the dimension of migrant's mental health problems. The test applied in combination with the use of a survey for the gathering of social variables enabled me to outline those aspects of migrant identity and life situation which most affected the migrants' mental health. These included aspects such as gender, age, marital status; their life situation – presence and place of residence, of partner and children; their work conditions – employment status; and legal situation – visa, work and contract.

Subsequently, in-depth interviews allowed the gathering of illness narratives and through it, illness experiences. This route led me to delve into the socio-cultural realms of migrants' distress and to explore the nature of such experiences. As symptoms were situated amidst the lived context where they emerged, migrants' narratives opened up a space for these symptoms to be used as a language of social distress. Overall, migrants' illness experiences provided a richer understanding of the complexity and multiplicity of individual and societal factors involved in the deterioration of migrants' well-being.

In the analysis conducted, I focused on the symptoms of distress as well as on their embedded-ness in social relations in the interactions that take place between individuals in different power positions. While factors of gender and age emerged clearly in the narratives, individual variations became manifested in body sensations, emotions and the subjective ways in which illness was experienced. The local contexts depicted, allowed me to visualise the dynamics and relationships involved in the social production of suffering and emotional distress. Experiences and symptoms of distress were also examined in the light of their embedded-ness in a cultural system. In concurrence with Good, I have argued that our primary access to experiences is through the analysis of cultural forms. Narratives provided a window to inquire into the cultural and symbolic realm that makes human experiences meaningful. Consequently, I paid attention to those cultural conceptions which gave meaning and coherence to the events occurring in local contexts. These events were relevant as they ultimately had an effect on the individuals' physiology and well-being. This approach and the various methods used led to the following findings.

Social suffering in the form of emotional distress emerged along two main areas of migrants' life condition –the displacement of their lives and their social exclusion in the host country. Within these general themes, the cultural analysis revealed pivotal socio-cultural structures underlying migrants' distress, such as the representation individual migrants have of their own self in connection to others. Frustrated goals and/or a sense of loss –dimensions at stake in migrants' emotional lives – were found to be articulated in migrant's representation of their own self. As discussed, the cultural representation of self organises a structure of emotions through which the events of the world resonate in the individual. Migrants' conception of the self are closely connected to the body, that the body-self is a culturally informed construction. Attention to this notion was essential for an understanding of the processes through which migrants' suffering became an embodied experience and expressed in a particular idiom of distress. Suffering was framed within a context of migrant's displacement of their lives and its consequential experience of uprootedness. In the process of relocation in the host society, migrants' lives are torn apart as the connection with their significant others are disrupted.

Culture-bound syndromes, namely *daño*, *evil eye* and *chucaque* characteristics of Latin American popular culture were found to be prevalent in this community of migrants. These syndromes were triggered by conflicts within the community as well as by discrimination experienced in their interaction with members of the Chilean society. Mostly, in these circumstances, *chucaque* was experienced by migrants as feelings of embarrassment and humiliation.

As discovered, these forms of distress were not voiced by migrants outside their own community. However experiences and idioms of distress diversify as migrants enter into contact with various interlocutors in Chile. In this interaction depression and stress emerged as new categories and idioms of distress. Experiences of *depression* and *stress* were often described by migrants using the language of *nerves,* language of affliction prevalent in Peru. Indeed, these newly adopted categories overlap with the previously existent folk category of *nerves* and less frequently, *convulsions* and *heart illness*.

Exploration of depression and stress as languages of distress began by focusing on signs and interpretations of distress. The questions addressed were 'what signs were recognised as indicative of these forms of distress' and 'who read those signs'. This analysis attended to the participants in the process of co-construction of illness interpretations. Migrants among themselves as well as in interaction with Chileans participated in the construction of interpretations around illness. As languages of distress, they were employed to convey a range of experiences of these migrants. While depression conveyed migrants' inability to provide for their families in Peru, stress conveyed a 'celebrated' state of exhaustion; the consequence of migrants' productive roles.

Gender related causes of distress are also observable. Causes of distress among women seem to be found in the oppressive relations they are subjected to in Chilean households where they work as domestic workers. Under live-in regimes, a process of suppression of women's social identity as well as of their identity as mothers gradually takes place affecting women and undermining their sense of self. Distress among migrant men tends to be sourced from failed love relationships. These are frictions that result from the ongoing changes in gender patterns, compounded by women gaining greater freedom as a result of their migration. Among both women and men the distance

from their families in Peru is cause of great emotional attrition. Emotional suffering should therefore be understood as taking place in a context of the displacement of migrant's lives and of changes that ocur in terms of previous power and current existent relations.

It is important to address here the analytical tension that has emerged in the study of the social and economic determinants of migrant's health vis-a-vis their collective and personal experience of illness. This is a tension that exists between two dimensions of this relation; on the one hand the suffering that is rooted in the social and economic conditions offered by the receiving society where migrants only attain a marginal social and economic insertion and encounter discrimination on everyday bases. On the other hand suffering is also rooted in migrant's own lives, where the dynamics of a transnational migration in itself creates critical conditions that affect migrant's health. In addressing this tension I have attended to migrants own interpretations of their suffering where migrants' locate themselves in discrepant positions. Some migrants try to create a sense of continuity between their lives in Peru and their present lives in Chile. Through counterwork these migrants reinterpret their previous forms of suffering and frame it into an undertanding that seeks to reconcile with the interpretations provided by the Chilean milieu. In this way, migrants validate their own illness experience and forms of suffering reinscribing them within the terminology provided by various agents in the new context. In other situations migrants see Chile and Peru as two contrasting worlds. Through counterwork these migrants resist the interpretations the Chilean milieu offers to their distress; they see their health situation as clearly differentiated – between a before and after migration– and dispute the interpretation of the nature of their suffering to various Chilean interlocutors.

Migrant's agency displayed in such contrasting counterwork involves as a consequence, the use of diverse resources to deal with their distress. While in the first case migrants enter more fluidly into a dialogue and use the resources offered by the Chilean milieu (by employers, medical doctors, co-workers and friends), in the second case migrants resist the alternatives offered by this same milieu. Indeed, perceiving the two worlds in such a constrasting form leaves lesser alternatives available to face illness and adversity in the Chilean context. At this point, a reflection on the contents of these interpretations and the consequent strategies followed to face illness is necessary. This brings in the question about the extent in which the Chilean interpretation medicalises migrants' distress, as well as the extent to which this response ignores the structural and societal causes of migrants' emotional suffering. However an equally important question is what are the alternatives left for those migrants who resist the Chilean feelings and interpretations of distress? This line of inquiry led to the analysis of migrants' strategies and practices to cope with and overcome their distress.

As it was found, migrants deal and cope with their emotional distress mostly outside the healthcare system –where medicalisation as a resort of treatment is not excluded. Means used to cope with distress which are rearticulated in the new context often follow traditional gender constructions. Men tend to drown their difficult emotions in alcohol. Women in turn, resort to dancing as a mechanism to liberate stress. Stress –as an interpretation of migrants' distress taken from the Chilean milieu – opens a window for migrant women to engage in more liberal behaviour. In other instances women's distress is managed at the workplace. Oppressive work relations of women working as

domestic workers are often the context which frames the management of distress, where medicalisation is one of the resources used to manage women's distress.

The context related nature of the emergence of emotional distress

The physical space of the community where cultural-bounded syndromes emerged brings about a discussion of 'the view from within'. Participant observation proved to be a necessary strategy to access the knowledge of how migrants' experience emotional distress. Furthermore, it also provided insights into the understanding of the nature of the phenomenon studied. Indeed, the condition under which the above described forms of distress were disclosed and became known to the researcher, shows how power relations influence migrants' use of various language forms to communicate their distress.

Display of these syndromes within the boundaries of the community brings methodological issues into the discussion, as it elicits the context-related nature of these experiences and idioms of distress. A brief reference to some methodological considerations is needed here to reflect upon the implications of the strategy followed for the phenomenon studied. Specifically, I want to refer to the way in which the presence of the researcher initially limited the information obtained. This reflection ultimately allows an understanding of how idioms and experiences of distress are affected by the nature of social interactions and the power relations at play. At first the researcher was seen as a representative of sectors of the society who do not believe in the existence of these illnesses – a Chilean, educated, scientifically trained person, from a different social class. The researcher's presence in short, for migrants, embodied a 'censoring interlocutor.' Probably one that is no different from those with whom migrants interact daily in Chile. It was only after spending quite some time inside the migrant community – and as an outcome of building trust – that knowledge of these culturally-bounded syndromes was possible to obtain. Otherwise, these forms of distress would have not been disclosed to the researcher. This proved to be true by the fact that such information did not emerge in the survey initially conducted.

In the closure and disclosure of this reality to the researcher – the existence and prevalence of these culturally-bounded syndromes– it is possible to visualise the kinds of dynamics involved in the various social spaces where migrants interact. As I assert, these micro-events may be indicative of what migrants face in the host society in general. Furthermore, as I would also argue, the various 'social layers' where migrants interact in the host society entail various possibilities to deal with their distress.

Social spaces may impose a restriction in this regard. Some other spaces bring about the need for migrants to negotiate over the nature, meaning and management of their illnesses – be they in folk or other forms of distress. However, as it was found, very often the nature of social relations in the social spaces where migrants interact, constrain migrants in their possibility to disclose their own interpretations of illness. In short, a double process was found to take place in those social spaces: migrants are confronted with other interpretations of illness and simultaneously – as occurred initially with the researcher – they tend to censor their own conceptions and practices.

In addition, the framing of these diverse social settings either allows or restrains the possibility for migrants to interpret and, linked to this, make use of their own resources to face adversity and illness. It is possible, therefore, to visualise the spaces of interaction with Chilean interlocutors not only as spaces where illness is produced but also as spaces where experiences of illness eventually change.

2. The second main goal of my study has been to contribute to Chilean State policies that are culturally sensitive and take the needs of migrants into account, including healthcare policies.

The dimension of women's reproductive health was chosen to explore the role of the State with regards to migrants' wellbeing. Specifically, this study examined through the perceptions of healthcare providers and migrant female patients, the existing policies in reproductive healthcare. The reason for selecting this area of healthcare was primarily because reproductive health was the primary motive for which migrants consulted the public healthcare system –of course the patients were mostly women. In general if the health problem is not acute, migrants do not seek medical care because of existing barriers of access. In second place, and maybe even more relevant, is the consideration of reproduction as a crucial dimension around which notions of health, preventive behaviour as well as gender, sexuality, nationality and rights, are articulated. These dimensions were found to be present in the interaction of migrant patients and healthcare providers. It is this area that an anthropological perspective can contribute towards the development of culturally sensitive policies.

I was also interested to establish whether or not migrants experience discrimination in the healthcare system. This, I analysed in two circumstances; i) in situations where access to reproductive healthcare is restricted or denied to female patients and ii) when as subjects of care, women migrants see themselves as being forced to submit to an imposed personal or cultural identity which is not a true reflection of them.

Findings obtained outside the healthcare system

The first dimension therefore involved establishing the existent barriers for women in accessing reproductive healthcare. Thus, I studied women's reproductive healthcare needs outside the healthcare system. Women were surveyed and interviewed in their community and the focus was placed on women's access, use and knowledge of contraceptive methods. This inquiry is relevant as it challenges a commonly held perception – by authorities and government representatives linked to migration issues as well as by healthcare providers – that women purposely fall pregnant to obtain visas and regularise their status in the country. The findings show that there are multiples factors intervening in the events of these women falling pregnant and that in most of these cases these pregnancies are unwanted.

The survey conducted proves that migrant women are using the contraceptive methods offered in Chile. Oral contraceptives and the *copper T* held first and third places respectively. Yet, the survey also showed that an important number of women are not using modern methods offered in Chile; they would prefer the Tri-monthly injection they used in Peru which at the time of the study was not available in the country. Migrant women resistance to use the methods offered in Chile was visible in

the fact that the second most used contraceptive method is a traditional one – the *calendar* method. It was also found that the knowledge women had of the contraceptive methods they were using was wrong in almost all the cases. This was true for women in various ages and educational levels. Barriers of access to healthcare and more specifically to family planning programs are economic, cultural and legal road-blocks, since illegal migrants have had even more restricted access to public medical care. While the detected barriers of access do not represent an over discrimination against migrants, it was also found that previous negatives experiences within the healthcare system discourage migrant women from consulting.

Cultural dimensions pose barriers to accessing reproductive healthcare for women, specifically in terms of their use of contraceptive methods. Power relations articulated in gender constructions were found to be relevant in understanding women's reproductive decisions. Migrant women are often not autonomous decision-makers in the sphere of reproduction and contraception. It was found that they were often influenced by their male partners or by older women. Furthermore these power relations had a transnational nature as women relied on members of their families who may or not be in Chile, but in Peru.

Equally relevant are cultural factors that play a significant role in women's acceptance or rejection of contraceptives. I explored existing conceptions which deter women from using some of the contraceptive methods offered to them in Chile. These are women's embodied perceptions of the body and the reproductive system. These perceptions limited women in their acceptance of modern contraceptive methods offered in Chile such as the IUD or the oral contraceptive.

However, in spite of all the existing barriers – or because of them– migrant women are resorting to alternatives strategies in their attempts to prevent pregnancies. They resort to traditional methods or obtain contraception in Peru. However these strategies are inefficient and insecure in protecting women from pregnancies.

All these factors show that migrant women, in spite of their efforts to prevent it, are at risk of unwanted pregnancies. Furthermore, it disproves the commonly held notion that women fall pregnant purposely to obtain their visas in Chile. These notions obliterate the real dimension of women migrants' needs in reproductive healthcare. They represent a transgression to women's reproductive rights, and reinforce the idea that pregnancy among migrant women is a sought after situation, as a consequence their contraceptive needs remain unattended.

Findings obtained inside the healthcare system

The study was also conducted inside the public healthcare clinics, and included the gathering of information among healthcare providers and migrant female patients. In this space I examined the role of medical practitioners in disciplining and attempting to assimilate migrants. This was displayed through their interactions with migrants when healthcare is provided.

Before I discuss the findings, I consider it necessary to acknowledge the fact that the healthcare provider in these primary healthcare clinics have been left alone in their task

to deal with the higher number of migrant female patients that began to demand care in the primary health clinics in Santiago. Implicitly therefore, a message was put forward, that no modifications, information or especial training was required to provide healthcare for the increasing number of foreign patients. Healthcare providers, independently have, in the course of the time, developed initiatives tending to address these women's differences. For example they have incorporated the use of these women's terms and language in their interaction with them. Healthcare providers are doing their best to provide care to migrant women in conditions they consider to be fair. However the findings of this study show a problematic way in which the women's differences are being dealt with.

Indeed, while there is not yet statistical information which would allow drawing epidemiological or social profiles of this population, they are in the process of being constructed as a different category of patient. Various categories of healthcare personnel participate in this construction. As it was established, migrant women are perceived as different, but this difference is undervalued. This is particularly so in light of the prevalence of a mono-cultural and hegemonic model which conceptualises and provides for a specific subject of care, the Chilean woman. The underlying premise is that while Peruvian migrants are not like Chilean women, they should and may become like them in the future. Linked to this premise is a notion of equity of care, based on the idea that everybody should receive the same treatment independently of their specific needs. Healthcare providers generally support this particular idea of equitable care even though the evidence of not attending to migrant women's specific needs suggest a detriment in the health of this particular group.

This conception of what it means to provide care 'with equity,' results in the consequence that important dimensions of women's differences are being denied in the care provided to them. An example of this was that, healthcare providers did not consider necessary to provide a wider range of contraceptive methods to satisfy migrant women's needs. Furthermore healthcare providers continued to prescribe the methods which have acceptance among Chilean women (such as the IUD and oral contraceptive) to migrant women in spite of the observed high percentage of rejection.

The extent to which this notion of equity is based on mono-cultural models is confirmed in various situations. For example while it is noticeable that migrant women are not autonomous decision-makers regarding their own reproduction, existent power relations are not challenged by healthcare providers, instead these are reinforced in the consultations. At other times healthcare providers actively judge and censure women's behaviour. Specifically, as women migrants prioritise their role as providers for their children over their presence next to the children. This aspect has become crucial in healthcare officials ideas of what it means to be a good mother. In the context of unemployment and economic crisis, Peruvian women are forced to migrate. The responsibility over children is therefore usually taken up by other women allowing the mother to migrate to provide for her children's subsistence. Furthermore motherhood in the context of Peruvian culture is often exerted collectively. The fact that women left their children behind is seen by healthcare providers as selfish and irresponsible. They are constructed as being bad mothers.

While levels of formal education among these women are relatively high, healthcare providers cannot understand the difficulties women have in understanding the messages

healthcare put forward. They also discard existent notions which explain women's rejection to certain contraceptive methods. Women are then constructed as not bright.

A clash was also observed between contradictory prevention messages spread in Chile and Peru by the respective public health campaigns. These messages are related to the prevention of cervical cancer. As women migrants often express concern on signs that have been tough to read, healthcare providers feel they are being inundated with idle concerns. As with this example, there are other situations where migrant women exhibit a whole range of concerns regarding their contraceptive methods, or pregnancies. These concerns are seen by healthcare providers as irrational, obsessive and demanding.

Cultural conceptions about pregnancy and birth were also explored. It was found that these conceptions were suppressed and censored by the women themselves – as an effect of the censorship previously exerted by healthcare practitioners in Peru. However these notions and practices continue to inform women's behaviour. This silence creates a gap between migrant women, biomedicine and healthcare practitioners.

