University of Amsterdam

UvA-DARE (Digital Academic Repository)

The cultural construction of women's aging

Confronting meanings, experiences, and practices in early 21st century Chile

Donoso Orellana, C.

Publication date
2023

Document Version
Final published version

Link to publication

Citation for published version (APA):
Donoso Orellana, C. (2023). *The cultural construction of women's aging: Confronting meanings, experiences, and practices in early 21st century Chile*. [Thesis, fully internal, Universiteit van Amsterdam].

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: https://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

UvA-DARE is a service provided by the library of the University of Amsterdam (https://dare.uva.nl)

Download date:10 Mar 2023

THE CULTURAL CONSTRUCTION OF WOMEN'S AGING

Confronting Meanings, Experiences and Practices in the Early 21st Century Chile.

The Cultural Construction of Women's Aging

Confronting Meanings, Experiences, and Practices in Early 21st Century Chile

ISBN: 978-94-6419-703-7

Printed by: Gildeprint - Enschede

Cover by Carla Donoso Orellana

Cover Fotography: Los Muertos Crew. Free licence.

This study was funded by the ANID Becas Chile , Beca de Perfeccionamiento Academico Universidad de Concepción and University of Amsterdam.

Donoso C. (2023). The cultural construction of women's aging. Confronting meanings, experiences and practices in early 21st century Chile. PhD Thesis. Uniiversity of Amsterdam, Amsterdam, The Netherlands.

The Cultural Construction of Women’s Aging

Confronting Meanings, Experiences, and Practices in Early 21st Century Chile

ACADEMISCH PROEFSCHRIFT

ter verkrijging van de graad van doctor
aan de Universiteit van Amsterdam
op gezag van de Rector Magnificus
prof. dr. ir. P. P. C.C. Verbeek
ten overstaan van een door het College voor Promoties ingestelde commissie, in het openbaar te verdedigen in de Agnietenkapel

op 8 februari 2023 om 13 uur

door Carla Donoso Orellana

geboren te Rengo

Promotiecommissie:

Promotor: prof. dr. A. P. Hardon Universiteit van Amsterdam
Copromotor: Dr. E. I. G. Sanabria Cermes3

Overige leden:

dr. H.J. Hiddinga	Universiteit van Amsterdam
dr. K. Krause	Universiteit van Amsterdam
prof. dr. A. Mol	Universiteit van Amsterdam
prof. dr. R. Reis	Universiteit van Amsterdam
prof. dr. W.H.M. Jansen	Radboud Universiteit Nijmegen

Faculteit der Maatschappij- en Gedragswetenschappen

Table of Contents

Acknowledgments i

Introduction 10

Menopause as a Marker of Female Aging: The Biomedical View 15

Agency: a Feminist Perspective on the Use of HRT 18

Menopause and Aging From an Anthropological Perspective 20

Aging, Gender and Power 22

Varying Experiences of Menopause 24

Meanings, Practices and Experiences on Menopause and Aging in Chile 27

The Chilean Health Care System 30

Dealing with Menopause: Women's Experiences 33

Menopause as Research Problem 35

Overview of the Chapters 37

Chapter 1. Research Methodology 40

Class as Prism 44

Autoethnography of Doing Yoga 47

Research Techniques 49

The Process of Research 52

Limitations of the Research Design 53

Using Textual and Visual Sources in Ethnographic Research 54

Data Analysis 56

Chapter 2. Public Policies Regarding Menopause and Aging 58

The Development of the Health Care System in Chile 59

Chile's Two Health Care Systems 63

Public Health in Chile from the 1800s to the 1970s 63

Pinochet and Privatization 65

21st- Century Reforms 68

Public Policies for the Elderly in Chile 70

Description and Analysis of the Public Health Policies on Aging 73

Chapter 3. The Biomedical Discourse on Aging and Menopause in Chile **78**

Dicourses on Menopause and Aging in Academic Papers 82

The Physicians'Perceptions on Menopause and Aging 89

Chapter 4. Mass Media Representations of Female Aging **98**

Press Review 102

Representations of Menopause and Aging in a Chilean Soap Opera 107

The Counter Example: The Film Gloria 111

No quiero Envejecer (I Don't Want to Get Old) by Pilar Sordo 113

Chapter 5. Social Class and the Bodily Experience of Aging **118**

Women's View on Menopausal Complaints 119

Body Perceptions on Aging 123

Aging and Sexuality 127

Are There Emerging Views on Female Aging? 129

Chapter 6. Looking for Alternative Paths: Why Aging Women Turn to Yoga **132**

The Experience of Doing Yoga 137

Conclusion **150**

Bibliography **156**

Appendix **180**

Summary **184**

Samenvatting **188**

List of Tables and Figures

Table 1. Field of specialization and gender of interviewed physicians 51

Table 2. Press sources 55

Table 3. Content of scientific papers reviewed 83

Table 4. Frequency and percentage of topics addressed in press 103

Table 5. Examples of headlines on menopause and aging in Chile 104

Figure 1. Word cloud of press review 2008–2017 106

ACKNOWLEDGMENTS

I want to thank all my colleagues and friends who helped me along the way of writing my dissertation. First, I am grateful to my supervisor Prof. Dr. Anita Hardon for her patience and support. Her enthusiastic and yet critical reading of my work was an incentive that kept me going in the most challenging times. My co-supervisor Dr. Emilia Sanabria provided me with invaluable help in improving my dissertation. Her comments, questions, recommended readings, and careful reviews were key in advancing my work in a way that I could not have imagined. I am also very grateful to Prof. Dr. Alex Edmonds who helped me clarify my ideas and research at an early stage of my project. I also acknowledge the committed support of a great team at the University of Amsterdam, especially Hayley Murray and Janus Oomen who helped me with all kinds of administrative procedures.

I also want to acknowledge the support and encouragement of the administrators, faculty, and students of the University of Concepción, Chile, where I proudly worked for 13 years as Assistant Professor. In the University of Concepción, I found the right place to nurture my ideas and projects within an environment of intellectual freedom, commitment, and cooperation. Those years are treasured in my heart as a transformative experience. I am also very grateful to the AISSR of the University of Amsterdam, the University of Concepción, and the Chilean Government Postgraduate Fellowship (Beca Chile) of the National Commission for Science and Technology (CONICYT) for the financial support that made this research project feasible.

I want to thank my research assistants, Carola Salazar, Fernanda Morales, Ingrid Gonzalez, and Joanna Donoso, who helped me put together all the data I needed to conduct this research. Particularly in the early stages, when I was facing the challenges of motherhood, their help was pivotal to my ability to continue my research. I am also very thankful to Erin Martineau and Alex Ross who patiently helped me with the proofreading and editing of my dissertation.

I am grateful to my family and close ones for all their support, patience, and trust all these years. Thank you all for providing me with the energy, care, and love I needed to keep going. Emiliano, and Amaru, I hope to make up for all the moments of fun and joy that I missed while working on this thesis. Sebastian, thank you for helping me in all sorts of matters, and for your support and help with writing and translation. I am deeply thankful to my family in the Netherlands that supported me in the most difficult times: Cecilia, Felix, Ayten, Romina, Luisina and Gabriel.

I also want to thank all the women, medical professionals, friends, and acquaintances that shared their stories with me. I am confident that I have made proper use of all the material with which you have entrusted me.

INTRODUCTION

I

This research explores the meaning of women's aging within contemporary Chilean society. When I started this research project, there was a popular expression that resonated in my mind: "*vieja menopáusica*" (menopausal old bitch), which is widely used to dismiss older women in Chile, and is even commonly used by young women. This expression conveys a deep rejection of the female process of aging. Any woman in her forties or fifties who displays an angry or bitter attitude or lacks the willingness to be polite or to please others belongs to the category of "menopausal bitch." Any unexpected behavior of middle-aged women that does not comply with social norms is easily attributed menopausal mood changes. As an anthropologist born and raised in Chile, this view seemed somehow natural to me for many years. It was such accepted wisdom that older women behaved in a strange manner when becoming menopausal that I do not doubt that I used that expression myself in the past.

However, when my mother entered her fifties, my view started to change. I became worried about her health, not knowing how the process would affect her. I was afraid of seeing her undergo what I thought would be horrible mood changes and physical pain. My perspective on menopause started to change; the naturalized phrase "menopausal old bitch" came to sound violent and undermining. I realized that despite defining myself as a feminist anthropologist, I had never asked to what extent Chilean feminists had built their agenda around the needs of younger (heterosexual, sexually and reproductively active) women. Older women were—and I believe still are—invisible to feminists, social scientists, and political activists. The only ones who seemed to care about their needs were health care professionals.

My initial reflections on the phrase "old menopausal bitch" led me to a couple of questions: If what is believed to be a bitter, complaining attitude of older women is socially condemned, what is deemed a socially appropriate attitude for an aging woman in Chile? What is the expected social behavior of older women? These questions have driven me along this research project, and it has proven a difficult one because meanings and practices change and overlap.

In the process of developing the research problem, I conducted a review of the available literature in Chile and Latin America, which showed that research on menopause and aging had been dominated by a medical view published widely in Chilean medical journals. This medical view posits that menopause and female aging are health conditions that can be treated with the help of hormonal replacement therapies.

In the Western world, menopause has been defined by biomedicine as an endocrine deficiency, the result of the progressive decrease of hormonal levels produced by the ovaries. It is further understood as a universal event that every woman faces in midlife, and it is believed to lead to the "de-feminization" and "deterioration" of the female body. Since it comprises the ending of the menses, and thus an end to reproductive life, menopause has also been understood as a universal turning point in women's lives (Ringa, 2000). In the second half of the twentieth century, hormonal replacement therapy started to be widely promoted as the best available treatment for the "disease" of menopause.

However, this understanding of menopause was criticized by reports of increased cancer risks associated with the use of hormonal therapies, as well as their limited benefit in preventing other medical issues such as coronary diseases and osteoporosis (Writing Group for the Women's Health Initiative Investigators, 2002). In addition, feminists have questioned the portrayal of menopause as a medical issue that demands the intervention of a patriarchal medical system (Guillemin, 2000).

As Meyer (2001) points out, this medical view of menopause involves the medicalization of women's aging. The concept of medicalization has been widely used to account for the process by which phenomena increasingly become seen as medical problems when they were not considered such before. Clarke and colleagues (2010) point out that "in the United States, the concept [of medicalization] gradually extended to any and all instances when new phenomena were deemed medical problems under medical jurisdiction from infertility to hyperactivity and so on" (p. xxxii). According to Riska (2010), the concept of medicalization is anchored in labeling theory and its analysis of social control; studies of medicalization in the 70's centered on patients and their lack of agency as a result of the new moral power of medicine. The way hormonal replacement therapies have been prescribed to women as the best way of dealing with menopause may be understood as the medicalization of menopause (Martin, 1986; Guillemin, 2000; Meyer, 2001). Hormonal replacement therapies are not only promoted as a form of coping with menopausal complaints but as a treatment that may enhance women's performance, particularly in the sexual domain. This phenomenon exemplifies what Clarke and colleagues call "biomedicalization" (Clarke et al., 2003; Clarke et al., 2010).

According to Clarke and colleagues (2010), in the last decades, medicalization underwent a transformation that resulted in a different model they term "biomedicalization." The concept of biomedicalization "is concerned with our growing capacities to control, manage, engineer, reshape, and modulate the very vital capacities of human beings as living creatures" (Clarke et al. 2010, p. xx). Explaining this term, the authors write:

> the addition of "bio" to medicalization signals the increasing importance of biological sciences to biomedicine—the life sciences and technologies broadly conceived as institutions, sets of practices, sites of knowledge production, implementation, and application. Second, the bio signals that questions of biopower and biopolitics are integral to our project. (Clarke et al., 2010, p. xvii)

While medicalization practices tend to emphasize exercising control over medical phenomena, biomedicalization practices are focused on transformations of such medical phenomena and bodies through technoscientific interventions intended not only for treatment but also progressively for enhancement (Clarke et al., 2010).

Riska (2010) asserts that this biomedicalization thesis relies on poststructuralist theory, especially Foucault's theorization of technology, biopolitics, and the self (Foucault, 1988). She argues that analyses of medicalization have seemed more concerned with the idea of victimization and empowerment strategies to confront medical power; in contrast, biomedicalization analyses take a more relativistic view (Riska, 2010). As Riska puts it "the representatives of this thesis tend to propose that biomedicine and technoscience construct a hyper-reality that obscures boundaries between agency and the target of this new kind of medicalization" (p. 122). Still Clarke and colleagues caution against thinking of

biomedicalization as a process that leaves medicalization behind; instead, medicalization should be understood as a phenomenon that exists under particular political and institutional circumstances. Therefore, the concept of biomedicalization allows examining how women adopt or resist the use of hormonal replacement therapies according to their views, expectations, and priorities. It would be misleading to reduce their relationship towards biomedical treatment only in the language of oppression, without taking into account their agency in the decision making.

Like Clarke and colleagues (2010), Lock and Nguyen (2010) point out that biomedicine is not the same everywhere; it is not a monolithic institution but subject to change and variability. They define biomedicine as increasingly consisting of "ever-changing assemblages of technologies that include both the apparatus of biomedical research and the dissemination of the resultant knowledge as technological practices organized in a transnational space linked to what many describe as 'global capital'" (Lock & Nguyen, 2010, p. 360). The assumption of the global applicability of biomedical technologies is based on the illusion of the universal body for which biomedical technologies are perceived as neutral. However, they bring unexpected consequences because they have uneven impacts on people living in diverse societies. The uneven use and results of biomedical technologies are not only linked to global economic inequalities (which result in either constraining or privileging conditions) but to the fact that the material body "is not everywhere the same, and there are local biologies that determine disease susceptibility, symptomatology, and response to treatment and medications" (Lock & Nguyen, 2010, p. 362).

According to Clarke (2010) the study of biomedicalization in different geopolitical sites requires anticipating and addressing a set of complications that may arise in such a project. First, biomedicine must be clearly defined, while also acknowledging the existence of other medical systems and without mixing them. Secondly, a study must account for the complex histories of imperialisms, colonialisms, and postcolonialisms and how these intersect, producing and shaping medicines and approaches to healing. For instance, medicalization may be an essential part of a colonization project or resistance to cultural domination and may materialize in the defense of indigenous medical systems. The third complication relates to the fact that there are no direct translations for the rise of medicine, medicalization, and biomedicalization as the notions are defined in the U.S. case. Each will have different meanings and characteristics (if present at all) across places and times. Therefore, empirical research should be used to define these processes in a particular place and time.

A fourth complication has to do with the boundaries between biomedicine and public health, which are recently troubled by the biomedicalization of public health. Clarke and colleagues (2010) caution that public health is increasingly relying on high tech biomedicine, which is transnationalizing and becoming "the global response" to specific health issues.

Relatedly, a fifth complication involves reflecting on biomedicalization in its transnational travels, creating linkages between (bio)medicine and modernity or modernities. Consumption of medical technology and the lack thereof often entangle with issues of personal, collective, and even national identities. Advertisements for medical technology in the mass media and on the Internet represent biomedicine as

modernity. Clarke and colleagues (2010) even assert that "in some ways, biomedicine is modernity 'in translation'" (p. 341). Overall, Clarke and colleagues (2010) suggest that "biomedicalization" should be handled as a keyword, that is, a concept whose meaning changes depending on the time, circumstances, and location.

In addition, Clarke and colleagues (2010) suggest the use of the concept of "healthscapes" to describe grand narratives in the social history of health and medicine. This concept should take into account who is involved in the practice of medicine, which sciences and technologies are in use, how the media represents medicine, and what are the political and economic elements and the ideological and cultural framings of health, illness, health care, and medicine. In the U.S. context, Clarke and colleagues (2010) identify three main healthscapes: the rise of medicine, medicalization, and biomedicalization, which may not apply to other sociohistorical settings. She also cautions that the resistance to medical practices and medicalization may also configure what she calls "oppositional healthscapes." Therefore, the study of a particular healthscape should also include an examination of countertrends. Such a framework is closely related to the concepts of medical pluralism and medical partialisms, which help shed light on "other" forms of healing and medicines. Nevertheless, Clarke and colleagues (2010) also note that biomedicalization in the U.S. has facilitated the integration of complementary and alternative medicines, such as chiropractic and acupuncture, which have become part of the history of American medicine.

Clarke and colleagues (2010) define "healthscapes" as traveling assemblages:

> of infrastructures of assumptions as well as people, things, places, images. Healthscape is a framing concept that provokes both "thick description" (Geertz, 1973) of a particular place and era and simultaneously captures the traveling potentials of "things medical" across transnational/global flows (p. 60).

In order to grasp the study of healthscapes, she borrows the science and technology studies method of "following the thing." For instance, to analyze the networks and arena of action of a particular medical technology, one should pay attention to the way it is produced, distributed, advertised, and consumed transnationally. Such a strategy should provide an empirical base to theorize the transnationalization of "things medical" in a more grounded and local-practice mode. Following the model of the U.S. healthscapes, Clarke and colleagues (2010) point to historical charts that gather a wide range of images from cultural and geopolitical zones of interest that give shape to particular healthscapes, which in turn may facilitate comparative research.

Furthermore, Lock and Nguyen (2010) call for the implementation of a radical new approach to studying biomedicine, one that transcends disciplinary boundaries in order to question unexamined assumptions, seeks to reduce inequalities and, at the same time, pays attention to local voices and local situations both biological and social. One of the challenging aspects of this research was to determine the specific features of the biomedicalization of menopause and its links to particular historical, economic, and political circumstances that configure specific healthscapes.

In this thesis I examine this coexistence of the medicalization and biomedicalization of menopause and female aging in Chile, and the tensions and frictions these divergent views. By looking into the historical and political evolution of the health care system in

Chile it is possible to understand the particular features biomedicalization has acquired in Chilean society within a specific healthscape. The development of a centralized health care system (which later becomes increasingly privatized), the ambiguous role played by medical associations when it comes to defending public health care, and the mixing of authoritarianism and respect toward the female clients in a private system are particular features of the biomedicalization of female aging in Chile. This process cannot be examined by dichotomizing medicalization and biomedicalization but by interrogating the complex ways in which they coexist and overlap with each other and how they find expression in practices—such as medical guidelines and prescriptions—as well as the meanings and experiences that women recount regarding being medically treated for menopause and aging.

Menopause as a Marker of Female Aging: The Biomedical View

As mentioned before, in Western biomedical literature, menopause has been defined as a medical condition caused by an estrogen deficiency or an ovarian dysfunction (Beyene, 1986). In industrialized societies, menopause has been assumed to have adverse effects on aging women. More recently, menopause has been also defined as a risk factor for osteoporosis (Sánchez- Ramírez & Alvarez-Gordillo, 2008). In fact, menopause is indexed in the International Classification of Diseases of the World Health Organization, defined as:

> a condition affecting females, caused by the loss of ovarian follicular function and decline in circulating blood oestrogen levels. This condition is characterized by the cessation of menstruation, hot flushes, atrophic genital changes, psychophysiological effects, and bone loss.
>
> Confirmation is by taking a patient history to determine psychophysiological effects such as the presence of amenorrhoea, and identification of hypooestrogenemia and elevated serum FSH levels in a blood sample. (World Health Organization, 2018, para. 2)

This definition assumes that menopause is a problem of hormone deficiency and therefore constructs hormonal replacement therapy (HRT) as the best solution to this problem. Categorized as a disease state, menopause is reduced to a set of specific symptoms requiring diagnosis and therapy (Guillemin, 2000).

According to Banks (2002), contemporary HRT for menopause has as precedent the ancient practice of organotherapy, which later led to the idea that the ovaries were the ultimate cause of "feminine" identity. In the nineteenth century, scientists became aware of the role played by the ovaries in shaping the secondary sexual characteristics in females and therefore their role in constructing the differences between men and women. Banks (2002) quotes the prominent pathologist Ludwig Virchow, who stated in 1848 that "all that we admire and respect in woman as womanly, is merely dependent on her ovaries" (p. 4).

According to Oudshoorn (1990), it was at the beginning of the twentieth century that the prevalent theory of internal secretions was replaced by the concept of hormones. Oudshoorn (1990) points out that British physiologist Ernest H. Starling reformulated this theory, defining hormones as chemical messengers that carried information from the organ where they were produced to the organ they were supposed to affect; the message transmission was believed to be carried out by the blood. At the turn of the

century, scientists began to look for the chemical substances contained in the sex glands, using the procedures of castration and transplantation, which later was substituted by the chemical extraction of the gonads. The chemical substances believed to produce in the sex glands were labeled as sex hormones: the male sex hormone was produced by the testes, and the female sex hormone produced by the ovaries. Oudshoorn (1990) asserts that this terminology created a sexual duality: sex hormones were defined as the chemical producers of masculinity and femininity.

According to Banks (2002), the chemical identification of estrogens helped the development of pharmacologically active hormonal therapy for menopausal women. This treatment was used for the first time in the late 1920s. At that time, ovaries were no longer considered the ultimate explanation for femininity and health; instead, estrogen was understood as the source. Therefore, scientists began to define menopause and aging as an estrogen deficiency disease (Banks, 2002). The idea that female sex hormones could be handled by pharmacological technology offered the promise of greater medical control over women's complaints, which were previously understood as linked to ovaries malfunctioning. This was the case for alignments in menstruation and several nervous diseases. According to Oudshoorn (1990), by linking women's symptoms regarding menopause to female sex hormones, gynecologists managed to maintain control over "women's problems." Following Latour's (1987) approach to studying science in the making, Oudshoorn (1993) points out:

> hormonal drugs are neither ready-made laboratory products that are subsequently marketed to their audiences, nor are they compounds simply discovered in nature. I will show how the shaping of hormonal drugs into the products we know today took place, not prior to, but during the marketing of these products, in a process that served the needs both of the pharmaceutical industry and the medical profession. (p. 7)

Despite attempts to market sex hormones during the 1930s, which involved the continuous trials of hormonal formulas in both the laboratory and the clinic, it was not until the 1960s that hormonal therapies became broadly known and generally prescribed in the developed world (Banks, 2002). In the 1960s, female sexuality became part of the menopause "problem" that could and should be medically treated in order to improve women's sexual response. In the U.S., gynecologist Robert Wilson played a key role in promoting the use of HRT, which he called a "biological revolution" (Wilson, 1966). According to him, the first users of hormonal therapy were "different in one vital aspect from any other woman since the beginning of the human race: they will never suffer from the menopause. They are the lucky ones who have benefited from the new techniques of menopause prevention" (Wilson, 1966, p. 17). Wilson (1966) called menopause a "female castration" and asserted that women have the right to stay "feminine forever." He also argued that women should take estrogen not only for their own wellbeing but also to ensure that they will have a happy marriage. According to Wilson, the need to remain sexually active, to maintain sexual attractiveness, and to avoid marital quarrels arising from menopausal mood changes could be all met with hormonal therapies to counteract hormonal production deficiency (Wilson, 1966).

The connection established by Wilson between hormone therapy and the preservation of female characteristics and active sexual functioning was persistently reproduced in both lay and scientific publications. In addition to medical journals and the

lay press, several clinical trials reinforced the idea that sexual functioning is an important marker of the health of menopausal women. This association has persisted, and it is found in the most up-to-date scientific literature. For instance, several studies have aimed at establishing how age influences sexual functioning and the extent to which HRT improves sexual performance, including aspects such as orgasm, lubrication, and pleasure. Several research projects concluded that estrogen helps to maintain healthy genitals, which consequently has a positive influence on mood and sexual satisfaction.

Those research findings have been made public worldwide in the most prestigious scientific journals (Ramírez, 2006).

The publication in 2002 of a report by the Women's Health Initiative (WHI) was a turning point in the expansion of hormonal replacement therapies for menopausal complaints. For decades, physicians had prescribed both estrogen replacement and estrogen/progestin therapies, not only to treat vasomotor symptoms but also as a preventive measure against medical conditions such as heart disease and osteoporosis. In 1991, a large-scale set of clinical trials and an observational study was started in the U.S. to evaluate the long-term effects of HRT. With a sample of 161,808 mostly healthy postmenopausal women, the clinical trials were designed to test the effects of postmenopausal hormone therapy on heart disease, fractures, and breast and colorectal cancer. The trial had two sections: an estrogen-plus-progestin study of women with uteruses, and the estrogen-alone study of women without uteruses (Women's Health Initiative, 2010). In both studies, a case-control methodology was implemented, and women were randomly distributed into two groups: a group receiving the hormone treatment under study or the placebo group (Women's Health Initiative, 2010). The trial of estrogen plus progestin was suddenly stopped before completion when the assessment of the overall health risks (including breast cancer) proved to exceed the expected benefits of the research outcomes (Chlebowski et al., 2003).

In 2002, the WHI published its conclusion that hormone therapy is not an effective treatment to prevent heart disease, and halted various WHI studies due to the worrisome evidence that exposure to HRT may involve serious health risks for women. According to the WHI research:

> relatively short-term combined estrogen plus progestin use increases incident breast cancers, which are diagnosed at a more advanced stage, compared with placebo use, and also substantially increases the percentage of women with abnormal mammograms. These results suggest estrogen plus progestin may stimulate breast cancer growth and hinder breast cancer diagnosis. (Chlebowski et al., 2003, p. 3243)

More than 15 years after the publication of the WHI report, the scientific community has not reached consensus on the risks involved in HRT. Medical opinion and menopause research have produced mixed and sometimes conflicting results about the safety and efficacy of HRT. After the publication of the WHI report, scientists and representatives of the pharmacology industry questioned the scientific standards of the WHI research. Some of the objections were related to its sampling procedures: it was claimed that the harmful side effects found in the WHI research related to the fact that some women enrolled in the study were older than 60 and, therefore, the sample did not represent the actual age at which women start HRT. Also, it was claimed that the WHI report was misunderstood

by the lay audience, especially when assessing the real risk of developing breast and endometrial cancer (Sánchez-Ramírez & Alvarez-Gordillo, 2008).

Nevertheless, a considerable number of women worldwide stopped using HRT after the publication of the report (Ettinger, Grady, Tosteson, Pressman, & Macer, 2003).

Since 2002, a great deal of research to assess the actual safety of hormonal therapies has been conducted. Currently, the need for reducing the use of hormonal therapy is widely recognized by the scientific community. The dosage level has tended to decrease since the publication of the WHI outcomes. The notion that HRT should be only used by women in desperate need to reduce the impact of menopausal symptoms has become mainstream.

According to the U.S. Food and Drug Administration, HRT is an approved therapy that may help relieve hot flushes, night sweats, vaginal dryness, and dyspareunia (pain during sexual activity), and may reduce the chances of getting osteoporosis. The FDA advises taking HRT at the lowest dose that helps and for the shortest period that is needed to reach expected results (FDA, 2018).

In recent years, research on osteoporosis has become a new site for the promotion of HRT. Before the 1940s, osteoporosis was believed to be an atrophic condition related to old age, which could manifest in any individual regardless of his or her sex. Since then, osteoporosis has been redefined from a condition of old age to a gendered medical condition mainly associated with menopausal women. Nowadays, technologies for measuring bone density are being used in screening for osteoporosis, even among asymptomatic menopausal women with no bone- associated complaints (Guillemin, 2000). According to Guillemin (2000), the screening of osteoporosis is nowadays a standard procedure in menopause clinics in a way that seems to conveniently associate it with the promotion of HRT as a preventive measure. Guillemin (2000) writes: "when women attend menopause clinic seminars or complete preclinic questionnaires they are left expecting to have their hormone levels tested, and if deemed to be low, to have hormone replacement prescribed" (p. 465). In practice, such procedures imply that "women seeking information about contracting osteoporosis end up bewildered at being prescribed long- term HRT" (Guillemin, 2000, p. 465).

In sum, the development and marketing of hormonal replacement therapies are not only a matter of laboratory discoveries but also relate to the construction of authoritative knowledge on women's bodies through the development of medical specializations and everyday practices that involve the action of technology. The biomedical discourse on menopause has evolved from a hysterization of menopausal women to a battle against "de-feminization" and more recently as a disease threat associated with osteoporosis. Therefore, in the realm of Western medicine, HRT is still considered and promoted as the best treatment available for menopausal complaints.

Agency: a Feminist Perspective on the Use of HRT

Feminist literature, for the most part, has stressed the view that HRT is imposed on women based on a negative perception of the aging female body, which in turns leads to the medicalization of menopause (Meyer, 2001). However, this approach does not take into account women's agency in the process of seeking relief for their actual

physical menopausal complaints within the biomedical system. Davis (1995), in her analysis of cosmetic surgery, points out some of the difficulties that recognizing this kind of agency poses for feminist research. What seems difficult in the case of HRT is to see the choice for this treatment as an act of agency in search of wellbeing and not as the result of the oppression by a patriarchal medical system. Davis (1995) attempts to solve this dilemma by developing what she calls a "feminist balancing act," which stands between a feminist critique and "an equally feminist desire to treat women as agents who negotiate their bodies and their lives within the cultural and structural constraints of a gendered social order" (p. 5). In this thesis, similarly, I do not assume that HRT constitutes a form of oppression in itself but aim to understand women's point of view and their agentive practices in the process of seeking relief through these therapies. At the same time, it is essential to analyze how women's views resonate with the discourse sustained by medical professionals.

Sanabria (2016) has studied the use of contraceptive hormones in Bahía, Brazil, and has documented how "the pill" serves new uses that are legitimized through social relationships.

Sanabria pays attention to the materiality of sex hormones, arguing that their efficacy is not reduced to their pharmacological properties but also includes their capability to enhance the plasticity of the body, thereby transforming social relations and interactions. She points to the fact that there is little debate on the potentially deleterious effects of hormone use in Brazil, particularly on future health risks; discourse focuses instead on its potential for producing desirable changes in women's bodies. Particularly in the case of menstrual suppression, Sanabria (2016) states that it "is based on a paradoxical proposition: the practice aims to stabilize bodies while inherently assuming their malleability. Menstruation is constructed as a form of bodily instability and hormones as the key agents in restoring balance and control" (p. 38). Hormonesare used to modulate, transform, and manage women's bodily plasticity and to support practices of self-transformation. Sanabria's ethnographic work emphasizes the perceived emancipatory side of plasticity and the potential opened by interventions rewarding social effects.

In contrast, potential adverse effects of menstrual suppression and other hormonal-driven changes in women's bodies are downplayed in the narratives Sanabria (2016) analyzes. She cautions, however, that debate over the use of hormones for menstrual suppression should not be understood in the binary categories of intervention vs. nature. In her view, intervention does not necessarily breach limits since the very concept of plasticity implies that there are no prebounded entities but only processes that constitute the body as bounded. Sanabria suggests that ethical evaluations of the use of biotechnologies should not be built on the assumption of a bounded, autonomous body but should address the process of science in the making or the matters of concerns (Latour, 2004); these should help people decide collectively what costs are acceptable (Sanabria, 2016, p. 206).

Sanabria's work on the notion of plasticity helps to overcome the "intervention vs. nature" debate regarding the use of hormones. This false dichotomy has kept hidden the processes that involve women's choices and agencies and the role that hormone use plays in social relationships.

Furthermore, medical anthropology understands biomedicine as a culturally

defined system that interacts with other cultural forms in order to deal with illness and disease, which permits the study of menopause and its treatment in relation to biomedical discourse. This approach is crucial for studying menopause and female aging in Latin America, where a variety of medical systems have been interacting historically. This factor is also relevant for a feminist analysis: even though biomedicine may be a hegemonic system, the existence of other healthcare systems may offer conditions for agency and resistance, especially concerning alternative ways of understanding and coping with menopausal complaints. In this dissertation, I explore how women experience their process of menopause and aging in relation to what is said and carried out in health care facilities of the Western medical system. I complement this approach with an exploration of the perspectives and practices of the medical practitioners who treat menopausal women. What kind of research they carry out; how they describe their scientific contributions, guidelines, protocols, and medical practice; how they explain women's medical conditions and need for treatment: all these are relevant data. However, a focus on the biomedical system (with all its complexities) does not account for the totality of interpretations and self-care practices that women carry out when it comes to aging, because alternative and traditional medicine systems have developed considerably within Chilean society.

Because the biomedical view has dominated most of the research on menopause, little attention has been paid to the cultural and social differences in the experiences of aging women. As this research project progressed, my focus shifted from an interest in menopause as a cultural phenomenon to a broader understanding of female aging in which menopause seems to be a marking event or a "rite of passage" to a new social status. In what follows, I address menopause as a significant moment in the broader process of female aging, as, in cultural terms, it is in the particular case of Chile. What seems to be critical in the understanding of female aging is the end of reproductive capacity, which involves new social roles for women.

Menopause and Aging from an Anthropological Perspective

From a bioanthropological perspective, aging is considered a universal fact insofar as an organism is seen as changing over its life span. From a biological standpoint, aging can be defined as a set of damaging changes that occur primarily in the post-reproductive period, which manifest as a gradual decline or deterioration in several bodily functions (Kaczmarek & Szwed, 1997). From such a perspective, there are two possible explanations regarding aging: either it is adaptive or non-adaptive. Adaptive theories see aging as a beneficial trait in its own right, for instance as a feature that strengthens intergenerational social bonding. It is believed that aging accelerates the renewal of generations and thereby increases the chance of a species more rapidly adapting to challenges in its environment (Kaczmarek & Szwed, 1997). This perspective has been pervasive not only in the biomedical sciences but also within bioanthropology, and it continues to shape the theoretical reflection and research in that subdiscipline.

Cultural anthropologists have extensively critiqued the so-called bioanthropological view because it does not account for cultural variations in the process of human aging (Martin, 1986) or for how culture influences aging as an epigenetic phenomenon (Lock & Nguyen, 2010).

Cultural anthropologists have called for comparisons of how culture shapes

the process of aging. According to Kaufman (1981) the founding statement for the development of the anthropology of aging was by made by Clark (1967), who suggested that American anthropologists reproduced prevailing attitudes toward aging, which made them ignore the role that the life cycle plays in human experience. Kaufman also pointed out in 1981 that anthropological studies had not, "addressed the issue of how culture continues to influence personality or behavior into old age, nor have they dealt with the problem of how identity is maintained when one is old" (Kaufman, 1981, p. 51). Keith (1980) notes that anthropologists have documented a diversity of adaptations to old age in various social settings, accounting for "emic" perspectives in old age as well as experiences of aging, and that such research has been a counterweight to prevailing gerontology theory, which rests on data from Western industrialized societies. However, Keith (1980) urged the development of a dedicated "anthropology of age":

> The ethnographic cases have not yet been distilled into alternative hypotheses to guide a more systematic and explanatory phase of cross-cultural research. The relationship between old age and anthropology will mature into an anthropology of age when research on the old is guided by and contributes to anthropological theory. (p. 340)

In the past few decades, the anthropology of age has evolved from a more localized research frame to a comparative perspective, addressing issues in contemporary societies. Van der Geest and colleagues (2010) describe the anthropology of aging as cross-cultural studies that address the question of old age from an emic point of view, describing how contextual factors of a cultural setting shape the way in which people conceptualize a good old age. For instance, based on ethnographic work, Van der Geest and colleagues (2010) assert that in Ghana, aging is anticipated favorably because it enables the elderly to enjoy rest as well as admiration for their wisdom from their carers. They contrast this appreciative attitude with aging in The Netherlands, where growing old is associated with loss and decline and successful aging means maintaining a feeling of well-being despite the losses that are perceived as inherent to growing old. Successful aging encompasses several strategies to deal with declining social contacts and limitations in physical and cognitive functioning, which are perceived as important means to maintain a feeling of well-being. Van der Geest and colleagues (2010) find that cultural meanings may shape the experience of aging even more strongly than material factors such as social security and access to health care.

Perkinson and Solimeo (2013) point out that research at the intersection of anthropology and aging has highlighted at least three areas for further study: 1) age adaptations in different cultural settings; 2) the "ageless self," or the idea that age can be irrelevant to self-image until major life transitions or serious illness cause people to see themselves as "old people"; and 3) successful aging from an anthropological perspective. According to Perkinson and Solimeo (2013) among the questions that have not been answered are: Is successful aging a relevant concept in other cultural settings? Are there cultural variations in the understanding of successful aging? How do specific definitions of successful aging influence systems of eldercare and support? The authors note that new technologies such as digital social networks open up further questions for anthropological research, such as the extent to which the experience of aging is affected by virtual cultural contexts, or how technology impacts the experience and self-concept of aging people.

Within sociology, the relationship between age and power has been deeply

analyzed.

Calasanti (2007) uses the concept of "age relations" to account for the power relations between social groups of different ages. The author goes beyond the mere fact that societies differentiate life stages and organize duties, tasks, and behaviors according to age to emphasize that such organization encompasses hierarchical power relations:

> what makes this a system of inequality, however, is the fact that different age groups not only gain identities but also power in relation to one another. Membership in age categories shapes our self-concepts and interactions in ways that have material consequences, such as unequal access to resources and, thus, influence our life chances. (Calasanti, 2007, p. 3)

This analysis particularly applies to Western societies in which an overvaluation of youth and health has been described not only in the functioning of the labor market but also in the marketing of commodities and the cultural industry. From Calasanti's (2007) perspective, what anthropologists might describe as cultural beliefs that convey a negative view of aging should be understood as part of a structure that reproduces inequality. This negative view on age and aging bodies is described as "ageism," which according to Calasanti (2007) may include stereotyping or prejudice against the elderly but always involves some exclusionary behavior. Ageism limits full participation in the social activities and networks that control the distribution of resources and privileges. Calasanti asserts that such marginalization occurs because of the social structure, rather than as a consequence of individual failure, in stark contrast to current discourses on aging that present it as a "preventable disease," thus portraying becoming older as an individual fault.

Aging, Gender, and Power

Scholars in the field of age studies tend to give a great deal of attention to the role that gender plays in how aging is perceived and experienced. One of the core questions of feminist theory is how to unravel the almost universal oppression of women. Radical feminism attributes women's capability to reproduce humankind as the cause of women's oppression under a patriarchal order. The fundamental ideas of this political analysis are very well condensed in Rubin's 1975 analysis on the "traffic in women." In this article, written at the emergence of radical feminism in the U.S., Rubin points out that all societies seem to share a need to control women's bodies and their reproductive capabilities through kinship systems that rule the way women are transacted, or "trafficked," between men. Compulsory heterosexuality and sexual rules are a means to ensure socially appropriate reproduction. Following Rubin, if reproductive capability is the very source of women's oppression, it might be plausible that women become more "emancipated" after finishing their reproductive duties with society; however, this does not seem to be the case. In some traditional societies, older women are granted a higher social status, while in other settings women are devalued and face loss of social privileges.

Rasmussen (1987) explains that, in the overall development of anthropology theory, many scholars have argued that in traditional societies older women acquired a higher status and greater authority because ceasing their reproductive roles gave them a sort of "androgynous" status. To feminist anthropologists such as Ortner and Whitehead (1981), gender is a prestige structure that generates a paradox for women because what

is more valued (reproductive capabilities) is also the object of major control. This structure generates rankings of both women and men: the highest status for women corresponds to those most sexually controlled, while men are defined in terms of exclusively male roles and statuses (Rasmussen, 1987). Some scholars have attributed aging women's apparent increase in status to their greater involvement in public sphere activities, meanwhile men tend to retire to the domestic sphere, entering a traditionally female traditional sphere (Rasmussen, 1987). Rasmussen (1987) points out the ethnocentric shortcomings of such analysis since it does not apply to contexts where there is no dichotomy between public and domestic domains, and suggests that holding more influence, freedom, and greater respect may make older women's position akin to that of men in general. She concludes: "the question of whether women loss or gain status at menopause, and some possible causes of this, should thus be rephrased to ask, what sort of change this represents; and how, rather than why, such a transformation takes place" (Rasmussen, 1987, p. 20).

According to Säävälä (1997) becoming a mother-in-law is seen as a cultural sign of seniority in rural India: such women acquire greater personal autonomy and are allowed to move relatively freely in the public sphere without social condemnation by other women. In addition, they gain the right to eat properly (eat more and better quality food) and to be served by younger members of the household. However, the most remarkable feature of such senior status is the gaining of decision-making power in the household. It is worth noting that this phenomenon does not relate to menopause as a biological fact but as a social event, and that is why a considerable percentage of women in rural India are willing to become sterilized as a way to attain such post- reproductive status (Säävälä, 1997).