Regarding practical aspect of the provision of care, the healthcare system has failed to acknowledge the demands from women's work engagements and the difficulties women confront in exerting their rights to free time to attend medical check ups. Women are constructed as demanding and aggressive when they express anxiety or frustration with having to wait in long poorly managed queues.

Women are not passive in this process; in fact they display various forms of resistance to the place assigned to them. They are transgressing the limits of the legality imposed by the Chilean system for example, in the form of usurpation of legal identities. However placed in the context of the meaning and practices around legality in Peru these acts acquire another connotation. They cannot be simply classified as criminal offences. Rather they should be seen as migrants' attempts to subvert the limitation imposed on them. In addition women use storytelling to express their criticism and prevent each other from the possibility of mistreatment in the healthcare society. Women among themselves are constructing forms of resistance against a system they feel discriminates against them. Paradoxically by telling and listening to stories in the waiting rooms, Peruvian women become aware of the similarities of their experiences with Chilean women thereby creating the space to build solidarity among them.

In sum, while migrant women are recognised in their difference in the public healthcare system this difference is at the same time neglected. The lack of sensitivity to women's cultural difference and their higher vulnerability is visible in the fact that the acknowledgement of women's difference has not involved major change in the care provided to them.

The limitations of the study

The approach to discrimination used in this study proved to be difficult to apprehend empirically. One such aspect is that discrimination might not be acknowledged by the sufferer – what seemed to me a clear sign of discrimination was not always perceived as

such by migrants. This discrepancy also applies to those who executed discriminatory acts. Often, healthcare providers were not aware of the fact they were holding discriminatory attitudes. This discordant dimension of the phenomenon poses particular challenges to the use of an emic or actors's oriented perspective in the study of discrimination.

One of the consequences of the discrepancy between event and perception is that the relation between discrimination and health becomes hazy, at times, contradictory. As the literature shows, and this study confirms, those who do not recognise that they are discriminated against seem to enjoy better health than those who acknowledge it. Thus studying the effects of discrimination on health becomes a complex endeavour where generalisations are often not possible. As perceptions of discrimination vary according to individuals, its effects are difficult to extrapolate at the group level. In view of this difficulty this study does not resolve the problem of how to target and apprehend that relationship. Indeed a medically validated instrument to assess migrants'mental health status was used in this study, but anxiety and depressive symptoms detected by the test cannot be assumed to be caused by discrimination.

In order to deal with this problem I emphasised the institutional form of discrimination. In my perspective, this form of discrimination ultimately results in the social and economic exclusion of migrants, which in turn has an effect on their health. Based on this understanding, I tried to establish a relationship between living, working and legal conditions –as indicative of exclusion– with higher scores of anxiety and depressive symptoms. However, differences between one and another set of symptoms did not appear to be so pronounced and significant to infer a strong correlation with social variables, and to sufficiently backup such relationships. Therefore the analysis I conducted, based on differential scores for anxiety and depressive symptoms does not have strong empirical support as the sample does not really bear statistical significance. Nevertheless, this analysis also relies on migrants' interpretation of their own illness experiences. Certainly this last dimension is less debatable than the one established between the mental health test's score and the social variables.

Final remarks

The analysis conducted showed that the experiences of illness among Peruvian migrants are shaped by the lack of resources and opportunities as well as the diverse forms of discrimination, racism and violence present in Chilean society. One central question is therefore the social causes of their emotional distress. This calls for an understanding of illness as not an individual problem but as a form of social suffering. While discrimination is an important factor in the study of socio-economic determinants of migrant's health, this thesis has also shown that migration itself affects migrants' health, particularly in situations of transnational migration such as between Peru and Chile. By attending to migrants' collective and personal interpretations around their experiences of distress, and by examining the strategies and practices migrants put in motion to cope with their distress, this study aims to contribute more generally to a better undertanding of the relationship between migration and health.

From a societal perspective it is important to address the following questions; to what extent can we identify migrants' ill health as the ultimate cost of this new form of cheap

labour? In the light of this question, what is the responsibility of the State and more generally of the society in providing forms of support to migrant's wellbeing?

An active State role towards integration should also consider giving migrants facilities for the validation of their professions which would entitle them access to more diversified jobs in Chile. Access to legal orientation and information for migrants about their rights should be facilitated, so they would be able to regularise their legal status, and vindicate their rights. Additional changes in the law are needed in order to assure migrant workers access to retirement funds as well as access to social security, once they return to their countries of origin.

A more comprehensive approach should be oriented at promoting migrants' rights to health, considering health from an integral perspective, more congruent with the World Health Organisation's definition of health as "not merely the absence of disease and infirmity but complete physical, mental and social wellbeing" (WHO 1978). A more holistic approach should include, for example, access to safe and dignified housing for migrants and their families. An integrative approach in turn, should consider not only the incorporation of migrant women into the Chilean healthcare system but also to be culturally incorporated and protected against discrimination.

Finally the knowledge produced by this study is expected to counterbalance current gaps of information present in Chilean society and particularly in the public healthcare with regards to the predicaments in the lives of Peruvian migrants in Chile. Furthermore this study aims to offer a view that restores the complexity and humanity of a population often seen in simplistic and inaccurate terms. A necessary commitment that I assume here is to ensure that the findings of this study will be given back to those who daily, give of their best efforts to provide care to migrants. Only then would I consider the second goal of my thesis as having been achieved.

Epilogue

Santiago, 1st of February 2003

Packing up

Demetrio, his wife Graciela (*Chela*) and their two youngest children had gone shopping. They came back with a new cooking stove. I heard they were getting ready to leave Chile. I wanted to share this moment with them so I decided to join the family while they were still packing.

I knocked at the room's weak door, asking for their permission to enter, smiling Chela invited me in; *entra Lorena.* She had changed clothes and was wearing a sleeping outfit to feel comfortable 'at home'. The room looked so small. It used to be packed up with stuff as I remembered it when I entered it for the first time. Demetrio and Graciela were selecting the items to take along with them to Peru. In the process Chela found a uniform that she had worn when she had worked as a cashier in a bus line. "Ah!" I said, "So you also worked in a bus", to which she replied; *yes*, *the only thing I have not yet done in my life is working as a whore or stealing.*

Demetrio listed what they were taking back to Peru; a colour television set, a cooker that they had just bought, and a *veache* (VIH video system) as well as a new iron machine, a microwave oven and a blender. I asked them whether they were planning to come back. *Graciela comes back,* said Demetrio. She was only going to stay in Peru for six months. Graciela has a resident permit ('*la definitiva'* as they call it), so to keep its validity she must not stay out of the country for more than a year. Graciela with great relief said to me … *now finally, I am going to take these youngsters back home,* referring to her two young children. The kids were happy to leave and I thought that this was understandable as for the past year they have spent most of their time inside that building. Both parents agree, in Peru they were better looked after. Amparo, nevertheless said she was going to miss the people she met and considered to be her closer friends: *Chamé, Toni, Marcos, y la señora Marisol.*

Demetrio showed me a pair of *walky talkies* that had been given to him in exchange for some money he lent. He told me that he would take them to Peru if the owner did not show up to claim them and pay him back the money borrowed. He estimated that in Peru they could cost up to 300 US dollars and can be used on the fishing boats at sea as they can reach long distances. I asked whether they would be allowed to take so much with them on the bus to which Demetrio replied –*yes we know that we can take this… and in the last case* '*se les tira un billete a los compadres'* – (*one can throw some money to the guys*" meaning to bribe them).

Demetrio took down a wall clock and put it into one of the bags; Chela did the same with a Chinese tea set which went into one bag. They were taking the Television set and the "*veache*" (VIH) which was carried in a hand bag; he has already taken a "Nintendo" to Peru. Demetrio planned to open up a Nintendo shop at home in Peru. I asked Demetrio how he felt about leaving Chile, he replied... *I am bored, tired, but thankful*

as well… you know Lorena I met people that are worth it, that supported us, I had bad times as well, but I feel fulfilled by all what I have gathered.

They continued packing and Amparito showed me the 'hip outfit' she was going to wear to Chimbote (pants with strings along both sides, very fashionable among youngsters). She was also taking videos and a very popular Brazilian music that was played all the time on the radio stations *aché* music. She was excited by the prospect of teaching her friends in Chimbote how to dance the rhythm. The next day was a Sunday and they were going to take a family picture in the Plaza de Armas.

Departure

On Monday I went to say goodbye to the Campos family. I was to go with them to the bus terminus. I reached the second floor around nine thirty in the evening, the time for them to get ready to leave and the door was open, I found Demetrio, Ñato and Carlos, a young man, husband of Demetrio's niece. They were all drinking beer in the usual Peruvian way. I greeted everybody and took part in the final toast. The parcels were piled up in the corridor, everything seemed to be ready. They took pictures with some of the neighbours. Demetrio asked me to stand with him and Amparo in front of the boxes piled up in three rows for a picture. *Where are they going to put all that?* I asked. Somebody replied that they would need three taxis. The atmosphere was active and people moved diligently. Demetrio continued taking pictures, and asked Marisol for a picture, she made attempts to quickly change her dress, but he did not allow her to leave and the picture was taken, they hugged goodbye afterwards.

Chela was coming back, so she was not saying goodbye to the neighbours. Demetrio and Amparo walked along the corridor to say goodbye to the two sisters and to Richard, to Marco, Eber, Tomi and to Chamé who came to say goodbye, they were sad to see them leave and commented that the kids had kept the place alive. They are the proof that this sad looking place could host the joyful personality of Amparo, full of life always dancing and singing.

We took the parcels down to the street, Graciela tried to count them but she did not succeed, Ñato and Demetrio junior went to call the cabs. The boxes were packed on the car grills, on top of the taxis. On our way to the terminus, the driver and Demetrio engaged in a conversation. Demetrio said that the situation in Chile had worsened, *I am thankful but staying does not pay off anymore.* The driver pointed out that they should have flown back instead of going by bus since, *it is a killing long trip and it is not so expensive by plane.* Demetrio who had made the calculations responded that paying for 4 tickets was like spending all their savings at once. The discussion continued and the driver insisted they should have flown back. He then asked Demetrio whether he was working in construction (as many Peruvian migrants), *no I worked in security,* said Demetrio, *four years -it has been four years… and I am tired already…* that is what he told everybody who asked him why he was leaving.

Demetrio then commented on the cost of life in Chile, and that he was offered *the minimum wage and with that one cannot live*. He used to get 280.000 Ch P (450 US dollars), working in La Dehesa, so he couldn't accept the offer. The driver then said, *it is very hard to be in another place*, *-yes of course it is-*, agreed Demetrio. The driver

then added, *well but if one is fine in another place why should one leave, maybe it is better to stay?* No said Demetrio *it is not worth it any more, by earning the minimum wage one does not make a living…* to which the taxi driver asked, *well but who gets the minimum wage? Yes*, says Demetrio, *many people.* The taxi driver did not insist anymore.

We were already reaching the Bus Terminus and prepared to get off. The taxi driver helped Demetrio to take the parcel with the T.V set off the top of the car. The place was packed full with people as it was holiday seasons. Demetrio and I took a big bag each, and headed into the mass of people. The place was so full that we could hardly move forward. I pulled a big bag and walked behind Demetrio. Soon I realized that we had taken a wrong direction. We turned back and returned to our starting point pulling the bags again through a place crowded with people, this time in a hurry. I was worried that we were not going to make it. Demetrio said that the bus would leave at 10:45 and it was 10:35.We got to the corner where we started and we saw the second taxi arriving with Ñato and Demetrio's son. We still did not know where to go with all the parcels. We all moved forward pushing boxes, pulling bags. I asked Demetrio again where we should go and he did not know, he said in despair, *Chela has the tickets* and that we had only 5 minutes left. I rushed to call Chela. I got the information and all of us rushed to the platform. The three men quite agitatedly kept pushing their parcels through the packed place to the indicated direction. When we arrived, Amparo was sitting quietly alone looking after the parcels that were carried in the third taxi. Lorena she said, *Chamé was crying about our departure, Eber did the same as well as señora Marisol and they were telling me – don't leave Amparo.* Because I felt quite agitated I did not reply. The bus was not there. I asked Amparo, -*what time does the bus leave..? – at 11:15-,* she replied. We began to reunite at the platform and I felt relieved! There was still half an hour left for the departure and there were all the parcels finally, three big boxes and lots of bags. Chela arrived soon with a coca cola and plastic glasses. We could relax a bit.

The family took pictures again with the big boxes at the back. The trip back to Peru takes three days. It is one entire day and night to the border and another day to Lima, and a third day to Chimbote, each time they had to change buses. I couldn't imagine what it was going to be like! After a short while the bus came into the platform and the passengers began to embark, it was clear the bus was going to be full. The bags were put inside luggage compartments in the bus, but the boxes were left aside on the platform. The luggage compartment was getting full with the passengers' parcels, while all of us were staring with some concern. Demetrio made an attempt to talk to the driver, and then Carlos (the husband of Demetrio's niece), approached him more determinedly. They had already agreed to offer some money to the driver and the bus assistants to allow them to take the parcels along in the bus (the weight and number of parcels largely exceed the passengers' limit). They had figured out that such arrangement would have been cheaper than sending the parcels independently.

It seemed that Demetrio was relying on Carlos to convince somebody. The more we waited the fuller the luggage compartment got and there was less room to fit the cooker, the big TV and the microwave. I asked Demetrio what he was going to do. He replied, "*well we have to talk to somebody*", but he was basically waiting for Carlos to do something. I heard Carlos saying to the various crew members; *I am aware what his job is, and what the procedures are and that I do not want to cause them any problem, we*

know that this is more of what is allowed to get into the bus but if there is some extra money to be paid we are willing to do so…. Time passed and their approaches to bribe the staff did not seem to have any positive response. They tried with each one of the crew and none of them seemed to get the message or to allow any room for negotiation.

As a last resort Demetrio asked me to talk to the driver. I approached the driver and I said, *this family is leaving the country. These are their belongings and they can't leave them here, none of them will stay. Is there any way to put this in the luggage compartment?* He said that he was going to call the cargo supervisor, who soon came and confirmed what we all knew; the boxes were classified as cargo, and should be transported as cargo. At this point it seemed that there was no other alternative, the bus was delayed already and Demetrio's family, were the only passengers still not embarking. They agreed that Carlos would send the boxes as cargo, there was no other alternative. Demetrio was upset that Graciela and the kids were already on the bus. Demetrio gave Carlos 10 thousand pesos but he said that it was not enough; then he left 20 thousand pesos. He got into the bus, finally they left waiving goodbye.

Once they had gone we found that the transportation cost was 48.000 Chilean pesos (USD $80). We couldn't send them because it was late, so we paid 4.800 (USD $ 8) for custody until the next day when Carlos returned to send the packages. They will have taken 4 days to get to Arica. Demetrio has some relatives in Tacna (the Peruvian city on the border), but he could not leave the country and come in again because he did not have a permanent residence, the only one that could do so was Graciela. They will have had to stay longer in Arica waiting for their packages. It was clear the family wanted to take all their items with them. Their arrival was important, they will have been seen by the community and the boxes with all the valuable goods were the best proof that their efforts were worthy. We left tired and sad that their treasure was left behind, an important part of their efforts and sacrifices.

Chimbote

Chimbote, August 2004

I went to meet the Campos' family on the outskirts of Chimbote. The town moved hectically. It had a central Plaza and a Cathedral, around which was a very busy commercial area. Everyone was trying almost desperately to sell something. I caught one of the many taxis that drove around the town hooting to attract the scarce clients. The city clearly lives in the aftermath of the end of the fishing industry. It is difficult to believe this city was once the biggest fishing harbour in the world. Now, for most of the year its inhabitants are without the purchasing power that used to move the entire economy of Chimbote. It is only three months a year when the prohibition to fishing is lifted, time when everything is reactivated, including people's illusions and memories of a more splendorous past. The rest of the time large parts of the population remain unemployed. Many of them, just as the Campos family, have been forced to migrate and maintain their families with the remittances sent from Chile and elsewhere.

The Campos family house was very humble, partially made of vegetable material, as were many houses in the town, in Chimbote it never rains. There I found Chela and Amparo, Demetrio, both father and son were out of town. When she saw me Chela

greeted me, *mi amiga Lorena!* , There have been few trips back and forth since I saw them at the Terminus in Santiago. First, Graciela returned with Amparo to Chile as she did not want to leave her daughter alone in Chimbote, Amparo matriculated in her old school again. Soon after the two Demetrios; father and son joined them in Santiago but Demetrio could not find a satisfactory job. They both returned to Peru two months later taking Amparo along to complete the second part of the school year in Peru. This time Graciela stayed behind in Chile. However she too had returned to Chimbote some time later because there was nobody that could look after Amparo who was sick with asthma. When Graciela was planning to return to Chile her plans were delayed by a relapse of a chronic neurological problem that has affected her for long. As she related, one day she woke up and she could not walk anymore. She travelled to Lima, where one of her oldest daughters from a previous marriage, lives. Graciela was hospitalised and specialised tests were taken. Now recovered and back in Chimbote she told me she had sold the TV and microwave to pay the hospital bills. While some of the fruits of their work in Chile were lost they have managed to invest in house repairs. With the money made in Chile they covered the dust floors of the house with cement, the house ceiling will have to wait. This was the most durable investments they had made thus far. Graciela and Demetrio were both unemployed as the prohibition of fishing was again in place in Chimbote. Graciela was determined to back to Chile as, *there is nothing in Chimbote.*

We spent sometime together and she asked to borrow some money from me to go back to Chile where she would give it back when we meet in Santiago. I asked about her sickness and she explained to me that the relapse was caused by *daño*. One day she found soil outside the house, which she interpreted was from the Cemetery; a clear sign of having being cursed. Her neighbours also suggested it; they said they all saw her walking and all of the sudden she could not walk anymore, inexplicable otherwise. After her treatment in Lima she visited a 'curandera' (traditional healer) well known for her powers, who worked in the township. The healer confirmed she had been victim of *mal daño* done to her by a jealous neighbour, a woman who lived near by. Chela knew her as the woman who had been Demetrio's lover when Chela had been in Chile. Chela was going that same afternoon to see the curandera to get her last treatment and invited me to accompany her. We walked through the neighbourhood and Chela told stories of the place; we talked about all the people we knew in Chile, of their whereabouts. We reached the home of the *curandera*, an unfriendly old lady. I entered the room after the ceremony was concluded. There was a strong smell of the cigarette used to perform the cleansing. The room was full of icons of all sorts, Catholic as well as from the Andean tradition such as dried embryo of llama. Among all the saints, the *curandera* had in her altar, I saw the image of Padre Hurtado, a Chilean Saint recently canonised in Roma. I asked her about the Saint and the *curandera* replied that a patient who had been in Chile had brought it to her and that she knew that Padre Hurtado was*muy milagroso* (very miraculous). Graciela then added that although the *curandera* was a powerful healer; the most powerful healers were in the Huaringa lakes in the Puira province a three days trip from Chimbote if not more. It was a long and onerous trip that she would have taken if she could have afforded it. Fortunately, she was getting better and she thought the healer was doing good work, she felt confident she would be able to leave for Santiago in a week.

The life of the family Campos continues to take place between two countries just as many other migrants. As far as I know they still depend substantially on the money

Graciela makes in Chile as a domestic worker, whereas Demetrio can only rely on the few months a year in which the fishing industry in Chimbote is reactivated.

I went to say goodbye to Graciela, she lived in another room in a migrant's house in the same area of Santiago. She was recovered and according to her, protected by the healer's medicine. I said that I was leaving. I was also embracing a transnational life of circular movements that would take me between Santiago and Johannesburg. Graciela then responded, *maybe I will come to see you there in Africa Lorena, let me know if there is work for me there*… we both agreed there was not need to say goodbye.

Endnotes

[i] To endorse the idea of the existence of different 'body disciplines' experienced in Peru and Chile, I quote here the contents of a brochure distributed by the Peruvian Consulate in Arica, a frontier city and entrance to Chile from Peru. It provides a "code of conduct" aimed to instruct Peruvian citizens entering Chile. Lists of do's and don'ts describe a range of undesirable behaviours punishable by Chilean law. Interestingly, it explicitly refers to how 'bodily related activities' should be conducted. It said: "If you enter the country by car, you should take into account the following: to obey strictly all the traffic rules (obey the stop signs, as well as the traffic lights, not park in forbidden places, give right of way to pedestrians at street crossing areas, not drive under the influence of alcohol, use seat belts). Violations of the traffic rules are severely punished by the authorities.
In the same way, it is also advised to avoid other types of infringements, which might be punished by fines or even incarceration.

1. Walking in public spaces under the influence of alcohol and drinking in public spaces.
2. Walk in public places without carrying your personal identification.
3. Insulting or trying to bribe a policeman is considered an offence.
4. Satisfying one's physiological needs in public spaces.
5. Showing one's genitals in public.
6. Trafficking and/or selling drugs.
7. Enter the country or leaving it illegally.
8. Smuggling cigarettes.
9. Stealing
10. Exhibiting or hanging posters or any symbol on the hill *¨El Morro de Arica"*. (Geographical and Historical site of the war against Peru and Bolivia, where both countries lost a portion of their territory, annexed by Chile, note of the author)
11. Exceeding the officially allowed period of residence in the country".

Instructions in: "*Basic Information for Peruvian citizens entering Chile by the Peruvian South Border"*. Brochure of the Peruvian Consulate in Arica, Chile.2002

[ii] The ingredients for a *pollada* for 80 people:

- 20 chickens
- Ingredients for a Russian salad:
  - 5 kilograms of potatoes,
  - 2 packages of carrots,
  - 5 beets,
  - ½ kilogram of green peas,
  - a package of mayonnaise to add to the salad and to use for decoration
- Ingredients for the chicken's dressing
  - Garlic, Paprika. Aji no Moto, Vinegar, Red Peruvian pepper (*rocoto*), Cumin
- 2 bottles of oil to fry the chickens
- 4 lettuce heads to use for decoration
- Disposable plates and cutlery

Gift packages contain:

- 1 bottle of champagne,
- a *Paneton* (a Peruvian Christmas cake),
- a bag of rice,
- 1 Canned Fruit cocktail,
- a package of cocoa (to add to the milk, as it is traditionally drunk on Christmas Day in Peru) and
- a Christmas greeting card

References

Alicea, M. (1997) "A chambered Nautilus: The contradictory nature of Puerto Rican women's role in the social construction of a transnational community", *Gender & Society* 11(5):597-626.

Altamirano, T. (2000) *Liderazgo y organizaciones de peruanos en el exterior: Culturas transnacionales e imaginarios sobre el desarrollo.* Lima, Pontificia Universidad Católica del Perú & Promperú.

Araujo, K., Legua, M.C. & Ossandón, L. (2002) *Migrantes andinas en Chile: El caso de la migración peruana.* Fundación Instituto de la Mujer, Santiago de Chile.

Aymerich, J., Canales, M. & Vivanco, M. (2003) *Encuesta: Tolerancia y no discriminación.* Tercera Medición, Facultad de Ciencias Sociales. Departamento de Sociología, Universidad de Chile.

Baer, H. A., Singer, M. & Susser, I. (1997) *Medical Anthropology and the World System. A Critical Perspective.* Westport, Connecticut & London, Bergin & Garvey.

Bash, L.G., Glick, S. & Blanc-Szanton, C. (1994) *Nations Unbound: Transnational Projects, Post-colonial Predicaments, and Deterritorialized Nations-States.* Langhorne, P.A., Gordon and Breach.

Bastia, T. (2007) "From mining to garment workshops: Bolivian migrants in Buenos Aires". *Journal of Ethnic and Migration Studies* 3(4):655-669.

Béhague, D. P. (2002) "Beyond the simple economics of c-section birthing", *Culture, Medicine and Psychiatry* 26(4):473-507.

Benecia, R. (2007) "Migrantes Bolivianos en la periferia de las ciudades Argentinas: Procesos y mecanismos tendientes a la conformacion de territories productivos y mercados de trabajo", Presentacion en la reunion del grupo de trabajo de CLACSO "Migracion, Cultura y Politicas": *Migraciones en America Latina y el Caribe: Una perspectiva critica desde el Sur,* Quito Ecuador, Octubre. Panel: "Ciudadania y organizaciones de migrantes trasnacionales".

Berg, U.D. & Paerregaard, K. (2005) Introducción. *El Quinto Suyo: Transnacionalidad y Formaciones Diasporicas en la Migración Peruana*. Edited by Paerregaard, K. & Berg, U.D. Lima, Instituto de Estudios Peruanos (IEP), pp 11-34.

Bernard, R.H. (1994) *Research Methods in Anthropology: Qualitative and Quantitative Approaches.* Walnut Creek, London, New Delhi, Altamira Press. A division of Sage Publications Inc.

Bollini, P. & Siem H. (1995) "No real progress towards equity: Health of migrants and ethnic minorities on the eve of the year 2000", *Social Science and Medicine* 41(6):819-828.

Bonka, S.B. & Hanson Freize, I. (2001) "Toward a concept of a migrant personality", *Journal of Social Issues* 57(3):477-491.

Brettell, C.B. (2000) "Theorizing migration in anthropology: The Social constructions of networks, identities, communities and globalscapes", *Migration Theory: Talking across Disciplines.* Edited by Brettell C.B. & Hollifield J.F. New York, Routledge, pp 97-135.

Bryceson, D.F. & Vuorela, U. (2002) "Introduction: Transnational families in the twenty-first century", *The Transnational Family: New European Frontiers and Global Networks*. Edited by Bryceston, D. F. & Vuorela, U. Berg, Oxford, New York, pp 3-30.

Cadena, M. de la, (2005) "Are mestizos hybrids? The conceptual politics of Andean identities", *Journal of Latin American Studies* 37:259-284.

Cain, V. S. &. Kington R.S. (2003) "Investigating the role of racial/ethnic bias in health outcomes", *American Journal of Public Health* 93(2):1991-1992.

Caggiano, S. (2007) *Racismo, fundamentalismo cultural y restriccion de la ciudadania. Formas de regulación frente a inmigrantes en Argentina.* CONICET - Instituto de Desarrollo Economico y Social IDES. Universidad Nacional de La Plata. Buenos Aires.

Campbell, J. (2000) "Narrative and method in the anthropology of medicine", *Anthropological Approaches to Psychological Medicine*. Edited by Skultans V. & Cox J. London, Kingsley Publishers, pp 105-122.

Centro Alternativas, (2002) Ponencias, "1er Encuentro Regional sobre Salud Mental. Derechos Humanos y Migraciones Internacionales", OIM-Universidad Diego Portales. Facultad de Ciencias Humanas y Educación. Escuela de Psicología. Santiago, Chile.

Çinibulak L. & Richters A. (2004) Turkish-Dutch women's views on childbirth: A question of medicalization or empowerment? *14th International Conference of Psychosomatic Obstetrics and Gynaecology*. Edinburgh, Scotland, May 16-19. MEDIMOND S.r.l., pp 187-192.

Clifford, J. (1988) "On ethnographic surrealism", *The Predicament of Culture: Twentieth-Century Ethnography, Literature, and Art*. Cambridge: MA, Harvard University Press.

Cobian, E. & Reyes, S. (1998) *Percepciones Masculinas de las Necesidades y Servicios de Planificación Familiar y Salud Reproductiva: Un Estudio Cualitativo en Chimbote.* Population Council/INOPAL III (Investigación Operativa y Cooperación Tecnica en Planificación Familiar y Salud Reproductiva para America Latina y el Caribe).

Cohen, A.P. (1985) *The Symbolic Construction of Community*. Sussex, London, New York, Tavistock Publications Limited.

Cohen, J.H. (2005) "Remittance outcomes and migration: Theoretical contest, real opportunities", *Studies in Comparative International Development* 40(1):88-112.

Contrada, R.J., Asmore, R.D. & Gary, M.L. (2000) "Ethnicity-related sources of stress and their effects on well-being", *Current Direction in Psychological Science* 9:136-140.

Corporación Ayun, (2000) *Salud y Migración: Conformación de una Red de Apoyo.* Santiago.

Crapanzano, V. (1977) "Introduction", *Case Studies in Spirit Possession.* Edited by Crapanzano, V. & Garrinson V. New York, John Wiley and Sons, pp 1-40.

Csordas, T. J. (1999) "The body's career in anthropology", *Anthropological Theory Today*. Edited by Moore H. L. Cambridge, Oxford and Malden, Blackwell Publishers Ltd., pp 172- 205.

Darghouth, S., Pedersen, D., Bibeau, G. & Rosseau, C. (2006) "Painful languages of the body: Experiences of headaches among women in two Peruvian communities", *Culture, Medicine and Psychiatry* 30(3):271-297.

De Soto, H. (1986) *El Otro Sendero: La Revolución Informal.* Lima: Editorial El Barranco.

Dohrenwend, B.P., Raphael K., Scwartz S. & Stueve A. (1993) "The structured event probe and narrative rating method for measuring stressful life events", *Handbook of Stress: Theoretical and Clinical Aspects*. Edited by Goldberger, L. & Breznitz S. New York, Free Press, pp 174-199.

Döring, T., Heide, M. & Mühleisen, S. (2003) *Eating Culture: The Poetics and Politics of Food.* American Studies: A Monograph Series, Volume 106. Universitätsverlag, Winter Heidelberg.

Dunk, P. (1988) "Greek women and broken nerves in Montreal", *Medical Anthropology,* 1(1):29-46.

Escobar, A. (1978) "Variaciones sociolingüísticas del castellano en el Perú", *Perú Problemas series* 18.

Escriva, A. (2000) "¿Empleadas de por vida? Peruanas en el servicio doméstico de Barcelona", *Papers 60*, Universitat Autonoma de Barcelona; Servei de Publicacions, pp 327-342.

Essed, Ph. (1996) *Diversity, Gender, Color and Culture*. University of Massachusetts Press, Amherst.

Esteves, F. (2004) *Intolerancia y Discriminación en la Sociedad Chilena*, Fundación Ideas and Departamento de Sociología de la Universidad de Chile.

Estroff, S. E. (1991) "Everybody's got a little mental illness: Accounts of illness and self among people with severe, persistent mental illness", *Medical Anthropology Quarterly* 5(4):331-369.

Ewing, K.P. (1990) "The illusion of wholeness: Culture, self and experience of inconsistency", *Ethos* 18(3):251-278.

Fabrega, H. (1970) "On the specificity of folk illness", *Southwestern Journal of Anthropology* (26):301-314.
Faist, T. (2000) "Transnationalization in international migration: Implications for the study of citizenship and culture", *Ethnic and Racial Studies* 23(2):189-222.

Fanon, F. (2001) (first published 1967) *The Wretched of the Earth.* Penguin Group, London.

Farb, P. & Armelagos, G. (1980) *Consuming Passions: The Anthropology of Eating.* Boston, Houghton Mifflin Company.

Farmer, P. (1988) "Bad blood, spoiled milk: Bodily fluids as moral barometers in rural Haiti", *American Ethnologist* 15(1):62-83.

Farmer, P. (1990) "AIDS and accusation: Haiti, haitians, and the geography of blame", *Culture and AIDS*. Edited by Feldman D.A. New York, Praeger, pp 67-91.

Farmer, P. & Kleinman A. (1989) "AIDS as human suffering", *Daedalus* 118(2):135-160.

Findley, S. E. (1988) "The directionality and age selectivity of the health-migration relation: Evidence from sequences of disability and mobility in the United States", *International Migration Review* 22(3):4-29.

Finkler, K. (1997) "Gender, domestic violence and sickness in Mexico", *Social Science and Medicine* 45(8):1147-1160.

Finerman, R. (1989) "The burden of responsibility: Duty, depression and nervios in Andean Ecuador", *Gender, Health and Illness: The Case of Nerves*. Edited by Davis, D.L. & Low, S.M. New York, Hemisphere, pp 49-66.

Foster, G. M. (1965) "Peasant society and the image of limited goods", *American Anthropologist* 67:293-315.

Frank, A. G. (1967) *Capitalism and Underdevelopment in Latin America*. New York Montly Review Press.

Fundación Anide y Colectivo Sin Fronteras (2004) *Niños y Niñas Inmigrantes en Chile: Derechos y Realidades.* LOM Ediciones, Santiago.

Fundación Instituto de la Mujer (2007) *Mujeres migrantes peruanas y salud reproductiva.* Informe de proyecto UNFPA.

Gans, H. (2002) "The sociology of space: A use-centered view", *City & Community* 1(4):325–335.

Genova, N. de (2005) *Working the Boundaries: Race, Space, and illegality in Mexican Chicago*. Durham, NC, Duke University Press.

Goldring, L. (2001) "The gender and geography of citizenship in Mexico-U.S. transnational spaces", *Identities* 7(4):501-553.

Good, B. J. (1977) "The heart of what's the matter: The semantic of illness in Iran", *Culture, Medicine and Psychiatry* 1(1):25-58.

Good, B. J. (1994) *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge University Press.

Goodman, Y. (2001) "Dynamics of inclusion and exclusion: Comparing mental illness narratives of Haredi male patients and their Rabbis", *Culture, Medicine and Psychiatry* 25(2):169-194.

Greenway, C. (1998) "Hungry earth and vengeful stars: Soul loss and identity in the Peruvian Andes", *Social Science and Medicine* 47(8):993-1004.

Grillo R. & Pratt J. (2002) *The politics of Recognizing Difference: Multiculturalism Italian-style.* Research in Migration and Ethnic Relations Series. Hampshire, Asgate Publishing Limited.

Groleau, D., Young, A. & Kirmayer, L. J. (2006) "The McGill illness narratives interview (MINI): An interview schedule to elicit meanings and modes of reasoning related to illness experience", *Transcultural Psychiatry* 43(4):671-691.

Guarnaccia, P. J., Febo, V. E., Miguel, S., Shrout, P. E., Lewis-Fernandez, R., Canino, G.J. & Ramirez, R. (2006) "A quantitative analyisis of ataque de nervios in Puerto Rico: Further examination of a cultural syndrome", *Hispanic Journal of Behavioural Sciences* 28(3):313-330.

Gobierno de Chile, Ministerio de Salud (2007) *Normas Nacionales de Regulación de la Fecundidad,* www.minsal.cl.

Guarnizo, L.E. (1997) "'Going home': Class, gender, and household transformations among Dominican returned migrants", *Caribbean Circuits: New Directions in the Study of Caribbean Migrations*. Edited by Guarnizo, L. New York, Center for Migration Studies**,** pp 13-60.

Hallowell, I. A. (1955) *Culture and Experience*. Philadelphia, PA., University of Pennsylvania Press.

Hardon, A. (2004) "Negotiating safety and acceptability of new contraceptive technologies", *Medische Anthropologie* 16(1):105-132.

Harrell, J.P., Hall, S. & Taliaferro J. (2003) "Physiological responses to racism and discrimination: An assessment of the evidence", *American Journal of Public Health* 93(2):243-248.