Based on research among the Aymara people in the Andean region of the North of Chile, Carrasco (1998) asserts that women older than fifty years old are called "*apache*," which means an old and nonreproductive woman. This stage in women's life starts with menopause. Among the Aymara, to be old is seen as the final step in the learning process of life, and therefore old people become highly respected and valued, and are seen as the symbolic representation of cultural tradition. They are expected to live with one of their offspring who will take care of them until they die. As Carrasco describes:

> old people are granted with more freedom in their behavior, especially in the case of women, which as some scholars have argued, may be linked to the breaking down of social restrictions due to their non-reproductive condition. There is no strong control over women's behavior as observed in the case of both teen and adult women; even if widowed, men and women are allowed to look for a new partner, which is socially accepted. (Carrasco, 1997, p. 97, my translation)

Among the Mapuche , an indigenous people who originally occupied the current Chilean and Argentinian territory, the status of older women seems to increase as they are regarded as possessing an in-depth knowledge of their culture that must be transmitted to younger generations; they are also recognized as a source of wisdom and understanding of the future of the Mapuche (Molinet, 2012). However, the higher social status of older Mapuche women within their society does not correspond to their position in the social structure of the country at large.

Namely, they lack access to medical health care in the Western medical system, especially in rural areas, they have a high degree of illiteracy, and they are underrepresented in Mapuche political organizations that are led by younger people (Molinet, 2012).

It is tempting to portray traditional or non-Western societies as sharing more favorable views on menopause and aging. However, it seems to be the case that its image of a "relieving" event appears in cultural contexts where female sexuality and menses are considered dangerous or polluting (Douglas, 1966). In a qualitative study carried out with women in Oaxaca, Mexico, Ramírez (2006) attributes positive meanings of menopause to the fact that motherhood there is granted high social value and female sexuality is associated with purity and chastity. According to Ramírez, post-reproductive women are expected to be sexually abstinent, which women experience as a relief; for reproductive women, sexual encounters are seen as fundamental to maintaining a harmonious marital relationship. Instead of worrying about marital ties, post- reproductive women, and particularly poor women, invest more in emotional bonds with their children. If women manage to maintain strong ties with their children, they attain great social power (Ramírez, 2006).

Similar findings are detailed in an earlier work carried out by Rasmussen (1987), which explored the meanings of female aging among the Kel Ewey Tuareg. She concluded that the key to interpreting the changes in older Tuareg women's status is found in the kinship domain, namely, in the opposition between agnatic and affinal kinship. Rasmussen explains that older women undergo transformations of kin and class associations rather than gender status; their status appears androgynous only if gender is isolated analytically from other spheres of social action and experience. Their status upon aging does not change from a polluting woman to a nonpolluting or manlike woman, but from active motherhood to successful motherhood, which implies something much different from biological reproduction as a relationship between affines. The basis of older women's power, Rasmussen argues, is the marriage of their children, specifically daughters and their concomitant obligations. Of particular importance are the first to two to three years of marriage when, due to matrilocal residence, the mother-in-law enjoys a considerable amount of power, making her capable of breaking up a marriage. The author concludes that the androgynous imagery associated with older women is a metaphor to express class transformations that go beyond gender roles, involving realignments of kinship hierarchies and economic changes linked to kinship (Rasmussen, 1987).

Varying Experiences of Menopause

Ideas about gender and female aging are relevant when it comes to analyzing differences in women's experiences of menopause. Within the realm of anthropology, it has been proven that menopause is not a universal fact but a sociocultural construction (Lock, 1993a). Cultural research challenges the biological view of menopause: if menopause was a universal hormonal experience, women all over the world would experience complaints about menopause in the same way, which is indeed not the case (Beyene, 1986; Lock, 1986). Comparison of menopausal symptoms of women from different developed and non-developed countries accounts demonstrates there is a wide variety of physiological, social, and cultural expressions of menopause (Beyene, 1986; Hunt, 2000; Lock, 1986).

Martin (1986) writes that menopause has been represented as a pathological state, one that is not only related to the negative stereotyping of aging women but also is a consequence of the view of "seeing the body as a hierarchical information-processing system in the first place" (p. 42). Martin suggests that this may be a way of

imposing metaphors to make interpretations fit into the facts, and asks if there might be another way to represent the same biological phenomena. By analyzing how metaphors are elaborated and disseminated within the medical field, Martin unravels the complex process of how interpretations become "medical facts," and empirically proves that it is possible to find different representations by asking women themselves.

Martin's findings indicate that women in the U.S. who undergo menopause do not seem affected by it; on the contrary, they define the process as rather normal. Those who suffered menstrual complaints were rather happy about not having to endure cramps anymore. The only thing that seemed worrisome for women was the hot flushes, especially those that took place at work, where women felt exposed and embarrassed. Martin suggests that hot flushes may not be just a pure manifestation of hormonal imbalance but may also be linked to social troubles, and describes the case of a woman who told her doctor that vitamin D had helped her stop the hot flushes. As soon as her doctor responds that that connection is meaningless, she experiences a hot flush. Martin suggests that in this case the hot flush may be an indication of being upset.

Martin also points out that hot flushes seem to be more prevalent among working-class women, which may indicate that they convey an expression of dissatisfaction linked to social and living conditions.

Martin's work is groundbreaking in the sense that it shows how a feminist anthropological perspective can be applied to critically examine the interplay between the Western medical system and women's bodily experiences and perceptions of reproduction and health. Complementing her work, several studies have shown that some of the menopausal symptoms regarded as typical in Western countries are not clearly recognized elsewhere. For example, surveys in Asian countries such as Hong Kong, Indonesia, Korea, Malaysia, the Philippines, Singapore, and Taiwan have elicited very low reporting of symptoms, possibly because these countries tend to grant those of older age improved social status (Boulet et al., 1994; Hunt, 2000). Lock (1993a) suggests that Asian dietary patterns may provide phytoestrogens that compensate the decreasing of hormone production. This finding led Lock to coin the concept of "local biologies" and to call upon medical anthropologists to analyze the interaction between biology and culture. Lock and Nguyen (2010) define local biologies as "the way in which biological and social processes are inseparably entangled over time, resulting in human biological difference—difference that may or may not be subjectively discernible by individuals" (p. 90).

Lock and Kaufert use the concept of local biologies in her comparative research on menopause in Japan, Canada, and the U.S. study shows that reporting of menopausal symptoms significantly varies, rather than being universal. Specifically, differences in the incidence of heart disease, breast cancer, and osteoporosis in Japan and the West were identified, which indicates that middle-aged Japanese women overall have better health when compared to North American women of the same age (Lock & Kaufert, 2001). This finding suggests the need for bringing into the analysis other cultural factors, such as a phytoestrogen-rich diet (soybeans, herbal medicines, and teas) and healthier habits such as not smoking, not consuming alcohol or coffee, and doing exercise. Furthermore, there are structural factors that are believed to positively influence Japanese women's health, such as the equal distribution of wealth in Japanese society, and access to good health

I

care and high-quality public education (Lock & Kaufert, 2001).

Lock and Nguyen (2010) challenge the assumption of the biological universality of the human body and question the culturalist idea that differences in individual bodily experiences of menopause are adequately attributed to cultural beliefs. They instead argue that menopausal experiences are the result of:

> local entanglements among historical and cultural activities, technoscientific interventions, and the biology of individual aging. … Dynamic biological change is inevitably implicated in this ceaseless entanglement, resulting in patterned variation in subjective bodily experience, and also geographical differences in the distribution of disease and illness. (Lock & Nguyen, 2010, p. 83)

More research is needed to flesh out how local biologies of menopause are produced in practice, including data from the basic sciences (Lock & Nguyen, 2010).

Combining historical, anthropological, epidemiological, and basic science findings to understand the production of human biological difference remains a challenge for medical anthropology. Though the local biologies perspective is valuable, the current project does not utilize this concept in the research design. Doing so would mean a different methodological framework, one that would incorporate the kind of basic data to describe and explain the production of local biologies in the Chilean case, and would necessarily include the input of biological sciences. But an anthropological approach to menopause does not necessarily limit itself to a symbolic view, as it may take into account other material factors that influence the way women experience menopause. Lock's work is an outstanding example of this kind of holistic view.

In sum, anthropological research indicates a relationship between the experience of menopause and aging and the cultural meanings attributed to those changes. Indeed, menopause may be viewed in a highly positive way by many women as it brings relief from the worry of getting pregnant and the bother and expense of menstruation. This variety in perceptions regarding menopause led Lock to question to what extent "menopause" is a useful term at all. Perhaps it is better to look at the emic or folk denominations given to the end of menses. Lock (1993a) discusses the existence of two different concepts in Japan, *heikei*, which refers to the actual end of menstruation, and *konenki*, which refers to a larger process that encompasses all the physical and emotional changes experienced by women along the process of reaching maturity. Lock (1993b) explores how Japanese perceptions of menopause are embedded in a particular cultural view of women and their bodies and also investigates to what extent those views are present in Japanese biomedical and nationalist discourses:

> Middle aged female bodies are normalized as nurturers of the elderly In this climate only "selfish" women suffer menopausal problems, a discourse circulated as part of a Japanese national identity set up self-consciously in opposition to the West. (p. 147)

In conclusion, medical anthropologists make a strong case that menopause and aging are not universal and incontrovertible facts, but varied, changing, contradictory, and overlapping experiences that women face when becoming older. Anthropologists of aging have called for studies of how growing older is constructed in particular settings, with the understanding that gender plays a vital role in shaping the attributes of aging for women.

In Chile, as in many so-called modernizing societies, the views of the Western medical system on menopause and female aging seem to play an important role in the broader social definition of these phenomena. Biomedical sciences have tended to portray aging as a deterioration of physical functions, including a reduction in the production of estrogen that can be restored by the use of hormonal replacement therapies. Women themselves may experience their aging as a medical condition that requires treatment and may seek relief in the health care system. In Chile, the cultural construction of menopause and female aging is not necessarily in conflict with the biomedical view; there is no dichotomy but rather a continuum where it is possible to find articulations and overlap of both perspectives.

Meanings, Practices, and Experiences on Menopause and Aging in Chile

When it comes to studying the situation of aging women in Chile, it is essential to consider some distinctive attributes regarding its history and cultural configuration. Chile is a compelling case of the change and overlap of a modern way of living shaped by capitalism and consumerism that accounts both for "modernity" and more traditional values centered in family life and conservative gender roles (Blofield, 2001). Conservative views on gender have found their most robust expression in the field of sexuality and reproduction; abortion was penalized under any circumstance until 2017, and many women (especially those who live in poverty) encounter difficulties in accessing contraception and sexual health care. Even though conservative values regarding motherhood have been changing among wealthier citizens in recent years, they persist solidly among the less privileged (Yopo Díaz, 2016).

In the last decades, Chile has experienced several demographic and economic changes. The number of children born per woman decreased from 5.4 in 1963 to 1.8 in 2014 (Instituto Nacional de Estadísticas, 2014), thanks to effective contraception health care policies. According to official data, in 2014 7.4% of Chilean women took part in the formal labor market, and around 39.4% of families were headed by a woman (Ministerio de Desarrollo Social, 2015). According to the Global Gender Gap Index 2016, Chile ranks 70th (out of 145 countries), but it also ranked 119th for economic participation and opportunity (World Economic Forum, 2016)). The nation ranks low also on wage equality for similar work (133rd), estimated earned income (97th), and women in parliament (96th) (World Economic Forum, 2016). Chile seems to be an "in-between" country: it is a very modern "neoliberal experiment" (Escobar & LeBert, 2003) but at the same time is still very patriarchal.

Chile's population is in demographic transition, growing old just as fast as European countries but without social security issues adequately solved. As of 2019, about 13% of Chileans are 60 years old or older. This number is expected to increase to 20% within the next three decades. According to the World Health Organization (2015b), the life expectancy for Chileans is 77 years for men and 83 for women. However, when we look at life expectancy according to social class what we find is that the life expectancy of working-class people is at least three years less than the that for upper-middle-class people (Fuentes, 2014).

Even though the demographic transition is a worrisome issue for Chilean society, as is the fact that women are the most affected by it, there is not much social science research on it. As we will see in the following chapters, public policies on aging do not adequately address the magnitude and complexities of a growing old population. With a weak social welfare state whose role has been limited to subsidizing the needs of the poorest, it is difficult to think of a long-term comprehensive public policy on aging. There is no comprehensive policy to look to modeled by other countries with a similar level of economic development; still, there are structural issues regarding health care retirement and welfare that need to be addressed.[1]

Furthermore, most of the feminist struggles on health issues have been focused on the recognition of reproductive rights (namely the legalization of abortion), since women's right to decide what to do with their bodies is considered a fundamental prerequisite for gender equality (Lamas, 2008). However, this emphasis on women's reproduction has left aside other embodied and social experiences (Sanabria, 2016). In the current feminist agenda, there is no attention to the needs of aging women (Morales, 2011).

The focus on reproduction has been a dominant feature in health care policies for women in Latin America. Based on research in Brazil, Diniz (2012) offers the term "materno- infantilism" to describe the view of public health programs that see women as reproductive entities whose main role is to bear children. The term also highlights the fact that women are not recognized as capable of making decisions on their own, a presumption that allows the guardianship role assumed by the health services as well as the medicalization of women's bodies "in their own best interest."

Diniz (2012) describes how, since 1983, Brazil has enjoyed a Comprehensive Women's Health Program, which was developed by feminist groups and the public health movement in the process of political democratization in the 1980s. This program led to the universal right to health care and the implementation of a comprehensive and equitable public health system "Sistema Único de Saúde" (SUS) in the 1988 Brazilian Constitution. Because this comprehensive program focused not only on women's reproductive years but also on their needs in childhood and old age, Diniz suggests, it caused a break from the materno-infantilism approach.

Diniz (2012) describes how electoral uncertainties preceding the election of Dilma Rousseff led her government to compromise with both religious and political interest groups by depoliticizing sexuality and reproduction in policymaking. This compromise crystallized in the issue of a Provisional Measure (draft law) that included the compulsory registration of every pregnancy and excluded any measure to address the main problems identified by feminist and human rights groups: the over-medicalization of childbirth and its adverse consequences, and the need for safe, legal abortion. Diniz makes clear that even though the feminist movement may have been able to make advancements in establishing a comprehensive view on women's health care, there is always a risk of going backward and compromising with conservative groups.

1 According to the World Health Organization (2015a) a "Global Strategy and Action Plan on Aging and Health" should focus on five strategic objectives:1) fostering healthy aging, 2) creating age-friendly environments, 3) aligning health systems to the needs of the older populations they now serve, 4) developing systems for long-term care, and 5) improving measuring, monitoring, and understanding of aging.

This case also shows how in practice women's health care policy persistently tends to focus on reproductive issues, even when intended to encompass other women's needs and concerns. In the case of the Chilean public health care system, when it comes to women's health, efforts have concentrated on increasing contraception and reducing maternal mortality (Castro, 2015). In 1963 the first population control program was implemented, with the purpose of controlling the population explosion and reproduction among those living in poverty (Castro, 2015). According to Castro (2015), the population control policy implemented in the '60s in Chile was strongly supported (in political and financial terms) by the U.S. "Alliance for Progress," which had the goal of preventing the spreading of communist ideas in Latin America. In response to the Cuban Revolution, the U.S. government implemented a modernization policy intended to push Latin American countries into economic development and social change without inciting political revolution. Fertility control was perceived as a "jump to development" (Castro, 2015). The successful implementation of fertility control policies in Chile included the promotion of contraceptive pills and intrauterine devices (IUDs), together with the development of a strong midwifery program to lead reproductive health care (Lillo, Oyarzo, Carroza, & Roman, 2016).

The early implementation of obstetric care is a crucial feature of the public health care system in Chile. The extensive training of midwives who undertook maternity care in the primary health care centers (Centros de Salud Familiar) and maternity units in the public hospitals explains how maternal mortality came under control during the '90s. In 1960, Chile recorded maternal mortality of 299 deaths per 100,000 newborns, one of the highest rates in the Americas. The most prevalent cause of death was abortion-related complications, which accounted for one-third of the deaths (Donoso & Carvajal, 2012). Since 1960 the increasing adoption of contraceptive methods, combined with as economic, social, and health care development, helped reduce maternal mortality by more than 50% (Donoso & Carvajal, 2012). According to a 2014 report of the Pan-American Health Organization (PAHO) in Chile:

> the maternal mortality ratio declined significantly between 1990 and 2014, from 39.9 to 22.2 per 100,000 live births, respectively. In recent years, the predominant causes of maternal death were indirect obstetric causes and other conditions complicated by pregnancy, which accounted for 25% of total maternal deaths in 2014 (PAHO, 2014, 1).

In 2013, Chile reached 99.9% of births taking place in institutions, which is considered a marker of success for health care policies seeking to prevent maternal mortality. However, as has been argued recently, the reduction in maternal mortality in Chile was accomplished at the expense of women's reproductive rights (Jara, 2018). Compulsory delivery in a hospital facility (enforced by police when necessary) and the obligation to undergo biomedical procedures for delivery show the degree to which birth has become medicalized in Chile (Jara, 2018).

Recognizing the extent to which women's health care has been focused on reproduction, it becomes relevant to ask what is going on with older women, whose needs are invisible. A prominent feminist activist explained the situation to me:

> It is funny, you know, when you see women at all these demonstrations fighting for the right to abortion, for the right to the morning after pill, what you see is that most of the women there are in their fifties or older, and where are the young ones? I don't know, but

> it seems that we the older feminists are so concerned about the fate of younger women and we haven't thought about ourselves, about our own needs.

This lack of agenda on female aging within the feminist movement is curious. When I asked another feminist in the city of Concepción about this, she replied, "You know what we say, 'first priority abortion, second priority abortion, and then we will think about the rest.'" Unfortunately, it has been a long struggle since therapeutic abortion was forbidden at the end of Pinochet's military dictatorship in 1989. Its decriminalization was an unfulfilled campaign promise for almost 20 years. Very recently, in 2017 in the last days of Michelle Bachelet's second term in office, a therapeutic abortion law was finally passed, but the health care centers are still in the process of implementing it, and are encountering strong resistance from conservative medical practitioners and health care clinics linked to the Catholic Church (Montero, Vergara, Ríos, & Villarroel, 2017).

The fact that the legalization of abortion has been taken as the most strategic struggle for Chilean feminists implies that non-reproductive women have remained almost invisible in the political agenda. This is not only the case for Chile but is a larger phenomenon that has lead feminists to neglect the needs of aging women which are not taken into account in the feminist agenda (Pearsall, 1997). In recent years, as part of the embrace of the concept of intersectionality within the social sciences, age has started to be included as a relevant category to analyze women's experiences (Pearsall, 1997). The intersection of gender and aging has not been extensively examined in Chile, but a limited number of theoretical and empirical studies on gender and age have been published (see Osorio & Sadler, 2005; Osorio, 2007; Osorio 2010; Osorio 2013; Navarrete, 2015).

Chilean anthropologist Osorio, who has conducted several research projects on gender and aging since 2010, asserts that in Chile menopause is a symbolic marker of old age for women, even though in legal terms women are considered officially in their "third age" at 60 years old (Osorio, 2010). For most women, the menopause process starts ten years before, and is experienced as the loss of reproductive capability. The author also describes aging women as performing the role of caregivers and providing unpaid work to their families in the role of "*abuelas*" (grandmothers). Particularly in urban working-class areas, older women make an invaluable contribution to the maintenance and development of their families and their social networks (Osorio, 2010).

In this thesis, I analyze the needs of aging women and examine how they are dealt with in the health care system. Since the beginning of the 20th century, the Western medical system has been extensively promoted as part of the Chilean modernization process (Illanes, 2010). In the last decades, steadily increasing levels of development (national income, health care goals, etc.) have coexisted with the fact that Chile is one of the most unequal countries in the world when it comes to income distribution. This inequality leads to the persistence of poverty, social segmentation, and marginalization in both rural and urban areas, and it finds expression in the highly segregated functioning of the biomedical health care system as well as the educational system (Robles, 2013).

The Chilean Health Care System

Since the privatization of the Chilean health care system in 1982 (during Pinochet's dictatorship) two segregated health care subsystems have coexisted. On the one hand,

there is a public health care system, underfunded and incapable of dealing with the demands of 77% of the Chilean population. On another hand, there is a private system that offers coverage to only 15% of the population, who pay high fees for private health care insurance (Ministerio de Desarrollo Social, 2016). However, when it comes to analyzing the way each of these subsystems addresses the needs of aging women, we find that both seem to discriminate against them, though in different ways. Because private health care insurance is legally allowed to select only healthy individuals, those who have ongoing illness-related expenses are excluded. This criterion also applies to women, who are considered "more expensive," both because of reproductive health care and health conditions that come about later in life due to lower pension amounts.