Hayden, B.A. (2006) *Salvadorans in Costa Rica: Displaced lives.* Tucson, The University of Arizona Press.

Helman, C. G. (1985) "Psyche, soma, and society: The social construction of psychosomatic disorders", *Culture, Medicine and Psychiatry* 9(1):1-26.

Hinojosa, A., R. (2002) Cohabitando fronteras culturales de la modernidad. El caso de los campesinos tarijeños en le norte Argentino. *The Andean Exodus. Transnational Migration from Bolivia, Ecuador and Peru.* Edited by Salman T. & Zoomer *A.* Cuadernos del Cedla, 11:1-28.

Hochschild, A. (1983) *The Managed Heart: The Commercialization of Human Feeling*. Berkeley, University of California Press.

Holper, D. (2003) "Weight loss among Peruvian live-in domestic workers in Chile: Embodying the vulnerable self", *Medische Antropologie* 15(1):91-107.

Hondagneu-Sotelo, P. & Avila, E. (1997) "'I'm here, but I'm there': The meanings of Latina transnational motherhood", *Gender & Society* 11(5):548-571.

Hondagneu-Sotelo, P. (1992) "Overcoming patriarchal constrains: The reconstruction of gender relations among Mexican immigrants women and men", *Gender & Society* 6 (3):393-415.

Hunter, J. L. (2004) "Cervical cancer en Iquitos, Peru: Local realities to guide prevention planning", *Cuadernos de Saude Publica, Rio de Janeiro* 20(1):160-171.

Ibarra, M.d.l.L. (2002) "Mexican immigrant women and the new domestic labor", *Human Organization* 59(4):452-464.

Jackson, M, (1983) "Knowledge of the Body", *Man* 18 (2):327-40.

Jelin, E. (2006) *Salud y migración regional: Ciudadanía, discriminación y comunicación intercultural.* Buenos Aires, IDES.

Jiménez, R. A. & Huantai, C. A. (2007) "Algo está Cambiando. Globalización, Migración y Ciudadanía en las Asociaciones de Peruanos en Chile", Santiago, Consulado General del Perú en Santiago - Observatorio Control Interamericano de los Derechos de los y las migrantes (OCIM).

Junghanss, T. (1998) "How unhealthy is migrating?", *Tropical Medicine and International Health* 3(12):933-934.

Kirmayer, L. J. (1988) "Mind and body as metaphors: Hidden values in biomedicine", *Biomedicine Examined*. Edited by Lock, M. & Gordon, D. Boston, Beacon Press. Kluwer Academic Publishers, pp 57-91.

Kirmayer, L.J., Young, A. & Robinson, J. M. (1994) "Symptom attribution in cultural perspective", *Canadian Journal of Psychiatry* 39:584-595.

Klaiber, J.L. *S.J*. (1978) "Los "cholos" y los "rotos": Actitudes raciales durante la guerra del pacifico", *Historica* II (1):27-37.

Kleinman, A. (1973) "Medicine's symbolic reality: On the central problem in the philosophy of medicine", *Inquiry* 16:206-213.

Kleinman, A. (1977) "Depression, somatization and the new cross-cultural psychiatry", *Social Science and Medicine* 11(3):3-10.

Kleinman, A. (1988) *The Illness Narratives: Suffering Healing and the Human Condition*. Boston, Beacon.

Kleinman, A. (1995) "The new wave of ethnographies in medical anthropology", *Writing at the Margin: Discourse Between Anthropology and Medicine*. Berkeley, Los Angeles, London University California Press, pp 193-256.

Kleinman, A., Das, V. & Lock, M. (1997) *Social Suffering*. Berkeley, Los Angeles, London, University of California Press.

Kleinman, A., Eisenberg L. & Good B. (1978) "Culture, illness and care: Clinical lessons from anthropologic and cross-cultural research", *Annals of Internal Medicine* 88:251-258.

Kleinman, A. & Good, B. (1985) *Culture and Depression*. Berkeley, University of California Press.

Kleinman, A. & Kleinman. J. (1991) "Suffering and its professional transformation: Towards an ethnography of experience", *Culture, Medicine and Psychiatry* 15(3):275-301.

Kleinman, A. & Kleinman, J. (1997) "The appeal of experience; The dismay of images: Cultural appropriations of suffering in our times", *Social Suffering*. Edited by Kleinman, A., Das, V. & Lock, M. Berkeley, Los Angeles, London, University of California Press, pp 1-24.

Kleinman, A. &. Seeman, D. (2000) "Personal experience of illness", *The Handbook of Social Studies in Health and Medicine*. Edited by Albrecht, G. T., Fitzpatrick, R. & Scrimshaw S. C. London, Sage, pp 230- 242.

Krieger, N. & Sidney, S. (1996) "Racial discrimination and blood pressure: the CARDIA study of young black and white adults", *American Journal of Public Health* 86(10):1370-1378.

Lazarus, R.S. & Folkman S. (1984) *Stress, Appraisal and Coping*. New York, Springer.

Leatherman, T. (2005) "Space of vulnerability in poverty and health: Political ecology and biocultural analysis", *Ethos* 33(1):46-70.

Levitt, P. (2001) *The Transnational Villagers*. University of California Press, London, England.

Levitt, P. & Schiller, N. G. (2004) "Conceptualizing simultaneity: A transnational social field perspective on society", *The International Migration Review* 38(4):1002-1039.

Lewis-Fernandez, R. & Kleinman A. (1994) "Culture, personality and psychopathology", *Journal of Abnormal Psychology* 103(1):67-71.

Lindenbaum, S. (2005) "The value of a critical ethnographic engagement: comments on the social production of health", *Social Science and Medicine* 61(12):751-753.

Lipschutz, A. (1937) *Indoamericanismo y raza india.* Santiago, Editorial Nacimiento.

Lock, M. (1993) "Cultivating the body: Anthropology and epistemology of bodily practice and knowledge", *Annual Review of Anthropology* 22:133-155.

Long, N. (1973) "The Role of regional associations in Peru", *The Process of Urbanization*. Edited by Drake, M. Bletchy, London, Open University Press

Long, N. & Arce, A. (2000) Anthropology, Development and Modernities: Exploring Discourses, Counter-Tendencies and Violence. London, New York, Routledge.

Lutz, C. & White, G. M. (1986) "The anthropology of emotions", *Annual Review of Anthropology* 15:405-36.

Manderson, L. & Allotey, P. (2003) "Storytelling, marginality, and community in Australia: How immigrants position their difference in healthcare settings", *Medical Anthropology* 22(1):1-21.

Manrique, N. (2002) *El Tiempo del Miedo: La Violencia Política en el Perú 1980-1996.* Lima, Fondo Editorial del Congreso del Perú.

Manso, I. (2001) "Phenomenology and ethnography", *Handbook of Ethnography*. Edited by Atkinson, P., Coffey, A., Delamont, S., Lofland, J. & Lofland, L. London, Thousand Oaks, New Delhi, Sage, pp 137-144.

Marcus, G. E. (1998) *Ethnography through Thick & Thin*. Princeton, New Jersey, Princeton University Press.

Markus, H. R. & Kitayama Sh. (1991) "Culture and the self: Implications for cognition, emotion, and motivation", *Psychological Review* 98(2):224-253.

Martinez, J. (2003) *El encanto de los datos. Sociodemografía en Chile según el censo de 2002,* CELADE/CEPAL, Santiago.

Mata, C.D. (2008) "Rice and coriander. Sensorial re-creations of home through food : Ecuadorians in a northern Spanish city", *Working paper N° 50*. University of Sussex. Sussex Centre for Migration Research.

Mattlingly, C. & Garro L. C. (1994) "Introduction", *Social Science and Medicine* 38(6):771-774.

Matos Mar, J. (1984) *Desborde Popular y crisis del Estado. El Nuevo Rostro del Perú en la década del 1980*. Lima: Instituto de Estudios Peruanos. Lima, Quinta Edición.

MEDICINENET *www.medterms.com*

McNay, L. (1999) "Gender, habitus and the field: Pierre Bourdieu and the limits of reflexivity", *Theory, Culture and Society* 16(1):95-117.

McNay, L. (2004) "Agency and experience: Gender as a lived relation", *The Sociological Review* 52(2):173-246.

Menjivar, C. (2000) *Fragmented Ties: Salvadoran Immigrant Networks in America.* Berkeley, University of California Press.

Menjivar, C. (2001) "The ties that heal: Guatemalan immigrant women's networks and medical treatment", *International Migration Review* 36(2):437-466.

Meyer, I. H. (2003) "Prejudice as stress: Conceptual and measurement problems", *American Journal of Public Health* 93(2):262-265.

Ministerio de Salud del Peru (1996) "Programa de Salud Reproductiva y Planificación Familiar 1996-2000", Resolución Ministerial, Peru.

Mintz, S. W. (1986) *Sweetness and Power: The Place of Sugar in Modern History.* Penguin Books, United States.

Minuchin, S., Rosman, B.L & Baker, L. (1978) *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge, Harvard University Press.

Montecinos, S., Castro, R. & Parra, de la, M.A. (2003) *Mujeres, Espejos y Fragmentos. Antroplogia del género y la salud en el Chile del siglo XXI.* C&C Aconcagua, Santiago.

Moore, H. L. (1994) *A Passion for Difference: Essays in Anthropology and Gender*. Bloomington and Indianapolis, Indiana University Press.

Moore, H. L. (2004) "Global anxieties. Concept-metaphors and pre-theoretical commitments in anthropology", *Anthropological Theory.* London, Thousands Oaks, CA and New Delhi, Sage, pp 71-88.

Morgan, L. M. (1984) "Dependency theory in the political economy of health: An anthropological critique", *Medical Anthropology Quarterly* 1(2):131-154.

Morris, D. B. (1998) *Illness and Culture in Postmodern Age*. Berkeley, University California Press.

Morsy, S. (1979) "The missing link in medical anthropology: The political economy of health", *Reviews in Anthropology* 6:349-363.

Morsy, S. (1990) "Political economy in medical anthropology", *Medical anthropology: contemporary theory and methods*. Edited by Johnson T. & Sargent C. New York, Praeger, pp 2-46.

Moulian, T. (1997) *Chile Actual: Anatomia de un Mito.* Santiago, LOM.

Munizaga, C. (1961) *Estructuras Transicionales en la Migracion de los Araucanos de Hoy a la Ciudad de Santiago de Chile*. Santiago, Chile, Universidad de Chile.

Muñoz, S. (2005) *Peruvian Migration to Chile: Challenges for National Identity, Human Rights and Social Policy.* CLASPO Report, CELADE Santiago.

Nencel, L. (2000) *Mujeres que se Prostituyen. Genero, identidad y pobreza en el Peru.* Flora Tristan, Lima.

Nichter, M. (1981) "Idioms of distress: Alternatives in the expression of psychosocial distress: A case study from south India", *Culture, Medicine and Psychiatry* 5:379-408.

Núñez, L (1996) "*Calidad de Atención en Salud Reproductiva; Un Análisis basado en la Perspectiva de Genero*". Pan American Health Organisation (PHO) Santiago, Co-authored with Fanny Berlagosky, Gloria Salazar, and Marisa Matamala.

Núñez, L. (2002) "Peruvian migrants in Chile", *Transnational Identities: A concept explored - The Andes and beyond*, *Part I*. Edited by Salman T. & Zoomers A. Amsterdam, *CEDLA Cuadernos* 11:61-72.

Núñez, L. & Stefoni, C. (2004) ¿Transnacionales o sobrevivientes? Migración Andina a Chile durante los noventa. *Annuario Chile 2003-2004. Los Nuevos Escenarios (inter) nacionales*. Edited by Stefoni, C. Santiago, FLACSO.

Núñez, L. & Holper, D. (2005) " 'En el Perú nadie se muere de hambre': perdida de peso y prácticas de alimentación entre trabajadoras domésticas peruanas en Chile", *El Quinto Suyo. Transnacionalidad y Formaciones Diasporicas en la Migración Peruana*. Edited by Paerregaard, K. & Berg, U. D., Lima, Instituto de Estudios Peruanos (IEA), pp 291-313.

Ong, A. (1995) "Making the biopolitical subject: Cambodian immigrants, refugee medicine and cultural citizenship in California", *Social Science and Medicine* 40(9):1243-1257.

Oths, K. S. (1999) "Debilidad: A biocultural assessment of an embodied Andean illness", *Medical Anthropology Quarterly* 13(3):286-315.

Paerregaard, K. (1997) "Imagining a place in the Andes: In the borderland of lived, invented, and analyzed culture", *Sitting Culture: The Shifting Anthropological Object*. Edited by Olwig F.K. & Hastrup K. London, Routledge.

Paerregaard, K. (2002) "Power Recycled: Persistence and transformation in peruvian transnationalism", *The Andean Exodus. Transnational Migration from Bolivia, Ecuador and Peru.* Edited by Salman T. & Zoomer *A.* Cuadernos del Cedla, 11:1-28.

Parkin, D. (1995) "Letticed knowledge: Elimination and the dispersal of the unpalatable Islam, medicine and anthropological theory", *Counterwork: Managing Knowledge in its Diversity*. Edited by Fardon, R. London and New York, Routledge, 143-163.

Parreñas, S.R. (2001) *Servants of Globalization: Women, Migration and Domestic Work.* California: Stanford University Press.

Parreñas, S.R. (2005) *Children of Global Migration: Transnational Families and Gendered Woes.* Stanford, Stanford University Press.

Parsons, C. D. F. &. Wakeley P. (1991) "Idioms of distress: Somatic responses to distress in everyday life", *Culture, Medicine and Psychiatry* 15:111-132.
Partners for Health, (2005) *A tool kit to identify and sight discrimination against migrants in health care, Partners for Health*. A project funded by the European Union, www.salutepertutti.org.

Pedersen, D., Gamarra, J., Planas, M. E. & Errazuriz, C. (2001) *Violencia política y salud en las comunidades alto-andinas de Ayacucho*, Perú Lima, Douglas Hospital Research Centre, McGill University, Montreal (Canada), Instituto para la Paz y el Desarrollo de Ayacucho, Ayacucho (Perú), Universidad Peruana Cayetano Heredia, Lima (Perú).

Perales, A., Montoya, A. & Sogi, C. (1995) *Social and Cultural Landmarks for Community Mental Health*. Lima, Universidad Peruana Cayetano Heredia. Departmento de Humanidades y Ciencias Sociales - Instituto Nacional de Salud Mental "Honorio Delgado - Hideyo Noguchi. Departamento de Investigación y Epidemiología.

Plummer, K. (2001) "Life stories and the narrative turn", *Documents of Life 2: An Invitation to a Critical Humanism*. London, Sage**.**

Polia Meconi, M. (1996) *Despierta, remedio, cuenta...: adivinos y médicos del Ande*. Lima, Pontificia Universidad Católica del Perú. Fondo Editorial 1996.

Portes, A., Guarnido L.E. & Landlot P. (1999) "The study of transnationalism: Pitfalls and promise o fan emergent research field", *Ethnic and Racial Studies* 22(2):217-237.

Portes, A. (2001) "Introduction: The debates and significance of immigrants' transnationalism", *Global Networks* 1(3):181-193.

Pugh, J. (2008) "Bridging Borders in the Andes: The Role of Permissive Permeability in the Construction of Communal Identity and the Prevention of Violence." Paper delivered at Conference on Constituting Places: Movements and Trajectories in Latin America. The Johns Hopkins University, Baltimore, Maryland, USA.

RENIEC. (1995) "Registro Nacional de Identificación y Estado Civil del Perú", http://www.reniec.gob.pe/portal/intro.htm

Richters, A. (2000) "Socio-cultural plurality in obstetric and gynaecology in The Netherlands: Research note", *Ethnicity & Health* 5(2):127-136.

Rosaldo, R. (1993) *Culture and Truth: The Remaking of Social Analysis*. Boston MA, Bacon Press.

Rouse, R. (1995) "Questions of identity: Personhood and collectivity in transnational migration to the United States", *Critique of Anthropology* 15(4):351-380.

Sassone, S.M. (2002) "Espacios de vida y espacios vividos. El caso de los inmigrantes bolivianos en el área metropolitana de Buenos Aires".*The Andean Exodus. Transnational Migration from Bolivia, Ecuador and Peru.* Edited by Salman T. & Zoomer *A.* Cuadernos del Cedla, 11:1-28.

Scheper-Hughes, N. & Lock, M. (1987) "The mindful body: A prolegomenon to future work in medical anthropology", *Medical Anthropology Quarterly, New Series* 1(1):6-41.

Scheper-Hughes, N. (1992) *Death without Weeping: The Violence of Everyday Life in Brazil*. Berkeley, Los Angeles, London, University California Press.

Scott, J. (1992) "Experience", *Feminists Theorize the Political*. Edited by Butler J. & Scott J. London, Routledge, pp 23-40.

Segura, D. & Torre, de la, A. (1999) "La sufrida. Contradictions of acculturation and gender in Latina health", *Revisioning Women, Health and Healing: Feminist, Cultural and Technoscience Perspectives.* Edited by Clarke, A.E. & Olesen V.L. New York Routledge, pp 155-165.

Simmons, O.G. (1955) "Popular and modern medicine in mestizo communities of coastal Peru and Chile", *The Journal of American Folklore* 68(267):57-71.

Skeggs, B. (2001) "Feminist ethnography", *Handbook of Ethnography*. Atkinson P., Coffey A., Delamont S., Lofland J. & Lofland L. London, California, New Dehli, SAGE Publications Ltd.

Spiro, M. E. (1993) "Is the western conception of the self 'peculiar' within the context of the world cultures?", *Ethos* 21(2):107-153.