In the case of the public health care system, health services are offered first through primary health care centers, which provide general medical attention. When women need specialists such as gynecologists and endocrinologists, they must be referred to secondary health care services. However, due to a shortage of medical specialists in the public system, women do not have timely and proper access to them. As explained in chapter two, most specialists in gynecology, endocrinology, and climacteric issues work within the private health care system.

The way the health care system operates and its (lack of) access to medical specialists in the field of menopause create a considerable impact on women's everyday lives. During an early stage of my fieldwork (which I had to combine with my regular work as a university teacher), I was in a meeting with other female colleagues from the Faculty of Medicine (all of them nurses and midwives in their 50s) when one of them took a pill, saying that she needed her Tibolone. Tibolone is a synthetic anabolic steroid that stimulates the response of estrogen, progesterone, and androgen receptors and therefore is used for the treatment of menopausal complaints as an alternative to estrogen/progesterone hormonal therapies (Escande et al., 2009). Immediately, the others began asking her about the effects of the pill, about how she felt, and so on. She proceeded to define it as something that "squeezes your ovaries, to get even the last drop of estrogen," and that it was better than other treatments as it did not involve taking artificial hormones. The conversation went on, and all of the women started to describe how they felt, remarking that hot flushes were the worst symptom of the menopausal process. To my surprise, one of the women asked to try a pill (and so she did) saying that she might start taking the treatment as well.

As Sanabria's (2014, 2016) work describes, the "informal prescription" is a common practice in Latin America. Sanabria (2014) has coined the phrase "diagnostic sociality" to account for the process of diagnosing one other and purchasing medicine directly in the pharmacy. Usually, women trust their mothers and other close female relatives and friends to assess what might be useful to overcome health complaints. The fact that this conversation took place, publicly, among a group of highly trained women, made me realize just how little is said about menopause in public discourse, and the lack of social instances for menopausal women to share their experiences and concerns. I also noticed the lack of information that women generally have about the options regarding hormonal treatments and their hesitation to start taking treatments when long-term outcomes are uncertain. There is no doubt that menopause and female aging constitute an arena where the biological and the cultural are inseparable. The pervasive medical discourse of defining menopause as a disease may resonate with women's experiences but at the same

time may dismiss other experiences that are part of aging but cannot easily read through medical language.

Chilean medical specialists seem very much concerned with the troubles of menopause and aging, which they call "the decrease in quality of life," which is mainly assessed through the Menopause Rating Scale. The Menopause Rating Scale is a globally used questionnaire in which women are expected to self-report the perceived severity of menopause-related symptoms in three main dimensions: psychological distress (depression, irritability, anxiety, and exhaustion), somato-vegetative symptoms (sweating/flush, cardiac complaints, joint and muscle complaints, and sleeping disorders), and urogenital symptoms (sexual complaints, urinary problems, and vaginal dryness). Research conducted in Chile with the use of this scale in the public health care system has consistently reported a high degree of menopausal complaints among Chilean women (del Prado et al., 2008; Lopez-Alegría & Soares, 2011; Blümel et al., 2018). A study conducted in 2008 in public hospitals in Chile with the use of the Menopause Rating Scale found out that 41% of the surveyed women reported severe climacteric symptoms and 39.9% had moderated complaints, which was also considered troublesome by the authors (del Prado et al., 2008)). In addition, 56.8% of women reported severe psychological symptoms, 20.8% reported severe somatic symptoms, and 35.7% reported severe urogenital symptoms (del Prado et al., 2008). A similar study from a decade later (Blümel et al. 2018) also found out that 42.9% of women reported very severe muscle and joint discomfort, 33.7% reported very severe physical and mental exhaustion, and 33.3% reported very severe depressive mood. The severity of the climacteric symptoms reported by Chilean women has been one of the core arguments for gynecologists and endocrinologists to advocate for more extensive use of HRT to deal with menopausal complaints.

From an anthropological perspective, there is much to unpack when analyzing the results of the application of the Menopausal Rating Scale in Chile. If the most severe reported symptoms among Chilean women are psychological, can we assume that they are caused solely by decreasing hormonal production? Are there other non-physiological factors that deserve exploration? The study conducted by del Prado and colleagues in 2008 established through logistic regression analysis that being postmenopausal is the most deteriorating factor in women's quality of life; a higher education level seems to have the opposite effect. Given these facts, it is plausible to assume that social and cultural factors play a considerable role in the way women experience menopause. The fact that women are postmenopausal it is not only related to the absence of their menses but also is associated with occupying a specific social position: becoming a grandmother, exiting the formal labor market, and being socially labeled as an old woman (Osorio, 2010).

The measurement of physical and psychological complaints in menopausal women is not done, and the results cannot be interpreted, in a social vacuum. There is a need to explore the everyday life experience of women's bodies. Together with economic constraints and the family troubles that are associated with the role of aging women in Chile, it is also necessary to pay attention to the experiences of aging bodies. According to Edmonds (2010), the quest for beauty (which for the most part involves the fight against aging) characterizes the modern self who is expected to care for and lead her personal project of body enhancement. The subject of aging bodies seems to be crucial for the modern self; as many body industry advertisements repeat at a global scale, one must

"become the best version of oneself".[2]

Edmonds (2010) asserts that in Brazil the development of the beauty industry has opened up new possibilities for status renegotiation because attractiveness is believed to grant access to networks of power. Edmonds and Sanabria (2014) analyze how in Brazil women resort to beauty technology and hormonal therapies to maintain their youthful, and thus desirable, looks. Plastic surgery and hormonal therapies overlap as a means of intervening in and optimizing the sexual health and wellbeing of Brazilian women. Edmonds and Sanabria (2014) argue that these therapies have become morally approved as routine ways of handling women's health; they are seen as legitimate practices of self-care in modern femininity and accepted forms of "somatic individuality" in the emergent biopolitics. In contrast, my review of the literature indicates that there is a strong resistance among Chilean women to the use of HRT, which may be related to the fear of potential side effects. In fact, the scientific papers published by medical specialists tend to stress the need to "educate" women about the benefits of HRT and the risks of not using it (Ruiz et al., 2002; Blümel & Arteaga, 2017). Social science research indicates that such resistance may be linked to the idea that suffering complaints and aging are something that must be accepted with resignation (Dois Castellon et al., 2017; Osorio, 2010), as such suffering is part of the traditional view of female identity (Montecino, 1990; Lagarde, 1990). However, such analyses must be joined with research among upper-middle-class women, whose perspectives have been little explored in social science research in Chile.

Dealing with Menopause: Women's Experiences

If menopause and aging involve a bodily transformation and the way one's body is perceived in the social sphere, we might ask: How do people deal with such transformations? How do social groups establish a connection between meanings and social practices when it comes to aging bodies? What are the answers offered by the health care system, in both private and public sectors? How do women deal with those answers? Do women search for different sources of meaning when it comes to aging?

At the same time, at the level of everyday conversations, menopause is always present, and not only to patronize women or explain their behavior but as a joke or a way of bringing women together based on a shared experience. I remember with amusement the way one of the secretaries in the academic department where I worked used to joke any time she forgot something, saying, "It's the menopause, you know," or "Please don't tell me anything because I am very sensitive today—it's the menopause." Within the Chilean context, these kinds of remarks are meant to show the existing trust between women, as they refer to something considered a very personal matter. In an ambiguous way, menopause can be something to laugh about among women who trust each other, but this everyday topic of conversation does not find expression in other public domains.

Elisa, one of my women I interviewed, who lived in a working-class neighborhood in the north of Santiago, explained to me the importance of hiding an aging body. It was a warm summer day in Santiago, and we were sitting in a small square near her house. We

2 See for example the book "Hello new me: A daily food and exercise journal to help you become the best version of yourself", by Happy Books Hub published in 2018.

managed to sit in the only spot that offered some shade at midday. The square was mainly a bunch of benches placed around a big flower pot filled with what once was greenery and fresh flowers. Now, everything had dried out. Keeping the surroundings green and clean is a luxury that most of the deprived neighborhoods in Santiago cannot afford.

I was supposed to go to her house for the interview, but when I was on my way, she called me and asked me to meet her in the square. Her daughter-in-law had unexpectedly shown up at her house, claiming that she wanted to organize and take some of the belongings she and her husband had left in storage in Elisa's house a few months ago, when they had moved to a smaller house. Elisa told me that she did not want her daughter-in-law listening to our conversations, or worse, jumping in to give her own opinions. She also feared that this would give place to "*cahuines*" (gossiping) within the family. Elisa did not want others to hear her and was afraid that the things she had to say could be misinterpreted or, worse, misused to create conflicts within the family.

I first met Elisa at the Neighborhood Association House where I was doing ethnography and where she attended gym classes for the elderly, which took place every Friday. To cheer her up a bit I mentioned an excursion that the Neighborhood Association was planning for the women who attended the gym class. They had decided to go to a swimming pool in a small town near Santiago, and everybody in the group seemed excited about it. Elisa did not seem that happy and said, "You know, maybe I will go, but I have no intention to go swimming in the pool. I don't like wearing a bathing suit. I haven't done it for a long time." Before I asked her why, she said, "I don't even like this kind of blouse that I am wearing today—I don't like to show my arms like this [she shows her left arm pointing at the fat in it], but because it is so hot today I had no choice." Elisa was referring to a feeling that I encountered in my research among several women, who all expressed shame about their aging bodies and made clear that fat and flaccidness were something to hide from the public eye. I immediately pictured in my mind a scene that I have witnessed at many beaches and swimming pools in Chile: women in the water wearing shirts, shorts, dresses, and skirts. They did not seem comfortable with their bodies and did not want to wear a bathing suit in public. As I discuss in the forthcoming chapters, upper- class women seemed to be more inclined to take care of their bodies in a way that socially allows a public display of them. However, the sense of shame still was felt by those who did not comply with Western standards of thinness. Carola, one of my upper-middle-class interviewees, explained that before undergoing an abdominoplasty she went shopping to have the pleasure to buy all the clothes she was going to wear after becoming thinner. She referred to this procedure as a "rebirth" and evoked her past when she was fatter as "*mi otro yo*" (my other self). A closer look makes clear that menopause and aging as bodily experiences may have different meanings for Chilean women.

As mentioned before, there is also a considerable level of medical pluralism, meaning the coexistence of different health care sectors, where one sector (typically the Western professional health care sector) is recognized as dominant over the others. Indigenous groups like the Mapuche and Aymara peoples have maintained their traditions despite colonization and state control. Also, most Chileans ascribe to what has been called the "*cultura mestiza*," which refers to the result of mixing indigenous, African, and traditional Spanish beliefs. More recently globalization and the spreading of the New Age movement have brought to Chile new ways of coping with illness, adding a variety of alternative treatments. Some complementary treatments have even gained a significant

deal of acceptance in the medical mainstream (Nogales Gaete, 2004; Soto, 2009; Avello & Cisternas, 2010; Contreras, Alamos, Chang, & Bedregal, 2015).

In the case of the Latin American societies, whose multicultural character is being increasingly acknowledged by their governments, the concept of medical pluralism tends to refer to the coexistence of several medical systems. The recognition of indigenous traditional medicines as medical systems has been part of the indigenous rights movements in Latin America, especially in their attempts to establish intercultural health policies. In Chile, a National Policy of Health Care for Indigenous Peoples was passed in 2006; it recognizes the existence of three indigenous medical systems that belong to the three larger indigenous groups: Mapuche, Aymara, and Rapa Nui (Ministerio de Salud, 2006). More recently, the Law of Rights and Duties of the Patient, passed in 2012, establishes people's right to access intercultural health care in the public health care facilities that are located in areas with a higher concentration of indigenous people (Ministerio de Salud, 2012).

The concept of medical pluralism is relevant for studying menopause in Latin America. Several research projects carried out in Latin America account for traditional knowledge transmission on menopause that challenges the authoritative knowledge of biomedicine (Ramírez, 2006; Argote, Mejías, Vásquez, & Villaquirrán, 2008). A variety of discourses on menopause may coexist, as well as a variety of traditional practices for dealing with menopausal complaints and alternative practices that result from global flows and trends. Clarke (2010) offers the concept of "medical partialisms" to acknowledge the fact that medical care is not always available, even when there is medical pluralism:

> things medical appear and disappear, clinics and pharmacies open and shut, providers die or move away, and so on. The concept of medical partialisms alerts us to issues of availability along with those of access—of all kinds of medicines. There is also stratified access to medical goods and services for individuals and social groups also vis-à-vis all kinds of medicines. (p. 345)

Therefore, medical pluralism and its limitations (medical partialisms) must be taken into account in order to analyze the health care practices related to menopause and aging, and whether they are helping or counteracting biomedicalization. Alternative medical systems might be of help in resisting biomedical views on aging and menopause, and may offer different kinds of self-care practices beyond biomedicalization, but they could also become "complementary" and adjuvant in biomedical treatments.

Menopause as a Research Problem

This research project begins with a question about the meanings given to female aging in Chile, and menopause as a significant marker of the aging process. Because of my personal experiences and my background as a feminist anthropologist working in the field of health care, this research topic became increasingly relevant over the years. First, I noted a lack of interest among feminist anthropologists on aging women and more particularly the way the feminist movement, preoccupied with women's reproductive health care issues, has neglected the needs of "post-reproductive" women.

Second, the fact that aging is increasingly seen as a disease in itself and becomes medicalized and regulated through hormonal replacement therapies and

other technologies of care situates this research within broader questions in medical anthropology, such as those addressed by Martin (1987) and Lock (1993a). Aging is no longer seen as a natural and unavoidable process affecting all human beings but as something that must be carefully treated and regulated. The biomedical system has thoroughly developed treatments and interventions aimed at this purpose. What seems even more interesting is the fact that such treatments are not gender-neutral but an attempt to maintain those features believed essential to masculinity or femininity. Aging women are advised to use hormonal replacement therapies as a means of keeping a young look, healthy skin, sexual attractiveness, and active sexual life. Hormonal replacement therapies are not only a way of softening the undesired menopausal complaints but also a strategy to help women maintain their "femininity."

I contend that the concepts of medicalization and biomedicalization are useful to account for the exertion of normative values on women, which finds expression in the promotion of hormonal replacement therapies. Building on from the concepts of medicalization and biomedicalization defined by Clarke (2010) I have examined how they operate in Chile, demonstrating that their universality cannot be taken for granted. I provide an overview of the development of the biomedical system in Chile and how it addresses women's health care, and particularly gynecological and endocrinological care. Analyzing how the medical profession has historically developed, and how it is currently arranged, situates the nature of health care provided to aging women.

I also use the concept of healthscapes elaborated by Clarke (2010) to describe the particularities of the Chilean health care system and its traits. Understanding healthscapes as grand narratives in the social history of health and medicine, allow us to examine the particular characteristics of the Chilean case. As Clarke and colleagues (2010) have cautioned the concept of healthscapes has been largely applied in studies taking place in the US, which does not represent the situation in other regions of the world. In the case of Chile's healthscape, the development of a national state-regulated health care system is a key feature, as is its later disintegration and partial privatization under the neoliberal policies implemented by a military dictatorship in the 1980s. It is also necessary to pay attention to the role played by medical associations and the political power they have exerted in shaping their own medical practice. In the following chapters, I pay particular attention to how medical associations, namely in the field of menopausal health care, produce, acquire, reach consensus, and communicate knowledge on menopause and its treatment. In sum, this dissertation analyzes the particular features of the medicalization and biomedicalization of menopause and female aging in Chile, and how the two interact and overlap.

There is also a complex dynamic interplay among the biomedical system, governmental public policy, the media, and understandings of public and private health care and their practices of diagnosis and treatment of menopausal complaints. Examining public policies and practices concerning menopause and female aging, I show how this phenomenon is being defined and understood, whose voices are heard in establishing those definitions, which problems become relevant, and how the governmental apparatus deals with them. I trace how the public policy discourse resonates with the ideas put forward by the Western medical system and particularly with the discourse of medical specialists in the field of gynecology and endocrinology.

Perceiving women's aging as a disease has become a trend in Western countries. Media outlets and the beauty industry have played an important role in producing and expanding the search for an ageless femininity. Media representations of menopause and female aging are thus important for this investigation. In an era of the global interconnection, it is pertinent to examine how different ideas and images regarding menopause and aging circulate and how they are negotiated and discussed within the Chilean context. For this purpose, I look into different sources of media representations such as newspapers and magazines, television programs and movies, and internet sites.

In the following chapters, I unpack women's perspectives and explore to what extent they resonate with what the biomedical discourse says regarding the quality of life, and whether women perceive HRT as the ultimate way to deal with menopausal troubles. I have used participant observation and ethnographic interviews as tools to dig into the meanings they provide regarding their own experience of aging.

The dissertation describes how female aging is constructed in Chile in different social groups, and then explores how women from different social backgrounds give meaning to their experience of menopause and aging. I analyze how those meanings are related to the ideas put forward by different actors, such as the Western medical system, alternative treatments, the media, and public policies. In this regard, I pay particular attention to the role played by the biomedical system, in particular, the medical specialists, in the production of meanings regarding menopause and aging.

Overview of the Chapters

In the first chapter I further develop the arguments and recount the methodological decisions leading to the research design, as well as explain the assumptions and problems encountered in the planning and implementation of the research.

In the second chapter, I describe the health care system's historical development, as well as its current structure, involving the coexistence of two separate subsystems: private and public health care. I discuss how aging women are affected by the neglect and gaps that discriminate against them in both systems. I also provide an overview of how public policy is addressing and portraying (and therefore constructing) the issue of female aging in Chile, by critically examining technical guidelines, policy and governmental programs developed and implemented between 2005 and 2017.

In the third chapter, I describe the biomedical view on menopause and female aging through analyzing academic papers published in Chile between 2002 and 2017 in Chilean medical journals. This chapter also presents the perceptions of 13 Chilean gynecologists and endocrinologists, all members of the Chilean Society for the Study of Climacteric, who were interviewed as part of this research. I reflect on the core ideas from the Western medical system that are present in the Chilean case, and how particular medical practices—concerning medicalization and biomedicalization—carried out by medical specialists in Chile shape the discourse on menopause and female aging in the society at large.

In the fourth chapter I present my analysis of media representations of menopause

I

and female aging, based on four sources: articles published between 2008 and 2017 in relevant online newspapers and magazines; "Socias," a popular soap opera broadcast in Chile in 2013; *Gloria*, a Chilean film released in 2013; and *No Quiero Envejecer* (I don't want to get old), a popular self- help book published in 2014 by Pilar Sordo, a prominent Chilean psychologist and author. These cultural products were selected because they all had notable impact on public conversations at the time of my research (2011–2018). Still, menopause and female aging are subjects not widely spoken about, and they are also perceived as not as controversial as other women's issues (such as abortion or transsexuality, which drew much attention during my fieldwork). In fact, there were many examples of menopause being discussed in the media. In fact, I was lucky that a soap opera and a Chilean movie (both very popular at the time) came out during this period. This variety of sources allows me to account for the way female aging is being represented in Chilean society and the consequences of such representations.

In the fifth chapter, through in-depth biographical interviews, I unfold the meanings that both menopause and aging have for middle-aged women by analyzing narratives of their experiences as well as accounts of their agency and resistance against the biomedical discourse. To do so, I explore the meanings they give to their body, the process of aging, and their lives as women in a broader sense, paying particular attention to whether they express menopausal complaints and their meanings and strategies to cope with them. These interviews were conducted in urban settings, with upper-middle-class women who were attending menopausal clinics or looking for alternative therapies, and with working-class women who were attending public health care centers.

In the sixth chapter, I explore the experiences and body perceptions of women who turn to alternative treatments, particularly yoga, in their search for wellbeing. These alternative practices are mainly available to upper-middle-class women who can afford private lessons and have the means to spend time on this practice.

Finally, in the conclusions, a summary of the research findings is presented and discussed. In general terms when analyzing the way the healthcare system operates in Chile, I contend that there are no comprehensive public policies to address the needs of aging women. The dominant narrative (healthscape) is a medicalized view of menopause, since hormonal replacement therapies are promoted as the solution for a wide range of issues that women may face as they age. I contend that media representations of menopause and female aging are in alignment with the biomedical discourse of aging as a disease.

When examining the meanings of menopause and aging among women in their midlife I found that both upper-middle class and working class reported complaints and worried about aging but they developed different coping strategies: while upper-middle-class women resorted to biomedical technology to fight aging, working-class women tended to face aging with resignation and gratitude for what they had accomplished in their lives especially regarding to motherhood.