Spradley, J. P. (1980) *Participant Observation*. Forth Worth, Chicago, San Francisco, Philadelphia, Montreal, Toronto, London, Sidney, Tokyo, Holt, Rinehart and Winston, Inc.

Staab, S. & Maher, K. (2006) "Dual discourse about Peruvian domestic workers in Santiago de Chile: class, race, and a nationalist project. *Latin American Politics and Society.* Spring, http://findarticles.com/p/articles/mi_qa4000/is_200604/ai_n17169672.

Stefoni, C. (2005) "Comunidades transnacionales y la emergencia de nuevas oportunidades económicas. De empleados a microempresarios", *Persona y Sociedad,* XIX (3):183-197.

Suro, R. (2003) *Remmitances, Senders and Receivers: Tracking the Transnational Channels*. Washington D.C., Hispanic Center.

Takeyuki, T. (1999) "Transnational migration and the nationalization of ethnic identity among Japanese Brazilian return migrants", *Ethos* 27(2):145-179.

Tamango, C. (2002) 'You must win their affection…': Migrants social and cultural practices between Peru and Italy", *Work and Migration. Life and Livelihoods in a Globalizing World.* Edited by Sorensen N.N. & Fog K.O. Routledge, London and New York, pp 106-125.

Tamagno, C. (2003) "Los Peruanos en Milan: Politicas de identidad y producción de localidad", *Comunidades Locales y Trasnacionales. Cinco Estudios de Caso en el Peru.* Edited by Degregori C.I. Instituto de Estudios Peruanos (IEP) Ediciones, Lima, pp 319-398.

Taussig, M. T. (1984) *The Devil and Commodity Fetishism in South America*. North Carolina, University of North Carolina Press Chapel Hill.

Venema, U.H.P., Garretsen, H.F.L. & Van der Maas, P.J. (1995) "Health of migrants and migrants' health policy, The Netherlands as an example", *Social Science and Medicine* 41(6):809-818.

Van Dijk, T. (2007) *Racismo y Discurso en América Latina*. Barcelona, Gedisa.

Van Ryn, M. & Fu, S.S. (2003) "Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health?", *American Journal of Public Health* 93(2):248-255.

Vanthuyne, K. (2003) "Searching for the words to say it: The importance of cultural idioms in the articulation of the experience of mental illness", *Ethos* 31(3):412-433.

Vertovec, S. (2003) "Migration and other modes of transnationalism: Towards conceptual cross-fertilization", *International Migration Review* 37(3):641-665.

Wallace, J. M. (1984) "Urban anthropology in Lima", *Latin American Research Review* 19(3):57-85.

Wallerstein, I. (1974) *The Modern World System*. New York, Academic Press.

William, R. (1977) *Marxism and Literature*, Oxford: OUP.

Williams, D. R., Neighbors, H. W. & Jackson, J. S. (2003) "Racial/ethnic discrimination and health: Findings from community studies", *American Journal of Public Health* 93(2):200-208.

Yeoh, B. & Willis, K. (2004) "Constructing masculinities in transnational space. Singapore men on the 'regional beat'", *Transnational Space*. Edited by Jackson P., Crang Ph. & Dwyer C. London, Routledge, pp 147-162.

Young, A. (1980) "The discourse on stress and the reproduction of conventional knowledge", *Social Science and Medicine* 14B:133-146.

Zavala, X. & Rojas, C. (2005) "Globalización, procesos migratorios y estado en Chile", *Migraciones, globalización y género en Argentina y Chile.* Programa Mujeres y Movimientos Sociales, Buenos Aires, Argentina, pp. 150-187.

Zimmerman M.K., Litt, J.S & Bose C.E. (2006) *Global Dimensions of Gender and Care Work.* Stanford, California Stanford University Press

Annex1

Questionnaire for immigrants in Santiago

Hello, we are_____. We are doing a study about the immigrants who are living in the Center of Santiago. This study is realized by an anthropologist investigating for Leiden University in The Netherlands and by a sociologist of Flacso in Chile. This is a short questionnaire concerning for example conditions of work and health. The obtained information will be used anonymously. This investigation is conducted to obtain information about the problems migrants confront in Santiago.

Section A. Room

Code

Street _____ Number_____

Floor _____ Room_____

Section A. Identification. In this section I'm going to ask you some details about yourself.

A1) What is your age? _____

A2) In which year where you born? _____

A3) Sex

A4) Where were you born? City or village _____ Country_____

A5) In which environment were you born? urban_____ or rural _____

A6) When did you came to Chile? _____ **(if the respondent visited Chile more than once, note down the year in which he came for the first time).**

A7) Now I want to ask you some questions about the places you lived before. Where were you living 7 years ago? City _____ Country_____

A8) and 5 years ago? City _____ Country_____

A9) Now I'm going to ask you some questions about your marital status. Are you married / divorced / single? **(circle the corresponding number)**

Married and your husband / wife is living in Peru	1
Married and your husband / wife is living in Chile	2
Married and your husband / wife is living in a country other than Chile or Peru	3
Divorced	4
Live together	5
Widow(er)	6
Single	7
Dn/Dr (don't read)	0

A10) Do you have children?

Yes	1
No	2

If the answer is No go to B1

B1) We are now going to talk about the studies you've done. Which form of education was the last one

you enjoyed? **(circle the correct answer)**

1) Primary school not completed
2) Primary school completed
3) Secondary school not completed
4) Secondary school completed
5) Technical school not completed
6) Technical school completed
7) University not completed
8) University completed
9) **Dn/dr (don't read)**

Only for those who did technical school and / or university
B2 In case you enjoyed technical school or university: Which is your profession?

Now I'm going to ask you some questions about your working conditions in Peru and in Chile. Can you tell me about the last job you did in Peru before coming to Chile? **(note down the answer)**

C2) How would you describe your working conditions over the past week? **(circle the corresponding answer).**

Working and earning money	1
Working without earning money, but has a job	2
Working for family, but without being paid.	3
Looking for a job, but has worked before	4
Looking for a job for the first time	5
Housekeeping work	6
Studying without working	7
Retired	8
Without work	9
Declared permanently disabled	10
Other situation	11
Dn/dr (don't read)	0

C3) What kind of work are you doing or were you doing in Chile if you aren't working ? (for example bricklayer, carpenter, mechanic, housewife, etc.)

C4) This work are (or were) you doing: I will give you the answers.

Manager of employer	1
Running own business	2
Housekeeping work	3
Working for a salary (labourer, journalist)	4
Working for the family without getting paid	5
Dn/dr (don't read)	0

C5) Do you or did you have a contract?

Yes	1
No	2

C6) The following question has nothing to do with inspecting your personal life (we want to remind you that this questionnaire is absolutely anonymous), we only want to obtain general statistics. What kind of visa do you have? **(circle the correct answer)**

Valid tourist visa	1
Visa for residentials	2
Provisional visa	3

Is in an irregular situation (expired visa, is temporary in Chile, on contract basis)	4
Dn/dr (don't read)	0

C7) Which amount is approximately indicating your monthly income (including extras, money from friends etc.). Show table.

0 - 49.999 Chilean pesos	1
50.000 - 99.999 Chilean pesos	2
100.000 - 149.000 Chilean pesos	3
150.000 - 199.999 Chilean pesos	4
200.000 - 249.000 Chilean pesos	5
250.000 - 299.000 Chilean pesos	6
300.000 and more Chilean pesos	7
Dn/dr (don't read)	0

C8) How many times did you sent money to Peru, during the last 6 months? I'll mention the answers.

6 times (every month)	6
5 times	5
4 times	4
3 times	3
2 times	2
1 time	1
Didn't sent money	7
Dn/dr (don't read)	0

C9) If you are sending money to Peru, how much approximately are you sending? Can you name the amount in dollars?

I don't send money	1
0 - 50 US Dollars	2
51 - 100 US Dollars	3
101 - 150 US Dollars	4
151 - 200 US Dollars	5
201 - 250 US Dollars	6
250 US Dollars or more	7
Dn/dr (don't read)	0

C10 Can you tell me for which purposes the money you send to Peru is being used?

D1) In this section I would like to know some more about the persons who are living in or sharing your room. I will ask about them one at the time.

Persons **(begin with the owner of the room)**	Name (only the first name)	What is the relation of this person with the owner **(friend, son/daughter, father, son in law, etc)**	Sex	Age 0-18= a 19-34=b 35-45=c above 45	This person (**mark the corresponding letter**) **a**. sleeps permanently in the room (more than 4 days per week) **b**. sleeps in the room a few days per week (between 1 to 3 days) **c**. very few times, just some days
Person N 1		**Owner**			

Person N 2					
Person N 3					
Person N 4					
Person N 5					
Person N 6					
Person N 7					
Person N 8					
Person N 9					
Person N10					

We are going to change the subject, I would like to make a comparison of your situation in Peru and Chile.

E1) in comparison to the situation in Peru, now you are: **(read the alternatives)**

Better	1
Worse	2
The same	3
Dn/Dr (don't read)	0

E2) To which socioeconomic status did you family belong, when you were living in Peru? **(read the alternatives)**

High	1
Medium high	2
Medium	3
Medium low	4
Low	5
Dn/dr (don't read)	0

E3) And in Chile, to which socioeconomic status you think you belong to?

High	1
Medium high	2
Medium	3
Medium low	4
Low	5
Dn/dr (don't read)	0

E4) Which of the following phrases can be applied to yourself? **(read the alternatives)**

a) I would like to settle down definitively in Chile.
b) I would like to stay in Chile for some years, and then go back to Peru.
c) I would like to go to a county, other than Peru and Chile.
d) I only want to return to Peru.
e) Dn/dr (don't read)

I would like to change the subject now:

F1) Are you participating in some kind of organisation, such as a migrant organisation, community center, religious group, sports club, political faction or an organisation for mothers?

Participates	1	
Doesn't participate	2	**Go to F3**

F3) Did you formerly participate in an organisation when you were living in Peru?

Participated	1
Didn't participate	2

F4) **Only for those who participated:** In which organisation? **Note down**

_____

Now I'm going to ask about your personal relations, for example with your parents or friends.
G1) In general, do you have a person with whom you can discuss the things you consider important?

Does have somebody to talk to	1
Doesn't have anybody to talk to	2
Dn/Dr	0

G2) Is there somebody on who you can count for help or support? (**write down relation: husband/wife, sister, mother , friend, etc)**	In which country is this person living?	How much do you value This persons help or support? **(see card 1) VG/ G/ R/ B/ dn/ dr**
--- *nobody*		
----------	----------	----------
----------	----------	----------
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G3) Can you identify yourself with one of the following phrases? **(Only circle one answer):**

Most of my friends are Peruvians. I hardly have any Chilean friends.	1
Half of my friends are Peruvians, and half of my friends are Chilean.	2
I have little Peruvian friends. Most of my friends are Chilean.	3
Doesn't have any Peruvian nor Chilean friends.	4

G4). I will continue to read some propositions. Please indicate your opinion about each single proposition. **(see card 2)**

	Agrees a lot	Agrees	Doesn't agree, doesn't disagree	Disagrees	Disagrees a lot	Dn/dr
a. Migrants should have the same rights as Chileans.	5	4	3	2	1	0
b. Actually, migrants have the same rights as Chileans.	5	4	3	2	1	0
c. Migrants should hang on to their own traditions and culture even when living in an other country.	5	4	3	2	1	0
d. In Chile migrants should "Chilenize" themselves	5	4	3	2	1	0
e. Chileans discriminate migrants.	5	4	3	2	1	0
f. Peruvians are solidary when staying in an other country.	5	4	3	2	1	0

H1) Did you knew anyone who was living in Chile, before you came to Chile?

	Yes	1	
	No	2	**Go to H3**
	Dn/Dr (don't read)	0	

Only for those who answered Yes in question H1**:**
H2) Who did you know?

H3) How or by whom did you get your first job in Chile?

A friend	1
An acquaintance	2
Family	3
The newspaper	4
Other	5
Dn/Dr (don't read)	0

H4) How or by whom did you find the work you are actually doing?

A friend	1
An acquaintance	2
Family	3
The newspaper	4
Other	5
Didn't change work	6
Dn/Dr (don't read)	0

H5) Indicate if know personally men or women in Chile in the following positions:

	Yes	No	Dn/Dr
Government officials	1	1	0
A person holding a good position	2	2	0
Persons attached to organisations / associations	3	3	0
Political leaders or persons working in politics	4	4	0

Now I want to ask you some questions about your state of health.

I1). Do you enjoy health services in Chile?

YES	1	
NO	2	**Go to I3**
Dn/Dr	0	

I3) Are you taking some medication or special remedies (including remedies based on medicinal herbs)?

YES	1	
NO	2	**Go to I6**
Dn/Dr (don't read)	0	

I6) Now I'm going to ask you about different aspects of your health situation which may have taken place in the **last 6 months**. Did you have any problems concerning your health?

Yes	1
No	2
Dn/Dr	0

I7) Of which problems were you suffering? **(note down the answer and continue with the questions in the table):**

Name of the disease(s)	I8 Did you suffer from these problems yet in Peru? Yes=1 No=2 Dn/Dr=0	I9 Did you consult anyone for the same problems in Chile? Yes=1 No=2 Dn/Dr=0	I10 Where did you go for this consult. **(show table)**

I11) In case you haven't consulted the doctor: Why didn't you consult him for this or these problems?

_____

Look at the following table and respond:

	YES	NO	Dn/Dr
I12) During the last 6 months, did you have any industrial accidents?	1	2	0
I13) did you consult a anyone in Chile for this industrial accident?	1	2	0
I14) To whom did you go for this consult **(see card 3)**			
I15) Did you suffer any health problems due to your working situation in the same period?	1	2	0
I16) Did you consult anyone in Chile for this problem?	1	2	0
I17) To whom did you go for this consult **(see card 3)**			
I18)were you preoccupied for your state of mind for the last 6 months? (nervous, stress, depression, other)	1	2	0
I19) Have you consulted anyone for this problem?	1	2	0
I20) To whom did you go for this consult **(see card 3)**			
I21) Did you had any dental problems?	1	2	0
I22) Have you consulted anyone for this problem?	1	2	0
I23) To whom did you go for this consult **(see card 3)**			

If the respondent said he didn't had a consult I24): why didn't you consult anyone? **(note down the answer)**

_____

I25) Comparing with Peru, do you think ------ Your state of health has improved in Chile ------ Your state of health has worsened in Chile ------ Your state of health hasn't changed at all in Chile

I26) Now I'm going to ask you some questions about your habits in Peru and Chile (about nutrition etc.). I would like you to evaluate the following cases. (**show card 4**)

In Chile	Has improved a lot	Has improved little	Has worsened a little	Has worsened a lot	Hasn't changed	**Dn/Dr (don't read)**

Your eating pattern	1	2	3	4	5	0
The quality of your sleep	1	2	3	4	5	0
Your physical activities (sports)	1	2	3	4	5	0
Your free time activities	1	2	3	4	5	0
Your physical appearance in general	1	2	3	4	5	0

I27) In the following cases I'm going to mention, do you think

	Has increased	Has decreased	Still is the same	Doesn't consume	**Dn/Dr (don't read)**
Your alcohol consumption	1	2	3	4	0
Your smoking habits	1	2	3	4	0
Your habits of smoking marihuana	1	2	3	4	0
Your use of other drugs	1	2	3	4	0
Your weight	1	2	3	-------	0

Section J. Gynaecological control for women

Have you confronted some of the following problems during the last 6 months you spent in Chile? (if the respondent arrived later than 6 months, the question should begin with "when did you arrive in Chile?")

	YES	NO	**Dn/dr don't read**
K1) Difficulties in your work	1	2	0
K2) Preoccupation for your children	1	2	0
K3) Problems with your accommodation	1	2	0
K4) Problems with the local residents	1	2	0
K5) Problems with the police or law	1	2	0
K6) Discrimination	1	2	0
K7) Serious financial trouble	1	2	0
K8) Illness or death of a relative	1	2	0
K9) Quarrel within the family	1	2	0
K10) Violence within the family	1	2	0
K11) Has been victim of an assault	1	2	0
K12) Risky sexual relationship	1	2	0

These are the final questions I'm going to ask you.
L1) Tell me in which two places you are spending **most** of your free time. **(only note down two alternatives)**

	1°	2°
In your room	1	1
In the room of your friends	2	2
Outside on the street, parks or squares	3	3
In restaurants, bars or dancings	4	4
In a Social Club	5	5
In a sports club	6	6
In the church	7	7

L2). Which of the following articles or elements mentioned can be found in your room? **(circle the mentioned answers):**

TV	0-1-2-3, more
Video recorder	0-1-2-3, more
Computer, radio or tape recorder	0-1-2-3, more

Kitchen (anafre or electric)	Yes No
Washing machine	Yes No
Refrigerator	Yes No
Microwave	Yes No
Telephone (mobile or other)	Yes No
Electrical lighting	Yes No
Windows	Yes No
Beds / Mattresses	0-1-2-3-4-5 more
What is the size of your room, measured in square meters?	

THIS SECTION IS FOR THE INTERVIEWED TO RESPOND. DON'T READ.
Condition of the floor and the room (to observe or to ask).

M1) The wall of your room is mainly made of: **(circle the corresponding answer):**

Bricks, concrete	1
Wood or partition	2
Loam	3
Other	4

M2) The wall which separates your room from the other rooms is:

Complete wall (reaches the roof)	1
Half complete wall (doesn't reach the roof)	2

M3) The material used for the roof of your room is made of: **(circle the corresponding answer):**

Zinc	1
Concrete	2
Slate	3
Wood	4
Other	5

Annex 2

Illness Narratives[153]

I. Cultural Identity

1. Which city do you come from in Peru?
2. Where did you live as a child, which region is your family originally from?
3. Which group (ethnic, regional, socioeconomic) do you identify yourself with? What aspects do you consider to be characteristic of your group or region?

II. I Would Like to Talk Specifically about your Health Problem

4. What is your health problem? Symptoms
5. What symptoms are you currently experiencing?
6. What are the symptoms, please describe them in detail?
7. When do you experience these symptoms? Are there certain situations in which you feel relief from these symptoms? If so when?
8. How long have you experienced these symptoms? Have they changed over the time? If so how?

Chain Complex Narrative

9. When did you begin to suffer from your health problem (HP)_____?
10. When did you realize that you had your (HP)_____?
11. What happened when you had your (HP)_____, did something else happen?
12. Do you consider that your (HP)_____is somehow related to specific events that occurred in your life?
13. Can you tell me a little more about those events and how they are linked to your (HP)_____?
14. Did you suffer from this (HP)_____ in Peru?

Migration and Health

15. Do you consider that having migrated to Chile has influenced your (HP) in anyway_____?
16. Can you tell me a little more about the way in which having come to Chile is related to your (HP)_____?
17. Do you consider that your living or work conditions in Chile have an influence on your (HP)_____ in anyway? How?

Prototype Narrative

18. In the past, have you ever had a health problem that you consider similar to your actual (HP) _____? If Yes, in what way is that past health problem similar or different to your actual (HP) _____?
19. Did a person in your family or in your social environment experience a health problem similar to yours? If Yes, how do you consider your (HP) _____to be different or similar to this other person's health problem?
20. Have you noticed that your friends from Peru suffer from similar health problems? If so, what similarities and what differences do you notice between your and their health problems?
21. Have you ever seen, read or heard on television, radio, in a magazine, a book or on the Internet of a person who had the same health problem as you?
22. If yes, in what respect is that person's problem different or similar to yours?

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[153] This interview is based on the McGill Illness Narrative Interview (MINI) by Groleau (2006)

Explanatory Model

23. Who told you that you had this HP_____? (Doctors, friends, other), where was this related?
24 What does HP_____ mean to you?
25. What do you call your (HP)_____in your own words? Do people in Peru refer to (HP)_____ in that same way?
26. Do you consider yourself "OTHER POPULAR LABEL"?
27. What does POPULAR LABEL mean to you?
28 How is your (HP)_____different and/ or similar to POPULAR LABEL?
29. According to you what caused your (HP)_____? *
30. Why did your (HP)_____start at the precise moment it did?*
31. What happened inside your body that could explain your (HP)_____?
32. Please explain this occurrence in detail?
33. How should you treat this health problem? How do you treat this health problem in Peru?
34. What could you do to prevent this health problem? How do you prevent this health problem in Peru?
35. Do you think that in Chile this health problem is treated differently? How?

III. Help Seeking Behaviour

36. Now tell me, have you sought help for this health problem?
37 Where did you go and who did you see for help? (including friends, pharmacy, herbalist, others).
38. Why did you choose to go to these places? Or ask these people?
39. Did you get any treatment for your HP? What kind of treatment was it?
40 (For medical treatments), were you able to follow the medical treatment and prescriptions? If not, why not? What did you do then?
41 Are you satisfied with the medical care that you got? Why?
42. What are you planning to do next regarding your HP_____?

IV. Acculturation and Health

43. Which aspects of the style of life in Peru do you consider to be "healthy" and worth maintaining (habits, customs, traditions, other). Is it possible to maintain these customs here in Chile?
44. Which aspects of life style in Peru, do you consider to be unhealthy?
45. Now regarding style of life in Chile, which aspects do you consider to be harmful for your health here and what is healthy?
46. To what extent has your style of life (food, exercise, hours of sleep, social life) changed while living Chile? Has your health changed in anyway while living in Chile?
47. Do you feel like you are part of the Chilean society?
48. Are you satisfied with your life here?
49. Your friends are mostly Chilean friends or Peruvians?
50. Do you prefer to live among Peruvians or among Chileans?
51. What are your plans for your future and the future of your children (stay, return to Peru)?

Annex3

The Residents of the Compound in the Building of Bandera Street

The residents will be introduced by going through each of the rooms.

Room 1
The first room in front of the entrance's door belonged to Tony and Elizabeth. Tony came from Pacasmayo in the North of Chile. He is 48 years old and in Santiago, he worked as garbage collector for a subcontracting firm in the upper side of the city.

Elizabeth was never addressed by her given name; instead everyone called her "Chamé". Chamé comes from Lima and is 35 years old. She worked some days a week cleaning in two Chilean households. Chamé was also in charge of cleaning the housing compound's common areas. She did this in exchange for her monthly rent. Due to this role, and out of personal interest, she developed a closer relationship with the landlady. For this reason, she was elected as a representative of the renters' association; practical reason supported this decision as she used to spend more of her time in the housing compound than any of the residents.

Chamé and Tony each had previous relationships in Peru. And, each was the parent of one child. Chamé had a son living in Lima, who was cared for by her mother. Tony had a daughter who lived with his ex-partner.

When I began my visits to the compound, there were another two young women living in this particular room. One was Graciela's niece (Graciela occupies room 6) but this girl soon migrated to Spain. The other young woman, Hilda, worked at night as a bartender in a cabaret situated next to the compound. Because of her job, Hilda was very much criticized by some of the community members. They believed that because she worked in a bar, she must also be a prostitute. This criticism then overflowed onto Chamé as she allowed Hilda to sleep in her room. After some length of time, Hilda moved out of the room.

Room 2
The second room belonged to Eli, a woman I met only at the time when the residents of the compound had been evicted. She worked as a live-in domestic worker and spent very little of her time in the compound. In the beginning, the information I received was quite uncertain as to the exact number of temporary inhabitants who used this room. I was informed by Ñato that a number of people would come in there late at night just to sleep. He heard they were working in Plaza de Armas as *marcadores* – people who placed international calls using stolen mobile phones. However, Eli, the official tenant of this room did not participate in the community activities. Furthermore, she continued paying rent to the landlady as she did not want to get involved in the community struggle to delay eviction.

Room 3
The third room was rented as a storage room by a vendor who had a stall in the street right next to the building's entrance. Although he came in twice a day to get or return his goods from the storage room, he seldom interacted with the people living in the compound.

Room 4
Room number four was the room at the end of this corridor and belonged to Marisol. She came from Trujillo, Peru. At 39 years, she is the mother of two children. One is in Peru and the other, a 20-year-old son, named Eber, lived with her in Chile. Eber, worked as a junior boy in a computer shop and lived in the compound permanently. Marisol worked as a day timer domestic worker. And, she also had an off-and-on relationship with a Chilean man named Marcos, who at times, when their relationship was good, also lived with her there.

Another temporary inhabitant of this room was Lili. Lili came from Huacho and worked as a live-in domestic. She only came to the room to spend her free days, over the weekends. Now in her twenties, Lili had left her country, her town and her home for the first time. I was never invited to enter into this room, but I heard Marisol had a fully furnished room with everything a standard household would have – including a washing machine.

Room 5
Room number five belonged to Don Luciano from Chimbote. He was a 50-year-old mechanic working for a mining company. He had a dark complexion and indigenous features. Luciano shared his room with Dany, his younger son. Dany was 25 years old and a former medical student at the University of Chimbote. He suspended his studies to come to Chile to get money together to finish his studies in Peru. He held an informal job, cleaning cars in the parking area of a supermarket.

Also living in this room was Javier, nicknamed Chapita, Luciano's nephew. He was about 30 years old and had a daughter in Peru. Chapita began a relationship with Yajaira, who lived with her mother, Graciela, in the next room. Because Yajaira's parents objected to their relationship, they moved out of the compound and began living together in another building. Soon after, they had a baby. Javier was initially working in printing shop, but he was fired and remained unemployed for quite some time until he found temporary work in construction.

Esperanza, Luciano's partner in Chile, was 55 years old and worked as live-in domestic. She spent every weekend with him. Luciano had a wife in Peru and also had a relationship with Esperanza. She too was married with a husband and grown-up children living in Trujillo, Peru.

Room 6
Room number six belonged to Graciela, the first person I got to know in the compound. Graciela's room was the first one to be erected as well as the one next to hers. She and her husband, Demetrio, are both 50 years old and come from Chimbote. She works as a domestic but comes home each night. Demetrio works as a security guard. Yajaira, 21, was the first of their children to come live with them in Santiago. She was soon followed by 19-year-old Tania and 14-year-old Demetrio. Soon after Amparo, their 12-year-old daughter came to attend school. Tania and Yajaira found jobs as domestic workers and Demetrio junior sometimes helped his father. Demetrio and Ñato are cousins and they got to know each other better living in Chile.

Room 7
Room number seven was occupied by Carlos and Luisa, and their son. This family comes from Trujillo. Carlos works as a gardener and Luisa is a daytime domestic worker. In addition, she does some sewing at home with her sewing machine. Their 25-year-old son, Eduardo arrived not long after I began visiting the place. After some time looking for a job, he began to clean cars with Dany, Luciano's son.

Eduardo is a school teacher who wanted to apply for an official recognition of his professional title in Chile. They have yet another son, Carlos, in Peru. At the time, they were trying to bring him to Chile. Carlos had a piece of land in Peru, which he was still cultivating. This family was the first to move out of the compound when the eviction order was placed. They decided to leave after their room was robbed. In that burglary, they lost documents, money, a camera and the sewing machine.

Room 8
Room number eight was home for Lucia and her two daughters. She and the oldest daughter worked as daytime domestics while the youngest daughter, who was only 12 years attended school. I only got to know her in the community meetings.

Room 9
The next room belonged to María Elena who was in her mid forties. She shared the room with her younger sister Cony, her son Marcos and his girlfriend, Vilma. María Elena sewed for a small workshop and also at home for neighbours and acquaintances, as she had her own sewing machine. Cony worked as live-in domestic servant and Vilma, who was 24, was a daytimer. Marcos was 21 years old and had no valid documentation. Since he had been unemployed for two years he spent most of each day in the compound. The family was from Trujillo, Peru, where Maria Elena had two other children. Vilma came from Lima.

Room 10
The last room in this corridor was the home of an older married couple. They appeared to be about 50 years old and did not take part in the community initiatives or collective agreements. They both worked at night as a security guard and cook respectively, in one of the Peruvian dance halls.

Room 11
This room belonged to Marta a 38-year-old single woman and her sister, Jenny. They come from Paijan and shared their room with Richard, Jenny's partner who came from Lima. The couple was expecting a baby and she was in her 7th month when I got to know her. Marta resigned from her full-time job to take care of her sister and was now daytime cleaning in two different households. Richard, who had been in the country five years, did not have a regular visa and worked illegally in construction.

Room 12
The next room belonged to Angela who was about 45 years old. She was married and had children in Peru. Angela worked as a cook in a restaurant. During weekends, her partner would come to stay with her as well as Angela's older sister Cristina, who worked as live-in domestic worker.

Room 13
This next room belonged to Hugo and Angelica, my neighbours. They had a grown up son living with Hugo's mother in Peru, but they also had a 10-month-old daughter. Angelica stopped working to look after her daughter. Hugo was the only professional among the whole group in the housing compound. He studied business management in the University of Peru. In his current employment, he was initially offered an administrative position but was never really appointed in that position. Instead, he had been performing manual tasks and had seemed frustrated in his aspirations. Angelica migrated at the age of 11 from the mountains of Peru to study in Lima. She was also the first to migrate to Santiago, followed by Hugo. She was now planning to migrate to Italy and leave her second baby in the care of her mother-in-law in Peru.

Room 14
This room belonged to me. It was small with no windows. My next-door neighbours had been living there before. However, they had moved to the next room because they thought the dampness of this room was making the baby sick.

Room 15
Room fifteen was Ñato's who came from Chimbote. Ñato had studied into his 3rd year as an engineering student in Peru. He moved into the hosing compound to help Graciela when he heard she was having problems with Demetrio who was constantly beating her. Soon after, Graciela's children came to Chile to live with them and the relationship with Demetrio improved. Apparently, the presence of the children comforted him. Unfortunately, Ñato was recently fired from the job where he had worked for the previous 6 years. He was an assistant technician installing air conditioning equipment. In spite of many promises from his employer, he never got a promotion, further training or a raise in salary.

Ñato initially hosted Lili on Sundays. Lili was Graciela's neighbour in Chimbote. He also shared his room on weekends with Olguita and Ana, two sisters 45 and 50 years old, respectively. They too, were from Chimbote and also neighbours of Graciela in Chimbote. Ana is a protestant evangelist and came to Chile with her 23-year-old daughter, Mary, who also stayed in the room.

Consuelo was another weekend guest in Ñato's room. She was a live-in domestic who regularly visited the compound on weekends. Consuelo met the two sisters Olgüita and Ana and her daughter at the border. They all were helped by a smuggling network which provided them with false stamps at the border. She joined the women as they knew Graciela in the compound. Consuelo came from the jungle in Peru and was in her mid 30s. She was the only member of her family living in Chile.

Room 16
Lucho lived in room sixteen. He was 38 years old and worked as gardener. Later on, although briefly, he was security guard. Lucho was unemployed for an extended period and his visa expired. As a result, he spent most of his time in the building. He did not want to go outdoors for fear of the immigration police. He was from Chimbote, where he had two daughters from two different relationships. In Santiago, he had a relationship with Rosita who worked as live-in domestic worker. Rosita had a weekend free every 15 days.

Room 17
Next to Lucho lived his cousin young Luis, who was 30 years old. He worked as hairdresser in Peru but now was a construction worker. He had a relationship with Rosa, a former technical nurse who works now as live-in domestic. Rosa came to Lucho's room every weekend.

Room 18
Next door, room eighteen was Celia's place. She was from Chimbote, around 30 years old and had a son who lived in Peru under the care of her mother. She worked as a daytime domestic. Celia completed a hairdressing course in Santiago, so she eventually cut acquaintances' hair in her room. She shared the room with Juanita, an older woman who comes to the compound only during weekends, when she has time off.

Room 19
This was the last occupied room and belonged to 30-year-old Luis, better known as el Ché. When I came to the compound, I learned he had only arrived recently from Argentina with his wife. The couple had met in Argentina and lived there for 6 years. After the Argentinian economic crisis, they moved to Chile and sent their two small daughters to Peru to be looked after by their grandmother. This was meant to be a temporary measure "until they managed to settle down".

Although he was Peruvian, he had acquired a strong Argentinean accent after many years of living there. This is the reason why he was given the nickname, Ché. Without a visa, he was only able to work at odd jobs. His wife worked as live-in domestic worker and come to stay in the room over weekends.

Luis Ché came from Chimbote; from a better-off family. He studied and had a good job in Peru. Among the many things he did to survive during these first few months in Chile, was film – for a price – social events and celebrations of the community, using his movie camera. He shared his room with two older women who worked as live-in domestics and came to the compound over weekends. Rosa, one of these women was his wife's aunt and she also came from Lima.

Room 20
Room 20 was empty and while I was there, it was not rented again.

Given the fact these rooms were really quite small, it was virtually impossible to fit more than two beds inside them. In most rooms, there was a spare mattress which could be put on the floor for the night. In this way, numerous permanent and occasional residents could be accommodated. However, none of the residents – with the exception of me – had his or her own bed. Instead, beds were always shared among two or three people. But, without a doubt, the most crowded room in the compound was Ñato's room. During any given weekend, as many as 5 or 6 people would sleep on his bed and on a mattress thrown on the floor.

Annex4

Respondents to the mental health interview: Short biographies

What follows are brief biographic notes of each one of the respondents of the health interviews. The biographic notes are presented in alphabetic order. These descriptions although brief, aim to provide information on each particular life as well as on the circumstances surrounding the emotional distress of these migrants.

Cesar was strong built man but had missing teeth and often stuttered. He was very polite and agreed to be interviewed as a way to *help me in my study* as he put it. We sat outside his room in Estación Central on a summer Sunday afternoon after he had finished work. Cesar was self-employed, a cardboard collector who sold these scraps for recycling. He defined his problem as *heart illness,* and explained it as: feeling like his heart was "hard" and of having an acute pain in his chest.

This sensation, he recalled, had started long before his arrival in Chile. It began early in his life, when his parents started having marital problems. As a child, he had become his mother's emotional support. The *heart illness* reappeared later in Chile, after he lost his job. When he was in this desperate situation, he felt as if *everything was falling onto me.* The pain in his chest become even worse after his mother fell ill in Peru. He said: *the pain has taken me, little by little has taken me more, now I feel it… Anything that happens and I feel it.* He said these symptoms had persisted for two years or more.

The causes of his current distress were sadness and worry. – Sadness from being so far away from his mother, plus his constant worry about her wellbeing. This was compounded by the fact that he found it difficult to support her financially. He felt weak, had little energy and he cried often. He admitted he used to drink excessively but now had stopped.

Johnny was visiting his brother Lucho, my neighbour who inhabited the room next to me in Bandera Street and we were introduced by Lucho. He was short, heavy-set and very dark skinned. His hair was long and when he got "dressed up," he wore a golden chain around his neck. Johnny also had a tatoo on his chest – *Sarita Colonia* the popular Peruvian Saint – a souvenier of his time spent in jail in the northern Chilean city of Arica.