On the other hand, women who practice yoga tend to have a more positive meanings regarding their aging process. I argue that yoga practice can be related to the idea of "affirmative old-age" and challenges the assumptions of the so-called successful aging.

Finally, I conclude that Chilean society is not prepared to face the rapidly increasing aging female population. Currently, there are no political subjects to represent aging women's needs regarding their wellbeing and healthcare. A medical anthropology perspective can certainly contribute to the development of a comprehensive response to the needs of aging women in Chile.

CHAPTER 1.

RESEARCH METHODOLOGY

One of the particular features of ethnographic research (shared with other qualitative approaches) is that the methodological design cannot be described in terms of a previously established framework but as a cluster of decisions that unfolded during the research process itself. Relevant aspects that require explanation are: how the settings and relevant data sources were chosen, how the research strategy was developed, how access to the collected information was obtained, and, finally, how the process of analysis was carried out (Silverman, 2013). In this chapter, I present my methodological decisions and their consequences for the research.

As mentioned in the Introduction, this research project used an ethnographic methodology. Ethnography implies a process of description and interpretation in which a coherent representation of what people think and say is elaborated; it is not a reflection of the "native's point of view" but an interpretative conclusion elaborated by the researcher (Geertz, 1983). Pink (2007) defines ethnography as:

> a process of creating and representing knowledge (about society, culture, and individuals) that is based on ethnographers' own experiences. It does not claim to produce an objective or truthful account of reality but should aim to offer versions of ethnographers' experience of reality that are as loyal as possible to the context, negotiations and intersubjectivities through which the knowledge was produced. (p. 22)

To justify why the study of the cultural construction of female aging in Chile can be approached with ethnographic methods, it is also necessary to attend to the particular features of ethnography when compared with other qualitative approaches. In the case of Chile, given the fact that is a country of 756,096 km^2 with around 18 million inhabitants, an intensive ethnography that would describe the amount of geographical, cultural, and social diversity would not be feasible. However, some aspects of such diversity can be accounted for through a multi- sited ethnographic approach (Marcus,1995). Multi-sited ethnography does not refer to research conducted in several settings (in a geographic sense) but implies a way of approaching a research subject. As Marcus (1995) explains it, a multi-sited approach moves:

> from the single sites and local situations of conventional ethnographic research designs to examine the circulation of cultural meanings, objects, and identities in diffuse time-space. This mode defines for itself an object of study that cannot be accounted for ethnographically by remaining focused on a single site of intensive investigation. It develops instead a strategy or design of research that acknowledges macro-theoretical concepts and narratives of the world system but does not rely on them for the contextual architecture framing a set of subjects. (p. 96)

In other words, to study the cultural construction of menopause and aging in a

socially and culturally complex society such as Chile, it is not possible to focus only on one specific community or social setting but to attempt a broader view that recognizes the role played by different actors. Marcus (1995) notes that the social and cultural study of science and technology is a major arena in which the relevance of multi-sited ethnographic research has been made visible. Lock and Nguyen (2010) point out that "by taking a multi-sited approach, the many factors relating to an object or phenomena selected for investigation can be described, including the perspectives of experts, policy-makers and practitioners" (p. 9). They also commend this approach for its ability to highlight how "scientists, health policy-makers, and publics are all caught up in culturally informed realities that are sometimes mutually reinforcing, and at other times divisive" (Lock & Nguyen, 2010, p. 10). I contend that exploring media representations, public policies on health care, and the contents of scientific journals in Chile constitutes a multi-sited ethnographic approach.

Multi-sited ethnography emerges as an answer to what has been defined as a crisis in traditional ethnography. The fact that the world has become increasingly interconnected in various ways has made it difficult for ethnographers to situate their fieldwork in clear-cut settings. Marcus (2005) cautions that multi-sited ethnography does not mean a mere extension of sites but a more theoretical rethinking of fieldwork itself, one that is oriented to the understanding of process and connections. Location no longer presupposes a particular culture, since culture and cultural identities find new ways to reproduce, change, and coexist in an era of transnational interconnections and mobility. Marcus (2005) defines multi-sited ethnography as a map of processes that "emerges from the objective following of a known conventional process, or an unconventional process—following a commodity chain/productive process, migration networks, or following a plot/narrative, a metaphor, or circulation of an idea" (p. 12). This involves understanding the field as spatially and temporally fluid. Increasingly, the setting that ethnographic research focuses on is not necessarily a geographical site but a space of connections between shifting locations in which the research topic develops (Clifford, 1997). The elements to be followed in multi-sited ethnography are not spatially contiguous but substantially continuous (Falzon, 2009).

The fact that multi-sited ethnography has been translated into research projects that involve several geographical settings at the same time has led to criticisms of superficiality and fragmentation. A simultaneous in-depth study of multiple research settings becomes impossible to implement (Hage, 2005; Mitchell, 2012). In addition, the idea of studying several research sites in which a particular phenomenon develops may create the illusion of "covering the whole thing," regardless of the fact that any methodological design involves the selection of samples, cases, and settings that are feasible to be studied within a specific time frame (Hage, 2005; Candea, 2007; Lapegna, 2009). There is also an epistemological shortcoming in the development of multi-sited ethnography: the difficulty of deciding which traces deserve to be followed and how to contain the multiplicity of a cultural phenomenon (Lapegna, 2009). In a later work, Marcus (2005) addresses these criticisms by putting forward the concept of "paraethnography," which "involves understanding the multi-sited field emerging from strategic collaborations with which fieldwork begins" (p. 13). Paraethnography has to do with building collaborative alliances beyond the zones of specialized technical knowledge in a way that may challenge the existing representations of the academic authority.

Hage (2005) also points out that multi-sitedness and the ethnography of interconnections have long been present in the history of anthropology. He brings up the example of the kula ritual described by Malinowski:

> Was Malinowski not a 'multi-sited' ethnographer when he dealt with the Kula if all that is meant by multisitedness is this circulation between geographically non-contiguous spaces? Was he not an ethnographer of movement rather than stillness? As is often the case, one finds that the elders of a discipline have done a great deal more than what the 'innovators' like to give them credit for in order to appear as avant-garde. (p. 467)[3]

Hage thus argues that multi-sited ethnography is not so new, because the idea of flow and diffusion has been present in anthropological theory since the foundation of the discipline.

Another appealing aspect of multi-sited ethnography has to do with what it offers in comparison to other methodological frameworks for doing research on global phenomena. Global ethnography has been criticized for its lack of substantial ethnographic work, which "may render monolithic descriptions of the people studied; missing variations of behavior that may defy the theoretical frame" (Lapegna, 2009, p. 13). Multi-sited ethnography insists on substantial descriptions before any theorization, as "overtheorization" may introduce preconceptions and consequently affect the quality of the ethnography. In other words, "the fieldwork must inform theory and not the other way around" (Lapegna, 2009, p. 14). Of course, it is naïve to think of an ethnographer researching in a theoretical vacuum, but what I believe multi-sited ethnography calls for is not anticipating any conclusion drawn on theoretical assumptions before the actual fieldwork is completed.

I argue that despite the criticisms, multi-sited ethnography still has something novel to offer anthropological research. It implies a particular design in which the different actors, elements, or social domains are approached with an ethnographic gaze. Unlike other methodological tools to address nonhuman actors (such as public policies or media representations), for instance, critical discourse analysis, the ethnographic approach involves close attention to the interactive way in which meanings are produced and how they are embedded in particular social practices that can be observed and accounted for. The multi-sited ethnographic approach acknowledges the thick description of social and cultural phenomena as the strength of anthropology. Even when dealing with cultural material produced by human practices that are not directly observable, it is possible to apply an ethnographic framework to describe and account for the complexities of such processes. Here, I present ethnographic descriptions of a soap opera, a fictional film, and video-recorded parliamentary debates on the accessibility of hormonal replacement therapies, and I argue that an ethnographic framework helps to capture details and connections that cannot be described with the use of other research methods and techniques. In that sense, an ethnographic analysis of such material does not merely imply an analysis of what is being said, but also the way the actors interact with each

3 On a second reading, such criticism seems somehow unfair, since Marcus (1995) himself mentions Malinowski's *Argonauts of the Western Pacific* as an example of doing multi-sited ethnography by following the people, which he defines as "the most obvious and conventional way of materializing a multi-sited ethnography" (p. 106).

other, the symbols that are displayed, and the relationship that is established between significations. As Geertz (1983) explains, thick description requires the understanding of a meaning in relation to other meanings. In addition, as Marcus (1995) points out, multi-sited ethnography is not only about how to do anthropological research but how to develop a theorization through the development of such research, being fully aware of the politics of writing and the role played by the ethnographer in constructing a particular representation of the research subject.

This research project required an approach that would allow for the exploration of multiple settings at the same time in order to account for the multiple factors and actors involved in the construction of cultural meanings regarding menopause and female aging. The production of ideas regarding aging and menopause may be located with the biomedical establishment and with the women who experience themselves the process of aging; further, there is a connection between those and the way the mass media and government policy represent and address female aging. In my research, I strived toward holism, while acknowledging that such a goal is pursued at the expense of losing some depth and missing some of the actors.

Class as a Prism

The use of a social class perspective has been problematic within anthropological theory and practice. When it comes to analyzing social class differences in anthropological theory, as in most social sciences, there is a tension between symbolic and material interpretations. Lewis (1959) theorized the existence of a culture of poverty, with a unique value system that perpetuates itself among the poor. On the other hand, radical Marxist anthropologists have claimed that culture is the result of material living conditions. They have also explored the potential applications of Marxist analysis to precapitalistic cultures (Godelier, 1977). Traditional Marxist anthropology focuses on the role of economic factors in cultural adaptation and development, and in the last decades there emerged some interest in the way material structures of domination correlate with cultural structures of domination. In other words, how social hierarchies become a system of signification that reinforces and reproduces domination (Brown, 1993). The political economy approach developed by Wolf (1985) emphasizes the conditions of oppression that affect particular social groups, and how these limit their choices and possibilities of further development.

According to Ortner (2006) the use of the concept of social class must be distinguished from an approach that treats social inequalities as stratification, that is, "as a set of differential positions on a scale of social advantage—rather than as a set of fundamentally conflictual relations" (p. 23). Marxist theorists argue that social differences are the result of capitalism, which creates an exploitative form of production in which workers must sell their labor force in exchange for a salary that does not correspond with the real economic value of it (Dos Santos, 1973; Ortner, 2006). Neo-Marxist theorists have reflected on the increasing importance of the salaried middle class, which is able to exert administrative and regulatory power over the working class even if they do not own the means of production (Ortner, 2006, p. 24).

Consequently, in a Neo-Marxist analysis, the distinction between the working class and the middle class has to do with the access to power and a higher position within a structure of domination.

Based on Mauss's definition of habitus, Bourdieu (1988) defines it as a perdurable and transposable scheme of perception, judgment, and action, which results in the social institution acting upon the body, resulting in a socialized subjectivity. Culture, language, and affective life imprint tacit norms and values that are taken as natural. The habitus reproduces these structured dispositions in an unconscious manner and in this way it regulates and attunes people's actions. In this perspective, the body is a physical and symbolic artifact that is produced naturally and culturally and placed in a concrete cultural and historical moment. According to Ortner (2006), the limitations of Bourdieu's concept of habitus lie in its neglect of individual agency. Habitus works insofar as individuals are not aware of the way they are reproducing their own domination (Ortner, 2006).

Within the anthropological study of health care, critical medical anthropology has also theorized the relationship between material conditions and symbolic production. This subfield focuses on the political economy to study how capitalism, power relationships, and government policies influence health and wellbeing (Singer, 1995). According to Scheper-Hughes (1994), critical medical anthropology intersects personal, social, and political bodies since it accounts for individual perspectives on illness. This perspective allows the recognition that individuals also have a stake in their bodies, and are not simply agents to these larger social forces. Therefore, critical medical anthropology acknowledges individual agency when analyzing how structural forces act upon the body. For example, Martin (1987) in her study of women's perceptions about their bodies, uses the concept of resistance to describe the strategies that women display to confront medical power, which may include defending alternative discourses and beliefs about one's body or finding ways to avoid medicalization.

In order to clarify the relevance of social class in this research project, it is necessary to establish whether or not social class involves particular ways of understanding the world.

According to Ortner (2006), a social class is framed by certain values and practices that are distinguishable from those of other social classes. Social class is a relational category and each class looks at the others with fear and mistrust. Ortner (2006) writes:

> the middle class, in contrast, is a source of tremendous ambivalence from a working-class perspective. Middle-class status is highly desirable for its greater material affluence and security, but undesirable for all the ways in which its patterns are culturally "other," and for the ways in which upward mobility would pull one away from kin, friends, or neighborhood. (p. 31)

In the Chilean context, social class is a relevant category given the high levels of social inequality that constitute social classes as separate worlds. The high level of segregation in Chilean society is the result of a process that has maintained income inequality, and corresponding educational inequality, over the last three decades (Espinoza, Barozet, & Mendez, 2013). Social class differences are also reflected in a high level of spatial inequality (Paredes, Iturra, & Lufin, 2014; Jiron, 2007). Basic services as education and health care are also segregated into private and public spheres. In other words, in order to operationalize

social class as a meaningful category for social research, income, type of work, educational level, residential area, and type of health insurance are key pieces of information.

Because of the different methodologies used to measure social stratification and class, it is difficult to find consensus on how social stratification in Chile is analyzed. A comparative analysis by Barozet and Fierro (2011) presents the following breakdown: 10.5% of the Chilean population corresponds to the richest with an average household income of 5,921 USD per month; 18.7% corresponds to upper middle class with an average income of 2,216 USD per month; 24.7% corresponds to the lower middle class with an average income of 1,608 USD per month; 36.5% corresponds to the working class with an average income of 603 USD per month and 9.7% corresponds to the poor with an average household income of 264 USD. More recent studies on income in Chile do not show substantial changes in the last seven years, particularly because the class differences reported in the early studies still exist (Duran & Kremmerman, 2018; INE, 2017).

Studies of cultural features of social class in Chile point out that among working-class families in Santiago there prevails a gender ideology that defines men as breadwinners and women as caretakers (Stillerman, 2004). Women may seek a job to increase their autonomy but there are ideological and structural factors that jeopardize that choice. Women feel guilty about "abandoning" their children to work, and the amount of money they earn may not suffice to pay for childcare and still retain some surplus money. The family income is constrained by a sense of obligation towards children's educational expenses and elderly parents' needs for support (Stillerman, 2004). Stillerman (2004) also points out that co-residence with elderly parents and other relatives is socially accepted and acknowledged as a mutually beneficial practice.

Nevertheless, people recognize its disadvantages, such as lack of privacy, sense of crowdedness, and lack of space for children to play (Stillerman, 2004). Working-class couples display consumption strategies that researchers define as pragmatic and self-controlled as a result of the feeling of economic insecurity (Stillerman, 2004, p. 73).

On another hand, defining "middle class" in Chilean society seems more problematic. According to Barozet and Fierro (2011) "the middle class in Chile does not correspond to more developed societies in which the middle class is the center of society. It is a vulnerable middle class due to its limited income" (p. 39). There also appears to be a differentiation between the "traditional middle class," those whose parents were also educated and had a higher income, and the so-called new middle class, who are the first in their families to go to university. Studies note a difference in terms of consumer patterns: the traditional middle class is more inclined toward cultural consumption of books and art activities, while the new middle class spends their money in technology and prestigious goods (Bazoret and Fierro, 2011). There is also an interest among both groups, traditional and new middle class, in finding houses in neighborhoods that promise safety as well as a sense of belonging among equals (Ariztia, 2014).

The Chilean middle class has been described as more inclined to value gender equality, which is visible in the increasing involvement of women in the labor market as well as the more active role that men are taking up in domestic work and parenting (Saldaña, 2018). Among young middle-class couples, there is a tendency towards complementarity in the distribution of domestic work; men however choose to perform the more pleasant and less demanding domestic tasks within the household (Saldaña,

2018). Unlike the working class, within middle-class families the role of grandmothers in grandchildren care is more limited and occasional, and couples tend to resort to paid domestic help (Campos & Saldaña, 2018).

In sum, the limited research on gender and social class differences in Chile accounts for differences between working- and middle-class constructions, especially when it comes to defining the role and expectations of women. In order to explore the social class differences related to female aging, I selected interviewees based on their residential sector, educational level, family income, and access to health care. The social class categorization was also used in the analysis of the collected information. Even though some structural features were used as criteria for selecting research subjects, in theoretical terms, the emphasis of the analysis was on understanding the particular meanings of the different groups in relation to menopause and aging. In that sense, the methodology design is based on fundamental theoretical assumptions regarding the symbolic nature of culture and the relevance of "searching for meanings," following the work of Geertz (1973, 1983) and Ortner (1981, 2006).

Autoethnography of Doing Yoga

As mentioned in the Introduction, in this research project I included my autoethnographic experience of doing yoga, which I undertook with the purpose of elaborating interpretations about the sense of wellbeing that yoga seems to provide to aging women. Because of the research questions that emerged in my fieldwork, I determined it was necessary to fully integrate myself into the practice of yoga, as a way of experiencing and being able to account for its effects in terms of perceptions of aging. That is why I framed this work into what is called "autoethnography," which Ellis and Bochner (2000) define as:

> an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural. Back and forth autoethnographers gaze first through an ethnographic wide-angle lens, focusing outward on social and cultural aspects of their social experience; they look inward, exposing a vulnerable self that is moved by and may move through, refract and resist cultural interpretations. (p. 739)

As the years passed, I started to feel that I was getting closer to my research target group. As I get older I realize that I feel what many of the interviewees said they felt when worrying about getting older. My methodological decisions and the way my research process evolved also reflect my own process of getting older and the fact that I could identify with the experiences recounted by my interviewees. Over time, the research came to include a more intimate or personal perspective on aging.

My own experience, what I embodied and experienced attending yoga lessons, became my way of knowing and describing this social practice. This quest relates to what Jackson (1989) calls radical empiricism; as a process that includes the ethnographer's experiences and interactions with other participants as a fundamental component of what is being studied, this requires the use of all the senses, the ethnographer's body, movement, feeling, and whole being (Jackson, 1989; Ellis & Bochner, 2000). Esteban (2004) terms it an "incarnated anthropology" (*antropología encarnada*) in which two analytical

dimensions are intertwined: the autoethnographic dimension, that is, relying on self-experience to comprehend others' experience, and an analytical perspective based on the concept of embodiment, which accounts for the interactions and resistances between an individual and larger social and cultural ideals.

I use autoethnography as a way to describe the integration of the self in the practice of yoga, which requires a commitment and reflexivity around the dilemmas of being at the same time a partaker and an observer of such practice. What autoethnography adds to traditional ethnography (which also requires the researcher's involvement) is a capacity to account for the most in-depth experiences, not as a researcher acting in the ethnographic scene but as one of the subjects. For example, an ethnographer can conduct participant observation in a religious ritual without sharing that particular faith; as long as she carries out the actions expected of a participant, such activity qualifies as participant observation. If the ethnographer shares the religious beliefs and faith involved in such rituals, she may choose an autoethnographic approach, since she can speak directly about the most profound experiences involved in such rituals. As long as self-reflexivity plays a significant role in the interpretations elaborated, the distinction between researcher and subject could be maintained. In that sense, autoethnography must be seen as a complementary technique that can add to the data collected by other sources, but it does not constitute "the ultimate truth" about what is being studied since a researcher's perspective is always partial and limited.

Participant observation is a tricky enterprise. We are supposed to do what others do, to behave in the way others are doing it, but—at least in traditional anthropology schools—we are taught that we should not feel like the others. We are told that we will never be one of them. It seems that participant observation may just be a strategy to get closer to people, so we can observe them without disturbing them in their activities. Of course, this traditional understanding of ethnography and participant observation has been profoundly challenged in the last decades. The postmodernist critique helps "to highlight the constructed, artificial nature of cultural accounts. It undermines overly transparent modes of authority, and it draws attention to the historical predicament of ethnography, the fact that it is always caught up in the invention, not the representation, of cultures" (Clifford, 1986, p. 2).

Since the concerns raised by postmodern anthropology (Clifford, 1986; Geertz 1988) and the criticisms against the naïve Malinowski-styled anthropology (Geertz, 1988), it seems that participant observation has been more liberally defined, and ethnographers can fully engage in a creative process. It is now accepted that ethnographic narratives can express a variety of feelings of excitement and frustration, experiences, and remembrances (see, for instance, Rabinow, 1977). This evolution also makes ethnography a more unstable product or even a "messy text" (Marcus, 2013). And shortcomings of postmodern approaches have been highlighted; for example, Pink (2009) contends that postmodern anthropology has a "verbocentric" approach that fails to account for the senses and the processes of embodiment.

Therefore, in positioning my research within the anthropology of the body, I refer to accounts of self-experience, in fields such as disability and postcolonial studies (Murphy, 1987; Anzaldua, 1987; Hooks, 1984; Howe, 2011; Griffin, 2012). These emphasize a need for talking from the body or from the way we experience our bodies, and putting that into an

understandable language that will be "translated" by others (Das, 2007).

Because of the nature of yoga as a physical practice, this ethnography must also pay attention to the senses. As Pink (2009) has pointed out, the recent development of an ethnography of the senses "entails thinking ethnographically about the senses from the starting point of the self-reflexive and experiencing body, thus regarding the sensorial in ethnography as embedded in the approach of the embodied ethnographer" (p. 46). Thus, the ethnographer's own sensorial experiences constitute the means for comprehending other people's experiences.

As will be explained further in chapter six, this autoethnography of doing yoga is based on six months of participant observation, from August 2015 through January 2016. Even though I continued practicing yoga afterward, I base the chapter on the data collected during this period, including observations (written in my fieldwork notebook) and interviews. During that period, I attended a yoga school located in the neighborhood where I lived in Concepción, taking classes three times per week. During the first three months, I attended evening classes, and then I switched to morning lessons. Doing so allowed me to meet most of the women who attended the school. My observations and interpretations about this autoethnographic experience form the basis of an ethnographic narrative presented in chapter six.

The school is run by its owner, who is also the only yoga instructor, though she also occasionally invited other instructors for specific activities beyond the routine classes. I came upon this place on the recommendation of one of my interviewees who took classes there. I had been puzzled by some of the interviewees' accounts that referred to yoga as an effective way to deal with aging-related troubles. I had no previous experience with yoga, and had never felt attracted to it. But because the school was so close to my place, and I had the opportunity to go with one of my informants, it seemed an excellent opportunity for doing ethnographic work. I informed the owner and also the class participants about the research I was doing and the fact that I was observing and using my own experience for research. Because I was doing nothing out of the ordinary, my presence seemed not to trouble them. I did not carry any recording device and did not take notes in the yoga classroom. Some yoga students refused to be interviewed when asked, mainly citing lack of time. One of them also told me that she found it very unpleasant to talk about aging, advising me to do research that could be "more fun."

Research Techniques

Ethnographic interviews. According to Guber (2001), the ethnographic interview is a research strategy that helps the researcher to find out what people know, think, and believe. In such a situation, the researcher gets information by asking the research subject. The information collected usually pertains to the interviewee's biography, perceptions about certain facts, emotions, opinions, norms, values, and ideal ways of behavior. Guber (2001) argues that what differentiates the ethnographic interview from other kinds of interview is the fact that it produces a new reflexivity out of the encounter of two different perspectives. The interview is thus a social relation from which enunciations and verbalizations are obtained within the framework of direct observation and participation:

the data collected is produced in the encounter itself (Guber, 2001).

One of the possibilities of an ethnographic interview is the use of no leading questions that will allow the interviewee to expand her own views. However, Guber (2001) cautions that the no-leading-questions rule does not guarantee that the researcher is not interfering with the production of information, which in fact is impossible to avoid. The researcher must be aware of the way she is interfering with the production of information and maintain a "free-floating attention" as a way of listening without criticism or selection. According to Guber (2001), the researcher must start by "discovering the questions," that is, finding in the flow of the conversation the right questions according to what is expressed by the interviewee. Sometimes it may not be evident how some topic set forth by the interviewee may connect to the researcher's interests. A second stage encompasses finding the way to expand, deepen, and systematize the collected information, and further exploring the meaningful categories that were identified in the first stage. In order to do so, more focused questions are required to establish the classification of meanings expressed by the interviewee.

I conducted ethnographic interviews with 24 working-class women and 13 upper-middle- class women in the cities of Concepción and Santiago. I started by contacting working-class women in neighborhood associations and other social organizations with which I had contact before. In the process of the analysis I decided to exclude additional interviews I had conducted with women older than 70, whose problems, interests, and views proved to differ from those of younger women. Upper-middle-class women proved difficult to contact, therefore, the process of conducting the interviews was slower and I had to resort to personal contacts (contacting friends of a friend and acquaintances) and snowball sampling. Conducting ethnographic observations in therapeutic groups such as bio-dance and yoga provided me with other contacts for interviews. I stopped carrying out interviews when I realized that no new information was emerging from the interviews. With most interviewees I conducted at least two sessions of recorded interviews and had several encounters in order to build rapport and trust, and later to give a proper closure to the research process.

Semi-structured interviews. In addition to interviews with menopausal women, I conducted 13 interviews with physicians who specialize in treating menopausal women and doing medical research in this field. The goal of such interviews was to find out how they perceive menopause and menopausal women, what they think of hormonal replacement therapy, and their perceptions of gender differences and female body.

To identify participants, a snowballing method was used, starting by reaching out simultaneously to several acquaintances and asking them to provide further contacts. Also, when conducting a review of the publications on menopause in national journals, I identified additional experts who I then contacted through e-mail and phone calls to their private practice offices. A later analysis led me to the finding that most of the practitioners working in this field are part of a network where those with more experience and prestige are recognized as leaders in the field of menopause treatment.

In order to facilitate the participation of the Medical specialists with limited available time, I used semi-structured interviews. I had to minimize the number of questions included in the interviews and select essential topics to focus on. The interviews with medical professionals lasted on average half an hour and were conducted mostly in

their private practice offices.

According to Galletta (2001) the advantage of a semi-structured interview is that it is sufficiently structured to address different dimensions of the research topic but still leaves space for participants to provide new meanings to the research topic. Using of a predefined list of questions gives the researcher more control over how the interview progresses, even though there are open questions that allow the participant to express her own views and concerns (Silverman, 2013). Some interviewees stick to the questions asked, while others will speak more about topics they find worthwhile.

To save time, the interviewees were also asked to fill out a short questionnaire to register information about their studies, work experience, use of work time and specialization. The survey also asked them to name the three most outstanding specialists in the field of menopause treatment and hormonal replacement therapies. This information was used to map their network of professional contacts.

Table 1. Field of specialization and gender of interviewed physicians

Specialization	Women	Men
Endocrinology	0	3
Gynecology	2	4
Gynecological Endocrinology	1	1
Oncological Gynecology	0	2
Total	3	10

As displayed in Table 1, the sample included 13 medical practitioners, of which ten were men and three were women. The proportion of men to women in the sample reflects the national gender gap among physicians. According to Chile's National Institute of Statistics, 66% of all registered physicians are male and 33% are female (INE, 2010).

Most of the specialists worked in Santiago, the capital of Chile. The three female specialists worked in the private health care sector; five of the male specialists worked in private clinics, four worked in the public health care sector and public universities (combining medical practice with scholarly work), and only one worked exclusively in the public health care sector.

Those who taught held positions at the most important national universities, such as Universidad de Chile and Pontificia Universidad Católica of Chile, and one also worked at the University of Valparaiso. At these universities, they taught courses on menopause and climacteric at graduate and postgraduate levels. They also worked in private clinics, such as Las Condes, Alemana, Indisa, and Reñaca. Many of them have been part of the board of the Chilean Society for Climacteric, or they have been representatives of this organization at a Latin American level.

Regarding the interviewees' age, even though it was not considered a relevant variable for selecting informants, in practice most of them were between 50 to 60 years old. That may have to do with the fact that they had become specialists in menopause

after a long period of work experience, choosing to focus on menopause once their careers had become established.

Participant observation. As mentioned before, several research activities involved participant observation. To conceptualize diverse activities as a technique to obtain information, the researcher must involve herself in experiences and perceptions of the everyday life activities of the research subjects.

That gives reliability to the data and allows the researcher to learn the meanings involved in such activities (Guber, 2001). Accounts of such experiences are the source of knowledge for the ethnographer, derived from what Geertz (1988) calls "being there." Guber (2001) describes the difficulties of combining participation with observation. Participation means carrying out the activities in the same way they are performed by the research subjects, to learn how to conduct certain activities and behave in the same way they do. The emphasis of participation lies in what is experienced by the researcher within the group under study. In contrast, observation implies the ability to register what is seen and heard. The researcher must be always aware of what is happening even if she is participating and must find ways of documenting the information collected, even when taking notes or recording is not allowed or feasible in the research setting.

According to Emerson, Fretz, and Shaw (2007) field notes "are a form of representation, that is, a way of reducing just-observed events, persons and places to written accounts" (p. 353). Field notes are inevitably selective as they record what seemed interesting, relevant, or puzzling to the researcher, which implies leaving out other matters that are not seen as significant (Emerson et al., 2007). While taking field notes aims to preserve the researcher's observations from fieldwork, they are in themselves interpretative, because "descriptive writing embodies and reflects particular purposes and commitments, and it also involves active processes of interpretation and sense-making" (Emerson et al., 2007, p. 353). Field notes can be used for writing an ethnographic account that will emphasize particular aspects of the event being narrated or can be used as a source in itself without many edits in the ethnographic report. In any case, Emerson and colleagues (2007) suggest that the use of a first-person narrative helps to avoid the illusion of objectivity and the tendency to mask the existence of multiple perspectives in the research setting.

The Process of Research

One of the features of ethnographic research is openness to exploring topics that emerge within the frame of the research project. The first methodological decision was to focus the research project in the two provinces in Chile, Santiago and Concepción, as a way to represent some of the diversity of the country. To provide a more extensive view of the situation in Chile, I decided to focus my research on the major areas of Santiago and Concepción and to interview women from working class and upper-middle-class backgrounds. Some of the factors taken into account when selecting the research setting were the existence of both public and private health care facilities for aging women and the feasibility of conducting the research in both cities.

At the time I began conducting my fieldwork I was living in the city of Concepción, and I arranged regular travels to Santiago to conduct interviews and observation, staying

there for several days in each trip. Before moving to the city of Concepción, I lived in Santiago for 12 years, first as a college student and later as an anthropologist working at NGO's related to healthcare and patients' rights. During that period, I conducted several research projects that gave me familiarity with most of the city's neighborhoods and, perhaps more importantly, taught me the intricacies of public transportation and how to move safely from one point of the city to another. By the time I began my fieldwork I had established a considerable network of relatives, friends, and colleagues living in Santiago, on whom I could rely for practical matters, such as accommodation, and also for introductions to key informants and contacts for interviews. What began as a chaotic picture of possible contacts for observation and interviews started to take shape as I made the methodological decision to focus on specific places of the city where I had good access to conduct my research. In Santiago, I focused on the working-class area of Pudahuel and the municipalities of Providencia and Las Condes, where I had access to interview upper-class women. In the province of Concepción, I conducted interviews in the municipality of Talcahuano, where I was allowed to interview women who attended a primary health care center there. I also contacted upper-middle-class women living in different areas of Concepción through snowballing from personal contacts. Finally, I also contacted women to interview through my participation in therapeutic groups of yoga and bio-dance.

I decided to begin by seeking the perspective of medical professionals and their patients. The first step was to explore the possibilities of participant observation and ethnographic interviews within health care facilities. My early attempts to do so encountered high resistance at the management level in both the public and private health care systems. The main concerns were patients' confidentiality and medical professionals' resistance to being observed (and judged) by an external researcher. I was advised in the health care centers to approach directly medical professionals I wanted to interview and look for patients to be interviewed in other places that would not imply the support of a specific health care center. Because of that, I resorted to snowballing as a way of contacting interviewees within the medical staff and approached patients with a specific background that matched my research interests. In Talcahuano (Province of Concepción), I was allowed to contact women who attended a primary health care center, and I also conducted an interview with the center's midwife who was also in charge of providing health care for older women.

Limitations of the Research Design

The time frame for research was a significant constraint that narrowed some of my decisions. Even though I knew the relevance of studying the situation of indigenous women and women living in rural areas, I was afraid that doing so would mean a longer fieldwork period. I sought instead a one-year fieldwork plan that would allow me to complete my Ph.D. within four years. In practice, this plan did not work out at all, and several personal events led me to take twice as much time to complete my dissertation. My original plan was to conduct interviews and observations during 2011 and 2012, and then begin the writing of the thesis. The research took longer than I expected, and I decided to incorporate other interviews and ethnographic observations such as those pertaining to yoga, which I did at a later stage of my research. That was feasible because the profile

of these later interviewees matched those already included in the research and thus did not imply a new social group. In other words, I continued working with upper-middle-class women but I intentionally sought out those who practiced yoga in order to further explore women's perceptions regarding menopause and aging in relationship to yoga.

Using Textual and Visual Sources in Ethnographic Research

To provide a more complete picture of the cultural construction of menopause and aging in Chile, this research project includes the analysis of the media representations. With the purpose of documenting what the press says about menopause and aging, I analyzed articles from six online newspapers widely known in Chile. I also analyzed other cultural products that somehow referred to the research topic, including a popular soap opera, a film, and a self-help book. All of these were produced in Chile and had some impact on public conversations at the time of my research. In general, however, menopause and female aging are subjects not widely spoken about, and there were few representations to choose from.

Press Review. I reviewed 209 articles that were published between 2008 and 2017 in six online newspapers and magazines, which were selected due their influence on public opinion and because they are fully accessible on the internet. It is important to note that there is not a fully independent press in Chile since most of the media (both printed and online versions) belong either to Copesa or El Mercurio, two corporate groups. Their editorial stances tend to be aligned and it is common for all of their media coverage to be devoted to the same topics.

The sample was intended to represent the different orientations that the press has in Chile, from right-wing conservative media to the so-called independent media. In the following chart, the news outlets are listed by media group.

Table 2. Press sources

Publication	Ownership, format, and political leanings
Emol	Emol is the online version El Mercurio, a right-wing newspaper and a prominent voice of politically conservative groups.
La Tercera	Owned by COPESA. La Tercera is COPESA's main newspaper, with both print and online versions. It expresses a right-wing conservative perspective.
Revista Paula	Revista Paula is the oldest magazine for women and was a leading feminist publication in the sixties. It has become more conservative and mainstream, and now targets upper-class women for its audience. It has both a print and online version.
Terra	Terra is a foreign media corporation that distributes content in several Latin American countries such as Colombia, Mexico, and Nicaragua. It had a website for Chile where it published local and regional news until 2016. Some of its content, particularly in the fields of health, well-being, and entertainment, is the same throughout Latin America.
La Nación	Independent media. La Nación is a state newspaper. Its paper version ended during the presidency of Sebastian Piñera, a right-wing politician, but it continues to exist as an online newspaper and is now considered more independent and progressive.
Radio Bío Bío	Radio Bío Bío includes broadcast radio and a webpage that publishes news and reports. It is owned by the Mosciatti family. According to a2016 survey, it is the most preferred radio in Chile (Leal, 2016).

Note: In order to review all of these press sources through 2017, given that Terra shut down its Chilean website in 2016, I reviewed its Brazilian site both in Spanish and Portuguese. Because articles were produced by an international press agency I sustain that there is no considerable difference between the content published on the Chilean and the Brazilian sites.

Analysis of scientific articles on menopause and aging. To analyze biomedical perspectives on menopause and female aging, I critically read 40 biomedical science articles published in Chile between 2002 and 2017. Most were published in *Revista Médica de Chile* (Medical Journal of Chile) and *Revista Chilena de Obstetricia y Ginecología* (Chilean Journal of Obstetrics and Gynecology). Also, in 2009, *Clínica Las Condes*, the journal of the private clinic by the same name, published a special issue on menopause and climacteric authored by highly renowned specialists. I identified the following topics as the most addressed: effectiveness, side effects, and risks of HRT (12 papers); menopausal women's quality of life (7 papers); relationship between climacteric and health issues such as hypertension, depression, thyroid, skin, etc. (6 papers); and the relationship between

menopause and cardiovascular health issues (4). To find the articles, I searched internet databases, such as Scielo.org (Latin American journals), jstor.com, and Medline. Search engines such as scholar.google.com and PubMed were also used in order to gain faster and focused access to the above-mentioned databases.

Data Analysis

According to Silverman (2013) data analysis "is a pervasive activity throughout the life of a research project" (p. 230) and cannot be understood as only a later stage of the research process. As Guber (2001) points out, the process of doing participant observation and ethnographic interviews cannot be divorced from the process of analysis itself, since the identification of relevant topics to be explored and described implies a continuous analysis.

Silverman (2013) suggests the use of relevant questions that can lead to a preliminary process of analysis. First, the researcher should identify the main units of the data and how they relate to each other. Second, they should identify the categories that are actually used by the people being studied. Third, the contexts and consequences of the use of categories carried out by the research subjects must be identified.

According to Jacobson (1991), the result of ethnographic research is an argument that is drawn from a set of theoretical principles and supported by empirical evidence. Jacobson (1991) states that recounting the ethnographer's experience is not sufficient proof that her conclusions correspond to the feelings and actions of her informants. However, the reliability of ethnographic arguments has become a debatable issue, particularly after the postmodern turn in anthropology.

Many anthropologists, particularly within the field of health care research, have turned to grounded theory when it comes to analyzing qualitative data. Snow, Morrill, and Anderson (2003) explain:

> one of the reasons for the proliferation of grounded theory studies over the past three decades has been that Glaser and Strauss provided a systematic and (at least to some) compelling articulation of this approach that other scholars were then able to apply to their own topics and settings. No matter what the pros and cons of the grounded theory approach, it has flourished in part because of the absence of other well-articulated models for linking ethnographic research and social theory. (p. 195)

The process of data analysis in grounded theory helps refine the data, using an iterative process that allows interpretations to be made from the data collected (Crang & Crook, 2007). However, grounded theory implies several conditions that are not followed in the present research, for example, the absence of pre-existing theoretical assumptions and axial and selective codification.

My analysis of ethnographic data relies on principles of interpretive anthropology, which allows us to describe the meanings that can be inferred from the data. Terms, concepts, classifications, distinctions, comparisons, metaphors, examples, and so forth, all expressed by the research subjects, are data that allow us to dig into the meanings attributed to the research issues. According to Geertz (1973), anthropological

interpretation consists of:

> tracing the curve of a social discourse; fixing it into an inspectable form. The ethnographer "inscribes" social discourse; he writes it down. In so doing, he turns it from a passing event, which exists only in its own moment of occurrence, into an account, which exists in its inscriptions and can be reviewed. (p. 19)

Geertz (1973) adds that the pictured sketched by the ethnographer cannot be complete but is only a fragment of a social phenomenon:

> the situation is even more delicate, because, as already noted, what we inscribe (or try to) is not raw social discourse, to which, because, save very marginally or very specially, we are not actors, we do not have direct access, but only that small part of it which our informants can lead us into understanding. (p. 20)

According to Osorio (1998), the basis of interpretative anthropology is informed by what Ricoeur calls the "hermeneutic circle": we need to understand in order to believe and we need to believe in order to understand (Ricoeur, 1969, quoted in Osorio, 1998). In order to bridge understanding and believing we need interpretation (Osorio, 1998). Osorio explains that to understand is to partake in a symbolic web that gives meaning to the event being observed. If I cannot do that, it follows that there is no way to interact with the subjects because I do not belong to their world. According to Osorio, the purpose of interpretive anthropology is to open that world through the registering of conversations between the anthropologist and the research subjects, because such conversation allows understanding the subjects' world as well as also the world of the anthropologist (whatever that is). Therefore, the hermeneutic culture is beyond the scientific world as it does not attempt to explain a social phenomenon but to find out the meaning of it.

I analyzed the data according to the steps laid out by Amezcua and Galvez Toro (2002):

a) Reduction of data. This step attempts to select and summarize the data collected. To some extent, this process is performed before the actual data collection by formulating research questions and a theoretical framework. Once the data is collected, summaries, codifications, classifications, and the establishment of relations between the research topics are ways of reducing the data. In this stage paying attention to metaphors, particular terms, and other forms of signification put forward by the research subjects is key to unraveling the meanings. The production of an ethnographic account can be considered as a process of data reduction and interpretation in itself, given the above-explained perspective of interpretive anthropology.

b) Presentation of data. Here, the researcher's reflexive view is presented through schemes, summaries, and diagrams.

c) Elaboration and verification of conclusions. The researcher uses various tactics to interpret the collected data, such as comparison, identifying patterns and recurrent issues, searching for negative cases, and triangulation. In the particular case of this research, significant attention was paid to an ex-post analysis of other research projects that focused on aging and menopause in Chile, the results of which provided support to the findings.