Later, just by chance, I found him again. He was now living in a compound in Estación Central. I was visiting there to follow up with other interviewees. Because he knew me, he agreed to answer the mental health test. Later on, I met him in his room to conduct the interview. He also invited me for a special lunch of *ceviche (a Peruvian dish)* prepared by a neighbour woman. This was when I learned Johnny was now self-employed as a car painter.

In spite of having scored high in the mental health test, he did not admit to experiencing any emotional distress. However, he had been suffering from constant stomach aches for some months. He blamed his stomach problems on the strong paint he used in his work. At this point, Johnny had been suffering severe stomach aches for approximately eight months.

He finally agreed to discuss the events leading to the appearance of his pains. He was living with his then partner in Santiago. Things were going reasonably well until she was offered a better job opportunity in Argentina. She, of course, decided to migrate immediately. But, Johnny could not join her because his visa to work in Chile was no longer valid and his Peruvian passport had expired.

His partner did move to Argentina and continuously telephoned him from there, asking him to join her. Instead of informing her about his real legal situation, he chose to lie and kept postponing his trip. One day, Johnny finally asked her to not call him anymore. Later he lost her contact details and that was the end of the relationship.

Following the break-up, Johnny began to drink excessively and did not eat regularly. He saw this as the most likely factor related to his stomach problems. He talked about his feelings of powerlessness and about the deception around not having been able to join his partner. However, he did find some consolation in the fact that the situation in Argentina deteriorated soon after that, due to the economic crises.

In Chile, he felt 'trapped' as his papers were still not in order. There was a real possibility of being caught by the police, being imprisoned or sent back to Peru. His fears of being detained were due to the fact that he had spent some time in jail in the north of Chile. He maintained he was unfairly accused of trafficking drugs.

Dago is a young looking man, thin and not very tall. He seems shy and is very polite. The formality in his gestures and in the way he speaks shows that he had arrived in Chile very recently. He had not yet incorporated Chilean slang or informality in the way he spoke. I interviewed him in his room after being introduced to him by his mother whom I had previously talked with in the Estación Central compound, where they live.

Dago told me his health problems dated back to his childhood. When he was 12 years old, he started to work late hours after school. He had the responsibility of looking after his small siblings – and even after his mother as his father 'disappeared' for a very long time. He also remembered conflicts and violence between his parents and the emotional effect it had on him. Later, he lost his grandfather who had been his main support. As an adult, he was separated from his wife who stood between him and his small daughter. Not having access to the child and the family situation, he felt lonely and began to consume drugs including crack.

Dago experienced serious *depression* in Peru while he was in treatment to quit drugs. He recalled how difficult it was for him when he was released from the Hospital, not being allowed to see his daughter. After recovering from drug addiction and depression, his mother helped him to migrate to Chile. Now living and working in Chile with an expired tourist visa, he shares a room with his parents who have reconciled. However, he sometimes felt worried, dizzy and weak, and feared he might (become depressed) fall into a *depression* again.

Elena is a short middle-aged woman with green eyes and light hair. During our conversation she spoke freely about her experiences. It seemed as if she wanted to open up to someone. This became more evident after I had given her the test. She lived in a migrant's house in Estación Central. We met a few times in her small room that she shared with her current partner.

Elena had suffered a *derrame*, (stroke) causing facial paralysis while still living in Peru. She believed the stroke had been caused by the depression she went through after she separated from her husband some years earlier. At that time, she had left her children in the custody of their father and relocated to Chile. She now feared the depression she was experiencing in Chile could lead to another stroke.

Adding to her situation was the knowledge that she couldn't afford to fall sick because there was nobody in Chile who would look after her. Working as a teller in the public transport system did not give her a steady income so she had to struggle to send money home to her children in Peru.

Elena's current partner was a younger man who worked as a bus driver. To her relief, he had recently stopped drinking and no longer was violent with her. However the arrival of her eldest daughter from Peru added another burden as well as concern. Elena now had to support her daughter, as the girl had not been able to find a suitable job.

Felix is slender build and dark skinned; curly hair and bright eyes. He is fit and good at sports. The tattoo on his chest was acquired in Chile. When I first visited the house in Estación Central, where he has a room, he was doubtful about my request for an interview. But after answering the test questionnaire, he agreed to talk with me. He felt the need to vent.

His partner was in Peru at the time, which increased his emotional turmoil and need to talk. Felix heard of and experienced stress for the first time in Chile. He explained his stress as related to conflicts with his partner and the hard physical work he performs.

Felix believes that in Peru, nobody suffers from *stress,* as he never heard of it before. He viewed the events of his love relationships as associated with his health problems. Felix recalled the experience he had with his first partner in Peru. He said he became *a sort of crazy* as he began a surveillance of her activities. He distrusted her loyalty as people gossiped about her, but he never found out the truth.

He was again experiencing something similar with his current partner, as he suspected she might be unfaithful. This made him feel worthless. He felt humiliated and thought people laughed at him. As well as these feelings, he now experienced stomach aches and felt *stressed* and *down* (bajoneado). Additional factors contributing to his current *stress* were the pressure from working continually for five years without a break. Also, he had not seen his children, who still lived in Peru, for the same amount of time. He said he felt a bit *depressed* as he missed his children very much.

Gladys is a middle aged woman and Marlo's neighbor. She is short and a bit overweight. She laughs easily and enjoys talking. I interviewed her in her room after several cancelled appointments. Gladys often suffered from terrible headaches, so debilitating that she could not carry on a conversation.

Gladys had a hypertension condition she called 'emotive blood pressure,' which means she believed her BP rate increased and fell in relation to the levels of tensions and worries in her life. This was a pre-existing condition; one she had long before moving to Chile. She feared that due to all the worries and tensions she had, she could suffer from a *derrame* or stroke.

The main cause of all her worries was clear. She was the primary economic supporter for her children in Peru. She believed her tensions and other health problems began the day she got married to a man whom she could never count upon for any form of support. Today, she supports her family materially and emotionally from a distance.

In Chile, Gladys alone had to find solutions for all her family's problems as well as cope with the difficulties of long-distance motherhood. Her husband still lives in Peru with their three young children. As he is unemployed, she cannot count on him economically or even to make simple decisions in the home. As Gladys puts it, "*Everything is me, me, me! He cannot solve anything".*

In Chile, Gladys began to experience *stress,* which she sees as related to the tiredness produced by the demands of her job. Stress also adds to the hypertension she already suffers from. However, for her, stress *just began* (in Chile). When asked how prevalent stress is in Peru, she said: *I don't know how it would be there because it has been long since I went last.*

Irma is good friends with Marianela. She projects an air of fragility and defencelessness. Although she doesn't wear makeup, she does lighten her curly hair. I met her at Marianela's room, as she often visits on Sundays. While talking she laughs as often as she cries, especially when she remembers her family in Peru. Getting to know Irma, it is hard to believe that she decided to migrate alone. After several years in Chile, she is still very attached to her family.

We spent several Sundays talking in Marianelas' room in Estación Central and sometimes went for walks in the only park in the area. Just after arriving in Chile, Irma was warned by a medical doctor that she was at risk of falling into a depression. However she did not agree with being labeled as a depressive. Instead, she sees herself as suffering from "nostalgia," from the great sadness caused by being away from her loved ones.

She recounts several factors associated with her distress. – Being alone and far from her family, having to work in an hostile environment in a household outside Santiago and being far from her few friends all contributed to her negative state.

The death of her father in Peru some time after her arrival into Chile affected Irma negatively. She could not travel to visit him in his last days. She recalls that was when she got ill. One day while at a friend's place, she fainted and was taken to the hospital. The doctor told her to look after herself because she could fall into a deep *depression.* However, she thinks what she has is '*tristeza*' ('sadness'). Irma was the only interviewee interested to know what her score was in the mental health test. While I provided it to her we also discussed the meaning of such measurement and looked at alternatives to deal with her distress.

Javier is young a man in his early twenties, with an indigenous face, dark skin and straight dark hair. He is short and thin. Although he was not very communicative, he was willing to talk and share his experiences. One Sunday, we met in the corridor outside his room where he answered the mental health test. I lost contact with Javier after the first time we met. He moved out of his room and I was not able to locate him. I later learn he was sharing a room with other Peruvian friends in another part of the city. Eventually, the in-depth interview was carried out when I finally located him again. In the meantime his depression had subsided.

When I first met him, Javier was sharing a room with his aunt and her family. During that time he became depressed. He experienced depression for the first time in Chile when he felt the pressure to be a partial provider for his family (parents & siblings) in Peru. He felt as though he had no support, that he didn't have anybody in Chile to rely upon. At that time, his aunt was also putting pressure on him, to contribute economically to her household as he was living in her home.

Javier viewed his depression as the result of all the pressure he was under. He remembered that his life in Peru had been so different.

Marianela is a very thin and energetic woman. Her skin is a light shade of brown. She is of average height, has straight hair, dyed to a lighter brownette colour and cut in a short style. She wears fashionable clothing and her smile is adorned with a golden cross incrusted on one front tooth. She uses colored contact lenses to make her brown eyes blue. All these features combine to make her look quite different from other Peruvian women and reflect how much her physical appearance has changed during her time in Chile. Although she was about to discuss her depression, she appeared to be in good humor.

Once in the privacy of her room, a shack behind a large house converted into shared migrants' housing in the Estación Central district, Marianela becomes more serious. She began experiencing depression after she arrived in Santiago. She soon realized she had a problem because she repeatedly changed jobs and was not able to confront her employers about the way they were treating her. *"…I don't have that* (ability) *of talking through things. I keep quiet…*(in front of the employers).

She thinks she developed her *depression* because she had remained silent and did not express her discontent in the workplace. Too many times, she was confronted with upsetting situations and on-the-job conditions that were unilaterally changed. She felt she was never consulted when decisions were made regarding the tasks she had to perform. Even now, she feels she is often informed at the last minute about having to cook or clean for extra people while being paid the same salary.

Marlo is a middle age man, with bright eyes and dark hair. He has a tattoo on his chest, naming his two daughters. Though he is thin and tall for a Peruvian, he is a very strong man. It is clear he is used to lots of hard, physical work. I was introduced to him by my fieldwork assistant, Ñato, who helped me gain his trust. I visited Marlo a few times in his room after work and on Sundays in the downtown area of Santiago where he lived.

During the interview he often got very emotional remembering his life – so much so, that he sometimes could not continue talking. Marlo was going through a difficult period, at the time of his interview. He had never experienced *depression* before. He believed his *depression* was caused by his "solitude," as well as the disappointment of being betrayed by his love partners. He admitted he had even attempted committing suicide and engaged in heavy drinking. However, a new love relationship had helped him to stop drinking. He left for Chile after he had separated from his partner in Peru. He felt disappointed about his relationships with women. Soon, after having found a good job, he began to drink heavily. As he says, *my life was to destroy myself.*

After a year and a half in Chile, his partner arrived with their children from Peru to live with him. Soon after this reconciliation, problems of infidelity appeared. First it was Marlo cheating on his "wife" and then she started cheating on him too. Marlo suspected there was something unusual occurring since the food she was cooking for him was the same everyday. He accused her of not looking after his well-being, hence putting the whole family at risk since he as the breadwinner and needed to be in good health to be able to work. Marlo also discovered his partner had been corresponding with another man in Peru. He found a suitcase with men's clothing inside, which she was about to be send off to Peru. Marlo was convinced the clothing had been bought with the family food money. He reacted violently and sent her and the children back to Peru. Following that last incident, his emotional state become even worse. He

continued drinking and his situation was further aggravated by more disappointments in other relationships.

Mary has very fair skin and light hair, which she now dyes because it is turning prematurely white. She is an attractive, energetic and sociable woman, who says she is often mistaken for a Chilean. We met a few times in her room in Estación Central. Sometimes we met alone, other times we were surrounded by her children who were often watching TV programs. Having the television set playing actually created some privacy for her to answer test questions and discuss her problems.

After the test, she agreed to a full interview which would happen at a future date. When the time came to conduct the interview, she changed her mind. I stopped by her room several times but Mary did not feel like meeting with me and I had to come back again and again. Finally the interview was completed, with Mary telling me her complete story. In the end, she felt pleased to have done it. Her depression had apparently subsided at the time of the interview.

Mary arrived in Chile on her own, followed later by her husband. The couple lived in a single room together with their three children. While their youngest child was born in Chile, the two older daughters were born in Peru and joined them later. For Mary, her *depressio*n was the result of the pressure she was subjected to when her daughters arrived to live with her in Chile. This was a pressure that she never experienced before in Peru. Her situation became unbearable. While working full time as a domestic worker, she also had to look after her own three children. She recalls that she began to feel bad.

I got too stressed out in my work. She felt family and employers – who would not take into account her new and increased responsibilities as a mother – were too demanding. One day she left her work, just for a short time, to attend to a request from her daughter. This event caused an argument with her employer who threatened to beat her. He even verbally humiliated her because she was Peruvian. Mary lost her job as a consequence of this dispute and remained unemployed for several months. It was at this time that her *depression* became serious.

Oscar is a young man in his early twenties who did not complete high school. He is thin and tall with dark skin and looks younger than his actual age. He dresses very fashionably and has longish straight hair and an earring – a look he acquired since moving to Chile. Oscar said didn't know whether or not stress existed in Peru, but he had experienced it living in Chile. He is self employed and manufactures birthday decorations. He constantly has to meet deadlines to fill orders from big party supplies shops.

He explains his problem as suffering from *stress* and sees it as the result of the pressures that are associated with leaving in Chile. He had experienced depression before and was treated medically in Peru. At that time, he had attempted to commit suicide. Causes of that depression were problems from his childhood and related to issues with his mother. He believes that in Chile, people are '*more nervous*' than in Peru. He sees the Chilean lifestyle as being *stress* itself due to the fast-pace of life in Chile. He attributes the rise in his distress to the fact that he moved into a more central area (Santiago downtown), when the demand for his work increased. So it was then that he began to work under heavier pressure and he worries day and night about his work.

Rocio lives in the same run-down neighbourhood as Marianela but in a different house. She was open and friendly at the time I met her. She, too, is of average height and has long light coloured straight hair which she ties up when she is busy. Her attractiveness is marred by missing front teeth, a signal of the hardship of her young life.

Living with her in her tiny room, were her husband and three small kids. So, we stood in the back yard of the compound trying to create some rapport and have some sense of privacy. Yet at the same time, we were encircled by shack-rooms as well as many of the people who lived in them. She talked openly and expressed her grief. She cried while answering the mental health test.

I visited her several times afterward. This was Rocío's second time coming to Chile for work. During her first stay, she did not experience any *depression*. However this time, unlike before, she did not have the support of her mother to help her face daily challenges. Several unrelated events had compounded, leading up to her current distress. – A fight with her neighbour, difficulties her son faced at school where he was treated badly. He complained to his mother that he was called names *Peruano muerto de hambre* (starving Peruvian*)* and was feeling isolated because children did not want to play with because he was

Peruvian. The ultimate negative event was having her small child rejected for a medical check-up because Rocío did not have his papers in order.

An additional source of distress was a possible pregnancy. Her menstruation had stopped due to a change of contraceptives available to her in Chile. In any event, she had not been using them regularly and didn't know whether she was pregnant or not. What she knew for sure was she and her husband could not afford to have a fourth child. She believed her distress was the result of *all the problems. I believe everything accumulates so there is a moment where one can't take it anymore.*

Rosita has long black hair and fair skin. She is a young woman, and a rather shy person. We knew each other as we both had rented rooms in the same compound in Bandera Street. At that time, she would only come back to her room on weekends as she was working as live in-nanny in a wealthy suburb of Santiago. At that time, it was clear to me she was going through a great deal of emotional distress. Soon she moved out of the building to another house with her partner and I lost contact with her.

We met again when her experience of depression had abated. It was then she told me she had changed jobs. Although Rosita was very shy she welcomed me when I visited her new room and she was very willing to talk about her past experiences.

Rosita suffered from *stress* for the first time while living in Chile. She attributed this to bad working conditions. Her problems had begun three years earlier when her mother and brother passed away within a short period of time. As she recalled it, she cried very often. After almost two years in Chile, she still experienced the sadness of having lost her mother and of being so far away from her children. – Rosita had left her children in the care of a relative in Peru and migrated to Chile. She did this in order find work to support her children.