CHAPTER 2.

PUBLIC POLICIES REGARDING MENOPAUSE AND AGING

The Development of the Health Care System in Chile

This chapter has two main objectives. First, I provide a description of how the health care system works, and the main historical changes that explain the coexistence of two highly segregated and unequal health care systems. I contend that this inequality affects the way aging women access health care, particularly when seeking relief for menopausal complaints. In the second part of the chapter, I describe and analyze public policies aimed at the aging population. Most of these efforts focus on the needs of the elderly living in poverty; there is no comprehensive public policy on the needs of aging women. The only visible effort to respond to women's needs is found in the 2014 technical guidelines for treating menopausal women, which contain a very medicalized view on women's needs.

As part of my fieldwork, I visited several health care facilities in both private and public systems. The primary health care centers, or "*consultorios*" as people call them, were usually crowded and seemed to have less light and fresh air. Elderly people, chronic patients waiting for regular checkups to get their medicines, children with respiratory diseases, and pregnant women made up most of the crowd. The waiting rooms always had fewer chairs than people, and some had big television screens showing Chilean programs that kept people entertained while waiting. In some low-income neighborhoods, the televisions had been stolen so many times that the staff had given up and stopped replacing them, even at the expense of making people more impatient and complaining. Early mornings were busy, as people tried to get there as early as possible with the hope of being seen quickly or at all.

Usually when people need emergency medical attention, they go straight to the public hospitals with the hope of being seen sooner by a medical specialist. This strains the hospital emergency services, which are not able to respond to the demand. Even though primary health care centers also offer attention for medical emergencies, I found that people just did not like going there: they thought that because the centers are staffed by general practitioners, not specialists, and have less technology, their issues were not being dealt with properly. As one interviewee said to me once, "I don't go there to get just an aspirin or paracetamol—that I can buy myself." This gap between the health care network and the expectations and needs of patients has been a constant source of conflict in the functioning of the public health care system at large.

Menopausal women go to the *consultorio* for specific checkups, particularly when they are due for breast and uterine cancer screenings, or if they have chronic diseases such as diabetes and hypertension. Some of them also see a psychologist[4]. If they need psychiatric drugs (most commonly antidepressants and anxiolytics) they are referred to the secondary level to see a psychiatrist; these schedule very few and far between follow-up appointments. For the most part, menopausal women rely on the attention provided by the psychologists at the primary health care centers.

I once went with Maria, one of my interviewees, to her appointment with the psychologist. The wait was long, so we spent long hours in the corridor sitting next to the psychologist office. There were other older women also waiting to be seen. At that time, a very famous Chilean TV host had died in an airplane accident, and most of the conversation centered on the tragedy. A woman who worked in the health care center approached us. She had the recognizable look of a health care professional, with some sort of uniform (but not the white coat that is reserved for physicians) that indicated her position within the institution. Also, her well- styled hair and make-up indicated that she was not one of the patients. Her somewhat disengaged attitude helped to complete the picture. She said, "I am a nutritionist here . . . [and] we are carrying out a campaign to promote healthier food habits. It is called 'five a day'. It means that you are supposed to eat five fruits every day. That is healthy; it helps you to have better health, not to be fat." She went on, and asked: "Do you know that is good to eat fruit? Do you eat fruit?" We all looked at her, like schoolchildren being interrogated by their teacher. Luckily, one the women sitting next to me said, "Yes, we eat fruit because it is good." The nutritionist looked pleased to hear the right answer. She added, "Well, I will give you this little something, so you will remember the importance of eating fruit every day." She gave to each of us a small plastic bag that had a drawing of various fruits and the motto "five a day" and she left. We all exchanged subtle looks of complicity, some smiling. We did not talk about it, but it seemed funny to have such short introduction to "eating properly." It seemed that the nutritionist was required to inform a certain number of people about the campaign, but she did not bother to establish a dialogue, to ask whether we had questions, or offer to explain anything further. Some of my interviewees had told me they had difficulty accessing nutritionist help at the health care center, describing how much they suffered for not being able to lose weight and their sense of powerlessness about it. The waiting went on; we came back to the topic of the tragic death of the TV host. Maria was finally called in; I was not allowed to enter the consultation room with her.

When she was done, I asked her how it was, and she replied, "As always, the same. I am trying to get a consultation with a psychiatrist, so I can get stronger pills to sleep."

When I recall these observations, checking my field notes, it is impossible not to think of the contrast with the private health care system. Most of the gynecologists work in medical offices or clinics. Consultation appointments are easy to get (within one week, for sure) and usually the waits are no longer than thirty minutes (which is very punctual in Chilean terms).

4 Centros de Salud Familiar (Primary Healthcare Centres in Chile) often offer psychological treatment to their patients. Psychologists are included as part of the primary healthcare professional team.

One of the gynecologists I interviewed offers his private services in a clinic. The decorated waiting room, with sofas, paintings on the wall, plants, and a small table with current magazines, felt like an invitation to relaxation. Classical music played at a moderate volume and a mildly fragrant smell was also pleasing. There were a few women in the room, all of them waiting in silence. Sometimes one of them made or received a phone call; if they stayed in the room they kept it short or went to the hall outside to talk more privately. As they were called in, the gynecologist opened the door of his office and greeted them with a kiss and a brief hug (something common in Chile among those who consider themselves equals). The consultations were short. I estimated no more than twenty minutes for each patient.

I had contacted the gynecologist through a friend we have in common, and he told me to come that day and wait until he was done with his patients. He explained that on that day, he would have fewer appointments, so there was a chance he would finish earlier and have time for the interview. However, I did not foresee that he would also be receiving a couple of medical visitors, sellers of medical products, who tried to jump the queue into his office. It was clear that they were used to doing so: they arrived with an attitude of familiarity, greeting the secretary, and confidently waiting for the opportunity to sneak in. They all carried a big black leather briefcase filled with brochures and samples, dressed in business attire. This professional look is an important asset to be well received by the physicians and they all clearly paid attention to it.

As a patient exited the physician's office, a salesman would stand up and look to see if he was invited to enter the office. The doctor would often make a hand gesture indicating that he must wait. Eventually, he would invite the visitor in, looking at the next patient and telling her gently, "Please. wait just a second." I surmised that he knew his patients well, and was able to assess who would be more willing to wait. In any case, the sales visits are actually short, and nobody seems to bother that much about it. This was, again, in stark contrast with the public *consultorios*. In the private environment, time seemed to have a different value—perhaps because the waits were shorter and the possibility of being attended was ensured—and people seemed to be more patient. The comfortable and relaxing environment helped, no doubt.

In the public health care services, in contrast, there was a collective sense of impatience: everyone seemed tired of waiting and they looked at each other, making gestures to convey how tired or irritated they were because of the long wait. An easy way to start a conversation with anyone in a public health care center is to mutter the sentence, "This is getting long" (*qué se demora esto*). This immediately launches a conversation in which one will describe how long they have been waiting and what the purpose of the visit is, among other details. There is also room for solidarity. Some people shared their food with others and looked after the belongings or children of someone who had to go to the restroom. Especially among older women it is possible to find that caring attitude. In the private clinic, such solidarity was not necessary, as the toilet was next to the waiting room and anything could be asked of the secretary. For instance, I saw someone ask her to charge her cellphone. Because of the privacy of the place (and the likelihood of security cameras) women with children did not seem worried about leaving their children alone while going to the restroom. In addition, I noted something that is very visible in Chilean cities: more privileged people usually do not carry many things with them, because everything can be left in the car that is parked just outside the building.

Finally, after waiting for two hours, I got to enter the office of the gynecologist. He was friendly and asked me a lot of questions about how our mutual friend was doing, since he had not seen her lately. He soon said that he had little time and asked me to keep the interview as short as possible, and advised me to read the recent papers on HRT because "everything is just in there." He said that they closely followed the science and no one dared to do anything different than what was recommended in the literature. As I imagined it would be, the office was comfortable and well decorated, with university diplomas and family photos to give a more personal touch to the place. He had a separated space with a gynecology chair and other instruments for examination and a small changing room. The place seemed designed to ensure the comfort of the patient.

In this chapter I explain how the striking differences between the public and private health care systems came to be, and how they differentially affect women. Given that access to health care deeply shapes how women experience their aging, it is important to identify certain features of the Chilean health care system, including how health care is funded and how it is accessible, or not, to different social classes.

During my fieldwork I came across a variety of cases of "health seeking behavior" (Kleinman, 1980) that indicated a highly segmented way of practicing health care. Women from the upper-middle-class group had "freedom of choice": they were able to choose which gynecologist they wanted to get medical services from (sometimes following the experienced advice of other friends), they asked for opinions from different practitioners, and they were even able to attend different private clinics to seek for the advice of a specific specialist. Generally speaking, the private insurance system (Instituciones de Salud Previsional, or ISAPRES) covered medical consultations at the patient's request. It is worth noting that access to endocrinologists (as further explained) was particularly difficult because of a shortage of specialists and the fact that an overwhelming majority of them is based in Santiago. Therefore, women who live in other cities, in addition to getting an appointment and securing insurance coverage, must travel to Santiago to access that sort of medical attention. In Concepción, I came across several women who told me of their trips to Santiago to get specialized medical attention, particularly from endocrinologists.

Working-class women mainly relied on the advice of midwives at the primary health care centers, and once in a while they got to see a general practitioner. Most did not have access to specialists such as gynecologists and endocrinologists, and, if they needed one, instead of waiting for months (or sometimes years) to get an appointment within the public health care system, they resorted to private consultations that they had to pay for completely out of their own pockets (approximately US$ 50 for one consultation). Because the way women access to health care in Chile seems to be so critical for understanding how they deal with menopausal complaints and other associated health issues (overweight, diabetes, hypertension, and so on), I now give an overview of the history of the health care system, describe how the health care system works, how explain how access and financial protection are provided, and most importantly answer why the striking inequalities of the Chilean health care system have become naturalized for women.

Chile's Two Health Care Systems

Health care in Chile is provided through two separate systems: one public and one private. The development of this mixed system in Chile is the result of several historical and sociopolitical events that had different effects, according to the political forces and agendas that came into play, resulting in an "accumulative synthesis" (Parada, 2004). For example, the development of a strong private health care system is in part the result of Pinochet's neoliberal policies that attempted to dismantle the public health care system, which were implemented by 1980 (Tetelboin, 2003).

2

Based on the classification suggested by Parada (2004) it is possible to identify six periods that account for the main structural changes in the health care system in Chile:

1. the consolidation of the state's responsibility for public health (1918–1924), which had as a main accomplishment the creation of "Caja del Seguro Obrero Obligatorio", a mandatory social insurance for workers in 1924;

2. the development of the national public health care system, which started in 1924 and was fully established in 1952;

3. the 1968 passage of a law on curative medicine, which allowed physicians to practice their profession independently. This opened up possibilities for the medical organization "Colegio Médico" to resist the public health care system and allowed physicians to continue to have private practices;

4. the modernizations brought about by an authoritarian neoliberal regime between 1979 and 1989, which encouraged the flourishing of a mixed and decentralized public-private health care market of services and insurances;

5. the strengthening of a mixed market in health care (1990–2000); and

6. the development of reforms that attempted to correct inequalities in health care, without challenging the fundamental political basis of the current model, which sometimes reinforced the public-private integration (Donoso et al., 2013).

Public Health in Chile from the 1800s to the 1970s

The Ministry of Health was created by decree in 1959, charged with planning, controlling, and coordinating activities regarding public health. Before this, there were other institutions in charge of public health affairs. Since the beginning of the 19th century several state-ruled health care institutions were founded. For instance, the Junta de Vacunas (Vaccine Council) was created in 1808 and the Junta Directiva de Hospitales (Head Council of Hospitals) was created in 1832. By 1850 there was an organized effort to provide public health care through the Sociedades de Socorros Mutuos (Societies for Mutual Help), which were workers' organizations that utilized solidarity systems[5] of private

5 The "Sociedades de Socorro Mutuo" were organizations of workers aimed at providing insurance in case of accident, disease or death of their members. They collected money on the basis of individual monthly payments, which was used to cover the medical expenses of those in need of medical treatment.

savings aimed at providing health care services and emergency funds to their members (Ministerio de Salud, 2016).

The development of the welfare state in Chile started in the first decades of the 20th century, when a set of initiatives regarding housing, labor, health care, and education were implemented (Larrañaga, 2010; Illanes, 2010). It was a response to the so-called social issue that was arising among the working class, both in the mining centers and in the main cities in Chile. The "social issue" referred to the concentration of huge masses of workers in mining towns in the north of Chile and in the construction of railways and ports. Poor working conditions catalyzed the formation of political parties intended to represent the interests of the working class (Larrañaga, 2010). This milieu of social agitation pushed the educated sectors to adopt a reformist agenda that advocated for the protection of the family and good treatment of workers (Illanes, 2010). The reformist agenda was supported by the Christian social forces within the Conservative Party and representatives of the Catholic Church (Larrañaga, 2010).

In 1924, the Ministry of Hygiene, Social Assistance, and Welfare was created, which would carry out tasks related to public hygiene. In 1927, a restructuring led to the founding of the Ministry of Social Welfare, which was charged with public hygiene, assistance, and social welfare; the inspection of work conditions and housing; the inspection of "*cajas de prevision*" (private organizations of solidarity savings) and the improvement of social affairs laws (Ministerio de Salud, 2016). After several changes, the Ministry of Health was finally created in 1959, and social security and labor laws affairs became part of the Ministry of Labor and Social Security.

By the mid-20th century, efforts were concentrated on improving medical education. At that time, there were several governmental agencies involved in health services; these were unified in 1952 to create the Chilean National Health Service (Servicio Nacional de Salud) (Cornely et al., 1977). Universities kept their hospitals and student health care services, and a few other units remained independent such as the medical services of the Carabineros (national police), the army, the prisons, etc. It is worth noting that during that period a private health care system existed mainly for the privileged who turned to private medical practitioners when needing health care (Larrañaga, 2010). In rural areas there was not sufficient provision of health care; people had to travel to the cities for medical attention and often resorted to traditional healers outside the biomedical system (Illanes, 2010).

During the first half of the 20th century, workers' movement put pressure on the governing class in order to ensure that their basic needs would be met by the state. The creation of the Servicio Nacional de Salud would be the culmination of efforts to organize a state planned and administered health care service. According to Cornely and colleagues (1977), since its beginning, and as elsewhere, the national health care service faced all the problems of providing comprehensive care to meet all health needs. One such problem was the lack of funds for preventive care: "early criticism came from those oriented to public health, charging that the larger burden of medical and hospital care consumed such a high proportion of available resources that prevention and community-based services suffered seriously" (Cornely et al., 1977, pp. 32–33).

From 1970 to 1973, during the government of Socialist president Salvador Allende, major developments in health care were accomplished (Cornely et al., 1977), including

more ambulatory and rural services, the increased use of volunteers, and greater participation of the community in health decisions, mainly through neighborhood health councils. Cornely and colleagues (1977) point out that some of these measures may have been challenging for the physicians' establishment, particularly those that gave more power to the community and potentially undermined the traditional high status of Chilean physicians:

> in the Chilean context, however, where physician decision making had never been questioned, these provisions, giving substantial functions to non-professionals and consumer groups that included the poor and illiterate, were quite unsettling. Furthermore, the Government sharply expanded reliance on the nationwide system of health centers, reallocating resources previously controlled by the hospital sector, which found itself in a lower priority position, a situation sharply resented by specialists. (Cornely et al., 1977, p. 33)

This may partially explain the loss of political support from the Colegio Medico that Allende faced in his last days in power:

> among the significant issues were the Colegio's opposition to changes in the form of medical care delivery, the perceived threat of change of the physician's status in Chilean society, and the physicians' minority position on the local health councils as compared with consumers and non- professional health workers. (Cornely et al., 1977, p. 34)

Further, the Colegio Medico and the physicians who resisted Allende's health reforms felt deeply threatened by the government's extending the National Health Service's influence over the private sector. They feared the complete statization of health care in Chile, which could lead physicians to "lose their professional status" (Cornely et al., 1977, p. 34).

Pinochet and Privatization

With the military coup on September 11, 1973, there came a dramatic transformation in the way public health services were administered. The military junta aimed to dismantle the National Health Service and ensure the development of a stronger private health care system, and created a "National System of Health Services" as the institution to regulate all public and private health organizations in the free exercise of the medical profession. The goal was to achieve "the growth and development of private and semi-private medicine so that each year a larger number of persons can be incorporated into these two systems" (Spoerer, 1973 quoted in Cornely et al., 1977, p. 34). Therefore, the main goal of the reform since the beginning of Pinochet's regime was the privatization of the health care system, making Chile a pioneer in privatization of public services.

The National System of Health Services was divided into two domains. The administration of public hospitals went to 26 new Regional Health Care Services, which inherited most of the duties of the former Servicio Nacional de Salud. These regional centers (there are currently 29) depend on the Ministry of Health who appoints the directors and decides on professional staff. The administration of the primary health care centers was transferred to the municipalities. The directors of such centers are appointed by city mayors (*alcalde*), even though funding for primary health care still comes from a central

government budget. This disarticulation was highly resented by certain stakeholders who argued that centralized organization was the key for achieving ambitious public health goals. This decentralization broke the health care network between facilities that work at different complexity levels in health care. This change also impacted medical practitioners' professional development; in the previous arrangement, they were supposed to work in primary health and later be promoted to hospitals where they would be allowed to perform more complex interventions, reaching a higher qualification and status. With these changes, working in primary health care centers became less important and Chile began to face a shortage of medical practitioners at this level (Montoya- Aguilar, 2010; Roman, 2007).

These reforms explain how women currently access health care services in Chile. In the case of the public health care system, services are offered first through primary health care centers, which provide general medical attention. The underfunding of primary health care as well as the lack of policies to ensure a sufficient number of general practitioners at this level, mean that most reproductive health care relies on midwives, who are neither professionally nor legally authorized to provide comprehensive health care to menopausal and aging women. As discussed later in this chapter, there is an ongoing debate regarding whether to give more "treatment power" to midwives to address menopausal women's needs or to ensure women's access to medical specialists at the secondary level.

After 1973, social policy was oriented towards market freedom; in the health sector, privatization was based on the idea that individual contribution would determine the level of access to health care (Missoni & Solimano, 2010). According to Laurell (2016) this is the result of the adoption of a neoclassic economic thought that sees health also as a domain of free market economy. This reasoning gave ultimately existence to a gap between privileged women who can afford to pay for specialized medical treatment for menopausal complaints (including the use of HRT) and those who must resort to the limited care provided at the public health care centers, which may include prescription of HRT but does not provide access to it. The neoliberal agenda makes clear that public health care was aimed for the poor who could not afford private medical services and "the public sector was seen as the provider of last resort" (Unger et al., 2008).

Article 19, Section 9 of the Chilean National Constitution, approved during Pinochet's regime stated that:

> The State protects the free and equal access to the actions of promotion, protection and recovering of health and rehabilitation of the individual. It falls to the State to co-ordinate and to control those actions related to health. The preferred role of the State is to guarantee that the execution of health actions fits with the norms and laws, even if actions are performed by public or private institutions. (translated by and quoted in Missoni & Solimano, 2010, p. 5)

In other words, the right to health care is replaced by the right to choose between public and private health care, and the state is no longer obligated to provide health care to all citizens. According to Illanes (2010), with Pinochet's military regime, 50 years of a welfare state in Chile came to an end. Illanes (2010) states that the public health care system was created "in the name of the people" and was intended to protect the working class from the continuous reproduction of poverty (p. 505). The new order brought back a separation between the people and the state, with the state assuming only limited

responsibility for meeting people's needs.

In 1979, The National Health Fund (FONASA) was formed and charged with managing the resources allocated from the national budget and received from the compulsory payments of employees (7% of their salaries), who either decided to remain in the public system or could not afford private insurance (Tetelboin, 2003; Unger et al., 2008). Coverage within FONASA was, and still is, classified into four different groups, from A to D: "A" corresponds to few resources or indigent, "B" corresponds to very low income, "C" corresponds to lower-middle income, and "D" corresponds to those with higher-middle income. Those in categories A and B were meant to only access the public health care centers.[6] Groups C and D were entitled to see private providers who accepted payments from FONASA but they had to pay up to 50% of the expenses out of pocket (Unger et al., 2008).