The Cases Selected

NAME	AGE AND YEARS LIVING IN CHILE	WORK AND EDUCATION BACKGROUNDS	LIVING AND FAMILY SITUATION	ILLNESS
1. Marianela ♀	39 years old. Arrived 4 years ago	Works as live-in domestic worker. Previously worked as a secretary in Peru.	Separated, has a son in Peru. Lives in the employers' household and rents a room to spend weekends.	*Depression* occurred first time in Chile. She suffered from convulsions before arriving, in Peru.
2. Rocio ♀	28 years old. Arrived for a second time a few months ago	Reproductive work, finished secondary school, worked as domestic worker in Peru.	Married, lives with her husband and three children in a room.	*Depression* occurred first time in Chile.
3. Irma ♀	39 years old. Arrived 5 years ago.	Works as live-in domestic worker. Worked as technical nurse in Peru.	Single, no children. Lives in her employers' household and spends weekends with friends.	*Depression* occurred first time in Chile. She defines her distress as "*nostalgia* and *sadness*".
4. Mary ♀	38 years old. Arrived 8 years ago.	Works as domestic worker. Is a technical nurse and worked as a receptionist in Peru.	Married, lives with her husband and three children in a room.	*Depression* occurred first time in Chile. She thinks she was also suffering from *daño.* (literally '*harm'*, cursed)
7. Javier ♂	23 years old. Arrived 2 years ago. When	Works in construction, did not finish secondary school.	Single no children, shares a room with friends.	*Depression* occurred first time in Chile
6. Marlo ♂	43 years old. Arrived 7 years ago.	Works in construction. Worked in the metallurgic industry in Peru. Did not finish secondary school.	Separated, has two daughters; one in Peru and one in Chile, lives alone in a room.	Drinks in excess. *Depression* occurred for the first time in Chile. Has attempted to commit suicide
7.Elena ♀	45 years old. Arrived 5 years ago. When	Works as a cashier on a public transport bus. In Peru she worked as receptionist.	Separated, four children in Peru. Lives with new partner in a room. Oldest daughter came to live with her.	Previously suffered a stroke and depression medically diagnosis in Peru
8. Dago ♂	22 years old. Recently arrived into the country.	Works in construction. Did not finish secondary school.	Separated has a daughter in Peru. Shares his room with his parents. He stays irregularly in the country.	Rehabilitated drug addict. Previously suffered depression medically diagnosed in Peru
9. Oscar ♂	23 years old. Arrived 4 years ago.	Self employed, manufactures birthday party supplies. Did not finish secondary school.	Single, has a daughter in Peru, shares his room with friends.	Previously suffered depression, medically diagnosed in Peru. Experienced *stress* for the first time in Chile.
10. Felix ♂	32 years old. Arrived 5 years ago.	Works in construction, finished secondary school.	Separated with two children in Peru. Shares a room with his new partner.	Suffered *stress* for the first time in Chile. Previously suffered from *nervios* and *susto* ('fright') in Peru.
11. Rosita ♀	31 years old. Arrived 3 years ago.	Works as waitress in a restaurant. Previously worked as a live-in nanny in Chile. Is trained as a technical nurse.	Separated, has two children in Peru, lives with her new partner in a room.	Suffered depression and stress for the first time in Chile

12. Gladys ♀	47 years old. Arrived 4 years ago	Works as domestic worker, she finished secondary school.	Separated with three children, two of them are in Peru. She shares a room with her oldest daughter who recently arrived into the country.	Suffers from hypertension. Experienced stress for the first time in Chile
13. Cesar ♂	35 years old. Arrived x years ago	Self employed, collects cardboard for recycling did not compete primary school.	Married, has a small daughter and lives with his partner in a room.	Drinks in excess. He suffers from 'Heart Illness".
14.Johnny ♂	39 years old. Arrived 9 years ago	Self employed, paints cars. Did not complete secondary school. Spent a year in jail in the north of Chile.	Separated, two children one in Peru one in Chile. Lives alone in a room. Stays irregularly in the country.	Drinks in excess. Suffers from stomach problems.

Annex5

Symptoms of migrants' self-defined depression, stress and distress

A: Symptoms of migrants' self-defined Depression

	Affective Symptoms	**Vegetative Symptoms**	**Cognitive Symptoms**	**Somatic Symptoms**
1. Marianela	-Feels like wanting to lock herself in her room. -Feels lost, as if the world is collapsing around her, as if she has nothing to hold on to. -Feels like crying and throwing things around.	-Feels weakness. -Feels sleepy during the day. -Lack of appetite.	Confusion and disorienta-Tion.	-Suffers "nerves" – has uncontrollable trembling. -Sensation of a 'knot' in her throat.
2. Rocio	-Does not want to get out of bed in the mornings. -Feels sadness and cries often. -Feels like wanting to run away.	-Feels weakness. -Feels like fainting. -Lack of appetite.	Does not report.	-Feeling of pain and tightness in her heart. -Difficulties with breathing. -Has headaches and dizziness.
3. Irma[154]	-Feels sadness and nostalgia. -Feels like crying. -Feels worry and tense.	-Lack of appetite and weight lost.	Does not report.	-Sensation of a 'knot' in her throat. -Feels pain in her heart.
4. Mary Her distress had elapsed when interviewed	-Did not want her children to talk to her. -Wanted to be left alone and not see anyone. -Felt anxious, wanting to leave, walk away and never come back. -Did not want to maintain personal hygiene. -Felt like crying.	-Felt like sleeping all the time. -Loss of appetite and weight loss. - Hair loss & her hair turned grey.	Does not report.	-Headaches. - Feeling as having 'something' (foreign) in her stomach. -Feeling her body trembling out of control.
7. Javier His distress had elapsed when interviewed	-Felt trapped, without a way out and without anything to hold on to. -Wanted to escape from his problems by drinking.	Does not report.	Does not report.	Does not report.
6. Marlo	-Feels sadness and the need to vent. Wanted to die. Cries often.	Does not report.	Does not report.	Feels pressure in the chest.
7. Elena	-Feels like staying in bed. She locks herself in her room and does not want to talk to anyone.	-Can't get any sleep. -Feels weak.	Constantly thinking about her problems.	Her face twitches. Feels like ants are in her body – especially in one arm and leg.

[154] Even though Irma initially mentioned depression as her problem, she expressed doubt about it and did not accept the diagnosis of depression.

8. Dago	Feels worried, desperate and fearful.	Feels as if 'he lacks something.'	Constantly thinking about the same thing.	Gets nervous – body gets tense and agitated without doing any physical activity.

B. Symptoms of migrants' self-defined Stress

	Affective Symptoms	**Vegetative Symptoms**	**Cognitive Symptoms**	**Somatic Symptoms**
9. Felix	-Feels like everybody is laughing at him. Fears he is being betrayed.	-Feels a lack of energy. -Feeling like fainting.	Does not report.	-Constant pain in his stomach. - Sensation of a small ball bouncing inside his stomach. -Feels a strong pressure in his head.
10. Oscar	-Feels boredom, wants to relax and to 'go out' go to 'other places.' -Feels irritated about everything. -Does not want to talk to anybody.	-Feels tiredness and lack of energy.	-He feels 'spaced out' and muddle-headed. Experiences difficulty concentrating.	-Headaches. Feels his nerves are upset. Feet and body cold.
11. Rosita Her distress had elapsed when interviewed	Doesn't feel like doing anything. Fears that something bad is going to happen to her.	-Feels tiredness. -Feels body weakness and a general lack of energy.	Does not report.	-Feels pain in the brain. -Feels her muscles are stiff and hard. -Fingers are temporarily paralyzed. Lack of air, feels as if her 'nerves' jump to her colon, Feels cold, memory loss; feels as if she was 'gone.'
12. Gladys	-Feels like being cornered. -Feels irritated.	-Feels tiredness and a lack of energy, also excessive exhaustion.	Does not report.	-Feels pain in the nape, neck and shoulders. Headaches.

C: Symptoms of other forms of distress

	Affective Symptoms	**Vegetative Symptoms**	**Cognitive Symptoms**	**Somatic Symptoms**
13. Cesar His distress had elapsed when interviewed	Cries often. Feels desperation.	Does not report.	Does not report.	Pain in his heart, feels his heart is hard. Feels tense and dizzy.
14. Johnny His distress had elapsed when interviewed	Does not report.	Does not report.	Does not report.	Feels stomach aches.

Annex6

Interview schedule: Key Informants

1) What are your duties and responsibilities? For how long have you been working here?

2) Can you tell me how long ago did you start to notice foreign users coming to the clinic?

3) How big is the population of migrants that come to this clinic? Have migrants changed since they first came here? If so how?

4) Is there any formal or informal occasion where the issue of migrants is discussed?

5) Does your program/unit keep records that are differentiated according to nationality?

6) How would you characterise the migrants that come to the clinic? Regarding
   - Schooling, origin (urban/rural)
   - Cultural aspects, traditions, habits, values beliefs
   - In their relation to their bodies and health
   - Their reproductive behaviour
   - Sexuality, partner relationships
   - Interaction with the healthcare providers
   - Epidemiological profiles

7) Now I would like to discuss patients specifically in family planning. Is there any particular issue about Peruvianpatients that you have noticed and you would like to comment about?

8) And what about antenatal care? Is there anything in particular that you notice is different among Peruvian migrants?

9) Do you think that the life and work conditions and their family situation have any influence on their reproductive health? If not, why not? If yes, in which way?

10) How would you characterise the relationship between healthcare providers and Peruvian Patients? What difficulties exist?

11) Has there been any change or modifications in the healthcare provider to respond to the particularities of migrant patients? Regarding:
   - Time schedule and appointments
   - Registration
   - Protocols
   - Norms
   - Staff number and training
   - Stock and diversification of resources offered (e.g. variety of contraceptive methods)
   - Other

12). If any, how were these changes implemented?

13). Are there follow-up mechanisms for these patients?

14). How do you envisage the provision of care for foreign populations in the future? What changes should be introduced in the care provided?

15) Do you think the healthcare provided should change in any way to incorporate cultural or national differences, if so, how?

Annex7

Interview schedule to be conducted with migrant female patients of family planning programs and antenatal care

My name is Lorena Nunez, I am a social anthropologist. I am writing my doctoral thesis on issues of Health and Migration; I am studying at the University of Leiden in Holland. This clinic has authorised me to conduct this interview. This interview aims at learning about the needs of care of the foreign users of family planning programs and antenatal care. Your identity will be kept in anonymity and what you share with me in this interview will help to improve the quality of healthcare in these services.

Clinic N°…….

A. Identification

a. Name: .....
b. Age:.....
c. Place of origin in Peru:..... .....
d. Year of arrival in Chile (first time),..... Have you moved back to Peru since then?....
e Year of last arrival in Chile.....
f. Contact telephone number:.....
g. Address .....

Program: Family planning **Antenatal care:**

B. Education: What is the last course that you completed?

1. primary incomplete		5. technical level incomplete	
2. primary complete		6. technical level complete	
3. secondary incomplete		7. university level incomplete	
4. secondary complete		8. university level complete	

C. Conjugal status

Marriage status	Conjugal situation in Peru	Conjugal situation in Chile
1.Single	1.Living together, partner in Peru	1.Living together in Chile, partner in Chile
2.Married	2. Husband living in Peru	2. Living with husband in Chile
4.Widow		
5.Separated		
6.Living together		

D. Number of Children

0.....
1.....
2.....
3.....
4.....
5 and more.....

E. Place of residence of Children

1.All the children are living in Chile.....
2.The children are living in Chile and Peru.....
3.All the Children are in Peru.....

F. Work situation

1. Working for an income.....
2. Seeking employment.....
3. Not working.....
4. Type of activity.....

G. Work contract Yes..... No.....

H. Health Insurance Yes..... No.....

I. Visa situation

Visa expired - irregular..... Residence Visa.....
Tourist visa..... Temporal Visa.....

I. Background

1. At what age did you have your first baby?
2. When did you start to *cuidarse (use contraceptive method*), before or after your first pregnancy?

II. Use of Contraceptives and Healthcare in Peru

3. What methods did you use in Peru? (Ask for all the methods used, traditional or modern)
4. (If more than one method) Why did you stop using a method and change to another one? 5. Did you fall pregnant using any of these methods? Which method were you using?
5. What method were you using before you came to Chile?
7. Who recommended that method to you? What were you told about this method? Do you know somebody that has used this method?
8. Do you know how this method works? How does it avoid pregnancy?
9. What are the good and bad sides of using this method?
10. Did you attend medical consultation for the contraceptive method you were using in Peru? How often?

III. Use of Contraceptive Methods in Chile:

11. What happened when you moved to Chile? Did you continue using a method? Which one?
12. What methods have you used in Chile? (If more than one method, why did you change methods each time?)
13. Did you fall pregnant using any of these methods? If so why do you think that it happened?
14. Who did you ask in Chile about the methods you could use? Where have you requested contraceptive methods? (Clinics, Chemist, other)

A. For women in family planning programs *ask questions in present tense*
B. For pregnant women *ask question is retrospective*

15. What method are you using now? / Where you using before you fell pregnant? Where did you obtain this method?
16. Why did you decide to use this method? Where you offered other alternatives? Did you ask for another method?
17. How do you feel with this method? What are the positive and negative sides of this method?
18. What have you heard about this method? What have you been told about this method? Is there any family member or friend using this method?
19. Could you explain to me how this method works in your body that you don't fall pregnant?
20. If you could choose, would you change methods? To which method would you change? Why do you prefer to use that other method? Have you tried to request that method you prefer? And what has happened?
21. If you need more information about methods or any other issues related to your reproductive health, whom do you normally ask? Or don't you ask anybody?

Questions to ask pregnant women

21. For those pregnant women who did not plan a pregnancy; do you think you would have fallen pregnant if you were in Peru? Why?

IV. Healthcare in Chile

22. Do you attend your medical check ups regularly in Chile?
23. If not, when was the last time that you came for a check up? Why did you not attend regularly? Have you expressed to anybody at the clinic, the problems you have had to attend the check ups?
24. In the care that you are given in the Clinic, do you perceive that you are treated differently to the Chilean user or the same?
25. Have you felt discriminated against? If so, how has that affected you?
26. How would you define your relationship with the midwives, with the paramedic, and the registration personnel?
27. What is the feeling you usually experience when you come to the consultations (calmed, tense, afraid, relaxed, and preoccupied, or with embarrassment). Can you tell me why you feel that way?

28. Is there anything that you would like to talk to the midwives about and have not been able to do so? Why has that happened?
29. Have any of the healthcare providers you have interacted with asked you about your personal life, or your problems? If that has not happened would you like that to happen?
30. What are the differences that you perceive to exist between Peru and Chile regarding healthcare?
31. Have you travelled to Peru for health reasons? Once you are there do you normally consults with doctors?
32. Do you feel part of the Chilean society? Why?

Curriculum Vitae

Lorena de los Ángeles Núñez Carrasco is a Chilean national; she was born in Santiago on the 30th of May 1964. Her Secondary Education was conducted at Liceo de Niñas N˚7, in Santiago (1978-1981). She obtained her honours degree in Social Anthropology in the Faculty of Social Sciences, Universidad de Chile, in Santiago (1983-1987). She is Master of Arts in Development Studies with emphasis on Women and Development. Her MA degree was obtained at the Institute of Social Studies (ISS) in The Hague, The Netherlands (1991-1992). Her ISS study was facilitated by a scholarship awarded by NUFFIC.

As a social anthropologist Núñez has extensive experience in the fields of gender and development and of international migration, health and culture. She implemented and managed development programs for women in income generating activities as well as the promotion of their political participation in Chile, where she also conducted research and training for women's leadership programs. Over the last years Núñez has been working in the field of culture and health among ethnic groups and international migrants. Her PhD research was on social exclusion and its impact on mental and reproductive health among international migrant workers, and was conducted at the University of Leiden in The Netherlands, through a scholarship awarded by WOTRO. She is at present a post doctorate fellow at the Forced Migration Studies Programme, at the University of the Witwatersrand in Johannesburg, where she is currently involved in developing the health and migration initiative.

Publications

Books

"*A Contramano, El Impacto del Programa de la Escuela de Lideres"*. Instituto de la Mujer, Santiago, 1997. Co-authored with Victoria Hurtado, Guadalupe Santa Cruz, and Alejandra Valdés.

"*Calidad de Atención en Salud Reproductiva; Un Análisis basado en la Perspectiva de Genero*". Pan American Health Organisation (PHO) Santiago, 1996. Co-authored with Fanny Berlagosky, Gloria Salazar, and Marisa Matamala.

Chapters in books

"En el Perú nadie se muere de hambre; pérdida de peso y prácticas de alimentación entre trabajadoras domésticas peruanas en Chile". In: *El Quinto Suyo, Transnacionalidad y Formaciones Diaspóricas en la Migración Peruana*". Edited by Ulla Berg and Karsten Paerregaard. Co-authored with Dany Holper. Published by IEP (Instituto de Estudios Peruanos), Lima 2005, 291-313.

¿Transnacionales o sobrevivientes? migracion Andina a Chile durante los noventa. In: *Annuario Chile 2003-2004. Los nuevos escenarios (inter) nacionales*. Edited by Carolina Stefoni, FLACSO, Santiago, 2004.

"Feeding bodies nurturing identities: The significance of food for the well-being of

Peruvian migrants in Chile". In: *Medical Anthropology Conference of the European Association:* Edited by Van Dongen E. and Comelles, J. "Medical Anthropology at Home; Welfare and Political Engagement", Perugia, 2004.

"Peruvian migrants in Chile".In: *Transnational Identities: a concept explored - The Andes and beyond*, *Part I*. Edited by Salman T. & Zoomers A. *CEDLA Cuadernos* 11, Amsterdam, 2002, 61-72.

"Possibilidades de combinar familia y trabajo en familias trabajadoras". In: *Políticas de Igualdad de Oportunidades entre Mujeres y Hombres en el Trabajo 1994-1999.* International Labour Organisation (ILO), Santiago, 2000. Co-authored with Francisca Marquez.

"Historias de Vida de Mujeres Lideres en Chile". In: *Veredas por Cruzar.* Instituto de la Mujer. Santiago, 1997.

"Calidad de la atención, en salud reproductiva: una perspectiva de genero". In: *Mujer, Salud y Desarrollo.* Panamerican Health Organisation (PHO) Santiago, 1995. Co-authored with Fanny Berlagosky, Gloria Salazar and Marisa Matamala.

Articles in Peer Reviewed Journals

"Clashing concepts of legal status among working and middle class Peruvians in Chile and the United States". Paper submitted to the Journal *Latin American Perspectives*. Co-authored paper with Elena Sabogal.

"Consideraciones en torno a la salud mental en la población migrante Peruana en Chile". In: *Revista de Psicología y Ciencias Humanas, Praxis Nº 7*. Edited by Ricardo López P. Jenny Radovcic A. Universidad Diego Portales, Santiago, 2005.

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