In order to ensure the funding of the private health care sector, the country then launched a private health insurance market in 1981, called Instituciones de Salud Previsional (ISAPRES). The ISAPRES market offered many different individual schemes, tailored according to sex, age, health risk, and most importantly the payment capacity of the clients (Unger et al., 2008). Users sign individual contracts that state the degree of coverage and benefits for individuals and their dependents. Those benefits vary according to the amount of premium paid and the health risk of the insured. Health schemes are legally authorized to exclude pre-existing health conditions, which makes those users with particular medical conditions more vulnerable (Dannreuther & Gideon, 2008). Because ISAPRES are based on individual risk without a solidarity sharing of health costs, the market concentrated on the well-to-do and young clients with lower health risks (Unger, De Paepe, Cantuarias, & Herrera, 2008). Even though the ISAPRES system has coexisted with the public health funding system since its founding, Unger and colleagues (2008) assert that the private system was intended to become dominant.

According to Unger and colleagues (2008) women tend to have a limited access to ISAPRES due to the well-documented gender gap in incomes as well as the fact that ISAPRES offer more expensive schemes to women on the basis of expected higher expenditures. Women at reproductive age had to pay higher premiums, which led to the development of *planes sin útero*, or "no womb health insurance." Under this scheme, women accessed cheaper health insurance but were required to pay out-of-pocket for maternity-related costs. This development was highly criticized by feminist activists in the realm of health care (Tajer, 2012). In 2014, women accounted for the 45.8% of ISAPRE clients, and 52.7% of FONASA users were women (Sánchez, 2016). However, these percentages include women who are dependents of policy holders. When we look closely at the number of women who actually have signed contracts with ISAPRES this percentage diminishes to 35.6% (Sánchez, 2016). Therefore, there is a persistent gap in the access to private health care for women in Chile.

The changes introduced in the financing system and in service delivery created a

6 This changed during Sebastian Piñera's right-wing government (2010–2014) when group B was allowed to access health care in the private system on the basis of co-payment. This was part of an agenda to further privatize national health care (Donoso et al., 2013).

deeply divided and unequal health care system that produced even greater inefficiencies, which deteriorated the quality and access to health care among many social groups. Resources are still unequally allocated to young, healthy, and male individuals in the private system, meanwhile women as well as the sick and elderly must resort to the public health care system. This inequality in the social distribution of health expenses has brought enormous profits to ISAPRES companies (Dannreuther & Gideon, 2008; Zuñiga, 2007; Parada, 2004).

At the same time, as part of the process of dismantling the national health care system and undergoing structural adjustment, the funding of public health services was dramatically cut, which negatively impacted the supply of health care in public facilities. This strategy was portrayed by the military regime as decentralization, but in practice the control of financing and program design remained in the headquarters. Furthermore, preventive measures and health promotion actions were insufficiently funded. Public hospitals and health centers lacked personnel and equipment, which in turn had as consequence long delays for services (Unger et al., 2008).

21st-Century Reforms

The first attempts to reform the national health care system developed in Pinochet's days came from the socialist government of Ricardo Lagos (2000–2006). In 2000, the Chilean Ministry of Health defined a list of key health objectives for the decade and elaborated several bills to reform the health care system. The bills submitted to Parliament were: the Health Authority and Management Law, aimed at dividing the regulatory functions (health public policies and epidemiology surveillance) from those related to the management of health service providers; the Private Health Law, which attempted to improve private sector regulations; the Financing Government Expenditure Law, which was intended to secure additional resources in order to financially support the reform; and the Regime of Explicit Guarantees in Health Law, which established a health plan that secures access to timely health care to those affected by a number of pathologies that were defined as health priorities.

The main goal of the Regime of Explicit Guarantees in Health Law (GES) is to guarantee prioritized access to health care to part of the population suffering a number of pathologies considered worth of urgent treatment. The current list includes 80 prioritized health conditions; at the beginning of GES, there were 56 health conditions on the list. It has been established that in the process of elaborating the list of prioritized pathologies, political considerations were also regarded such as the feasibility of providing universal coverage (Donoso et al., 2013). While the GES plan also states a set of guarantees intended to secure access, quality, opportunity, and financial protection to the patients affected by the selected pathologies, in both private and public health care systems (Bastias et al., 2008), it would be misleading to equate this policy with universal access to health care. As Zuñiga (2007) argues, the GES policy is loaded with several exclusionary conditions (such as age ranges and place of residence) that in practice set up barriers to access health care.

The criteria used to select these prioritized conditions included effectiveness of

treatments available and their cost, the response capacity of the health system, financial burden, and social consensus in term of which pathologies should be prioritized. According to Bastias and colleagues (2008) this prioritization was based originally on an algorithm that considered several sequential variables. Guarantees of access and opportunity, in contrast, were defined according to experts' technical opinions regarding each condition. The guarantee of financial protection was defined using studies that assessed the impact that a universal health plan would have on the financing of the health care system (Bastias et al., 2008). As González (2016) has stated, which pathologies are included in this plan has been influenced by social movements and patients' organizations by exercising political pressure.

At the same time, health conditions in Chile have improved extensively in recent decades. For instance, life expectancy has reached 80 years for women and 73 years for men. In 2015 the infant mortality rate was 7.01 per 1,000 live births, marking Chile as having the lowest rate of infant mortality in South America (Missoni & Solimano, 2010). Chileans' living conditions have improved during the last decades, due to socioeconomic development and strong efforts in improving preventive health care. According to Contreras (2003), poverty rates were reduced from 40% in 1990 to 18% in 2003. According to the World Bank, the percentage of poverty in Chile in 2013 was 9% of the population.

The Chilean epidemiological profile has experienced significant changes in the last decades, moving from the preponderance of communicable diseases to a considerable increase in non-communicable and chronic diseases. This transition is linked to the aging of the population (in turn related to a decrease in fertility rates), urbanization, environmental deterioration, and lifestyle changes regarding feeding patterns and sedentary practices. In spite of positive average health indicators, morbidity and mortality vary considerably across socioeconomic groups and place of residency; this suggests that programs and policies have not been completely effective in helping Chileans who remain in poverty (Missoni & Solimano, 2010). Health disparities are also explained by the high level of economic inequality in Chile. According to the OECD, when income inequality is measured by using the Gini coefficient, Chile turns out to be the most unequal country within the OECD. The reported incomes of those who belong to the top 10% in terms of wealth in Chile are 26 times higher than that of those who belong to bottom 10% (OECD, 2015).

As mentioned before, the structural segmentation of Chile's health care system resulted in low-income, high-risk populations being served mainly in the public health care system, which could not meet that demand; meanwhile high-income, low-risk populations (mainly young and healthy men) are treated in the private sector (Missoni & Solimano, 2010). Because of age discrimination (adverse selection) in the private health insurance system, most elderly people are forced to move to the public health care system as they grow older and their premiums start to increase; this happens even if they have had private insurance throughout their working years.

Overall, the development of two separate health care systems has consequences not only in the quality of health care people have access to but also in the way they experience citizenship. As Sanabria (2011) has argued, two parallel forms of citizenship coexist in the case of health care system in Brazil. One is available to the privileged, who pay for private care, and is based on ideas of personal autonomy, individual choice, and self-enhancement. Another one is provided by public health care, and it frames women's

decisions in terms of the individual's moral responsibility to the collectivity. In other words, the limited options that poor women have in terms of contraceptive technologies and use of hormones are framed as a "social responsibility" that women must undertake. While this description fits the scenario of health care for women in Chile as well, I also found that privileged women were constrained in their access to health care through private insurance and in their options for menopausal treatment, due to the power of the biomedical discourse. As will be argued in the following chapters, medical practitioners as well as the media, consider HRT as the cornerstone for treating the complaints of menopausal women, no matter what class.

Public Policies for the Elderly in Chile

One of the main problems elderly people face in Chile, as well as in other Latin American countries, is the fact that their pensions do not cover their basic living expenses. The minimum wage in Chile is around US $ 385 per month, and around 53% of Chilean workers earn less than US$ 429 (Duran & Kremerman, 2015). It has been estimated that the average monthly pension is US$ 214. Therefore, when retiring men and women face poverty and lack of access to minimal services. This problem is even worse in the case of women, who for many years did not have a pension at all if they did not have long-lasting paid work. In 2008, Bachelet's government implemented a retirement reform that established a basic pension for everyone who reached 65 without having enough funds for retirement. The amount of this pension is around US$ 100. It has been estimated that 60% of women will receive this pension (Diaz & Mora, 2011). There is also a retirement supplement aimed at those who may have retirement savings, but the amount of their pension is too low to meet minimal needs. According to the Ministry of Social Development (Ministerio de Desarrollo Social, 2017) the estimated cost of a monthly individual basic food basket is US$ 67.5; "extreme poverty" is an income under US$ 173 per month. As a matter of fact, most of elderly retirees fall into poverty and extreme poverty.

In 1981, Chile initiated a pension reform that introduced mandatory funded individual retirement accounts through private companies called Administradoras de Fondos de Pensión or AFPs (Pension Fund Management Companies) (Calvo et al., 2010). Workers are compelled to fund their retirement savings through monthly payments of 10% of their salaries. Workers pay also administration costs to the companies up to 2%. Funds are managed by private companies that invest that money in stock markets in order to capitalize the fund. When bad investments are made, the workers lose part of their savings and AFPs are not held accountable for that. Workers may choose between different saving plans, from A (most risky) to D (least risky), with the idea that more risk equals more profit, at least with good investment decisions. But because of a limited amount of information, many do not know which funds their savings are invested in.

In the 1990s economists and policy makers announced that by 2020 people will retire with a pension 100% equivalent to their monthly income ("Gerente que anunció pensiones del 100% del sueldo responde a críticas," Radio Cooperativa, July 15, 2016). The facts have proven otherwise. According to a study conducted by Fundacion Sol (2015), 87.5% of men and 93.8% of women receive a pension lower than US$ 255. In addition,

projections indicate that someone who earned a monthly income of US$ 1,000 for 35 years will receive a pension amount of 39% of such salary. Critics of the AFPs system argue that after 35 years it has proven a failure since it cannot offer pensions that allow elderly to survive and meet their minimal needs (Kremerman, 2017). In rebuttal, AFP executives as well as other advocates state that the system is threatened by an increase in life expectancy and the unstable conditions of the labor market. Public dissatisfaction and fear of the negative outcomes of AFPs have sparked a social movement called "NO + AFP" (No más AFP, or no more AFPs), which for the last two years has organized massive demonstrations all over the country, creating a public agenda and political pressure for redesigning the pension fund system in Chile.

A qualitative study carried out by Gomez-Rubio and colleagues (2016) with retired women aged 62 to 74 years old, showed high level of dissatisfaction with the AFP system, particularly due to the low amount of the pensions. Women also highlighted the gender-based aspects of their situation: they receive lower wages than men, rearing children entails postponing their careers, and a lack of formal job contracts results in years of not saving retirement funds.

Some of them also acknowledge the fact that AFPs "punish" women for living longer, by calculating lower pensions in order to ensure that their funds will last for a longer time. It is worth noting that negative perceptions about AFPs were shared by both professional and non- professional women; even though the latter earned more money during their working life, their pensions were perceived to be just as meager as those of lower educated women. Women's low pensions define how they experience their later years in life, and they often must resort to finding additional sources of income, such as informal jobs, receiving help from relatives (mainly offspring), or selling their house. The authors also mention that retired women are expected to help raising their grandchildren, carrying out a considerable amount of unpaid caring work (Gomez-Rubio et al., 2016).

These unfavorable conditions for retirement explain why many people continue to work after reaching retirement age (60 years for women and 65 for men). According to Vives and colleagues (2018), among women, participation in formal work decreases and part-time work increases from the age of 50 onwards. Between ages 60 and 64, there is a significant increase in day and night shift-work, which may be related to the work of caring for older relatives. Vives and colleagues (2018) conclude that "women generally face a greater disadvantage in quality of employment, tending to have more precarious jobs than men and experience greater concerns regarding their job security" (p. 3). Women also face the burden of unpaid domestic work because of traditional gender roles.

Given current discussions about extending the age for retirement, there is a need for evidence on the health and safety of the aging workforce especially in the case of women. The findings of Vives and colleagues (2018) show that women leave the formal work market before the actual retirement age, "with employment rates dropping 10 percentage points in the 10 years preceding legal retirement age" (p. 9). This situation is attributed to "health selection," that is, they are no longer hired because of the expected deterioration of their health. Therefore, the authors argue that is unlikely that extending the retirement age would affect women's participation in the formal labor market and consequently their future pensions:

> it appears that if older women and men must improve their income by means of extending their work life, this may contribute, via health selection mechanisms, to actually increase rather than decrease health inequalities across the axes of socioeconomic status and gender, since only the healthiest and possibly those with less strenuous working lives can actually continue to work into older age. (p. 13)

2

Considering the worrisome scenario regarding quality of life in old age, it is relevant to examine the state institutions that are supposed to deal with such issues. The National Service for the Elderly (Servicio Nacional del Adulto Mayor, or SENAMA) is a public agency that was created in 2002, which falls under the Ministry of Social Development (SENAMA, 2018). Its main goal is to contribute to improving the quality of life of the elderly in Chile. SENAMA (2018) defines as "elderly" any person who has reached 60 years old, with no regard to gender differences.

In 1995, Christian Democrat Eduardo Frei's government created the National Commission for the Elderly, an advisory task force in charge of formulating plans, policies, and programs for the elderly. The commission was head by First Lady Marta Larraechea and was joined by 38 parliamentarians, public office representatives, scholars, and representatives of social and professional associations. Later, a National Committee for the Elderly was created, which was charged with coordinating the National Public Policy for the Elderly (SENAMA, n.d.).

SENAMA's goals are: to promote the active aging and the development of social services for elderly, regardless their condition; encourage their participation and value in society; promote their self-care and autonomy; promote the acknowledgement and accomplishment of their rights; and, through intersectoral coordination, design, implement, and evaluate policies, plans, and programs (Diaz & Mora, 2011). The strategic goals are:

To protect and guarantee the rights of the elderly.

To promote the social participation of the elderly.

To strengthen the social security system of the elderly.To advance towards a cultural change that allows the acknowledgement of the elderly as subjects of rights.

To strengthen the territorial management and decentralization of SENAMA.

SENAMA carries out several programs to help vulnerable elderly, however such initiatives tend to be short term and not sustainable. For instance, there is a workshop for elderly leaders all around the country. At a local level, there are councils that bring together representative of elderly organizations to advise on the right implementation of programs, and seek to address problems and diverse situations. However, it has been pointed out that elderly leaders are not collaborating with other leaders (Diaz & Mora 2011), and therefore they do not get timely access to information and do not take part in local decision processes. SENAMA has also implemented a social housing program, but the lack of coordination with other governmental offices such as health care services and the Ministry of Housing with private construction companies resulted in a low number of people benefited from this program (Diaz & Mora 2011).

Overall, Diaz and Mora (2011) state that SENAMA lacks a clear profile of the population that it seeks to help, except for knowing that it is a vulnerable population. This lack of definition has to do with the more precise features of the population and the internal differences that exist within this group. Also, the program does not clearly define what they understand by autonomy, self-management, and independence of the elderly. Finally, the program has only records of coverage and performance aspects related to efficiency and economics; therefore there is a need for other indicators, such as to what extent the program reaches the more vulnerable population and how it deals with gender gaps (Díaz & Mora, 2011).

Research conducted by Salazar (2017) finds that when it comes to ensuring care for the elderly, family is still the strongest institution, and because of traditional gender roles the preferred caregiver is a woman, usually a daughter or daughter in law. Salazar points out the complexities of caregiving relations in Chile: not only are adult children obligated to take care of their elder parents but also the elderly are obligated make a significant economic contribution to the family, especially through offering care to their grandchildren so younger women can work. The author asserts that there is intergenerational solidarity within Chilean families but the challenge is "how to extrapolate that solidarity to the rest of the elderly population, because the existence of stereotypes of the elderly as a frail and dependent group, and the privatizations of services are leading some sectors of the Chilean population toward individualism" (Salazar, 2017, p. 74).

It is worth noting that—beyond the scope of SENAMA and its concern for the elderly— there is no governmental program addressing specifically middle-aged people. The only evidence of concern one can find has to do with health care of perimenopausal women through the recently issued "Technical Guidelines for an Integral Health Care of Women in Climacteric Age at the Primary Level of the Health Care Network" (my translation), which was published by the Ministry of Health in 2014.

It is also necessary to reflect on the consequences that demographic transition brings about for middle-aged women. Research indicates that the age of those caregivers for the elderly ranges between 40 to 60 years old (Salazar, 2017); they are caring for their parents with no proper social support in place. The gaps in social security and retirement policies further exacerbate things for middle-aged women, not having the necessary resources to ensure their wellbeing and proper access to health care. The available data indicates that this problem will only increase in the future since there are no comprehensive policies that can foresee and effectively engage in the challenges posed by an aging Chilean population.

Description and Analysis of the Public Health Policies on Aging

Regarding treatment offered to menopausal women, the National Health Plan for Health Objectives 2020 establishes as main goals: to reduce to less than 15% those women who manifest a significant decreasing in their quality of life, increase to 30% those women who carry out climacteric check ups and prescribe HRT to at least 70% of women with altered quality of life at public health care centers (Salinas, 2017).

In 2014, the Ministry of Health issued the document *"Orientaciones Técnicas Para*

2

la Atención Integral de la Mujer en Edad de Climaterio en el Nivel Primario de la Red de Salud – APS"(Technical Guidelines for an Integral Health Care of Women in Climacteric Age at the Primary Level of the Health Care Network). The main goals of this national strategy are 1) to contribute to improving the quality of life in the climacteric period, by relieving the somatic, psychological, genital-urinary, and sexual symptomatology related to this life stage; 2) to contribute to reducing risk factors and encouraging early surveillance of age-related co- morbidity, especially cardiovascular diseases, bone breaks, and cancers; and 3) to contribute to women's development in their bio-psychosocial milieu, to value their multiple roles and to advance towards gender equality. The technical guidelines are described as a reference for providing health care to women aged between 45 and 64 years, who are in the age of climacteric and younger women who had either a surgical or early menopause.

There are two noteworthy facts: first, these guidelines were elaborated by a team of 28 professionals, and 93% of them are in health care professions (36% physicians, 46% midwives, 11% nurses). In the writing team there were only two non-medical-related professionals, an anthropologist and a secondary teacher. Secondly, the guidelines focused on designing an appropriate process for assessing what is called "psycho-social risk" through providing a battery of instruments, such as a survey for classifying risk according to family history, the APGAR rating system,[7] and a screening for domestic violence. In exceptional situations, the document also recommends the use of other instruments such as the genogram and the ecomap. The recommended intervention consists of providing counseling to women undergoing climacteric plus encouraging their attendance of workshops on issues such as healthy eating habits, self- esteem, communication skills, sexuality, working out, leisure time, and life planning. After six months, health care professionals must evaluate whether there are changes and improvements regarding the risk situations. Women's workshop attendance is also evaluated. After 12 months, the health care professionals must assess women's adherence to medical prescription and treatment together with workshop attendance. The instruments related to psychosocial risk must be also applied to measure possible changes.

The official guidelines of the Ministry of Health focus mainly on the biomedical consequences of climacteric and menopause for women. Together with the above-mentioned instruments and interventions suggested to health care providers in primary health care centers, there are some recommendations regarding the diagnosis of medical issues. Vaginal atrophy, persistent urinary tract infection, urinary incontinence, genital prolapse, perimenopause abnormal bleeding of the womb, ovary lumps, contraception during perimenopause, asymptomatic endometrial thickness, and abnormal genital bleeding after menopause are highlighted as issues that health care professionals may encounter when dealing with perimenopausal and menopausal women. The document also provides guidelines for prescribing HRT for menopausal women, which is highly recommended for women who score 15 or more in the Menopausal Rating Scale (MRS).

It is interesting to note that in 2017 a bill to ensure access to HRT in the public health care system was presented to Congress by Congresswoman Marcela Hernando,

7 APGAR is a family therapy rating system, with an acronym of the first letters of five words: adaptability, partnership, growth, affection, and resolve, which each correspond to the questionnaire categories. Each family member indicates a degree of satisfaction in each of the five categories on a scale of 0 to 2. The system is used most frequently in studies of families with a geriatric member (Mosby's, 2013).

who is also a physician. While the above guidelines established by the Ministry of Health recommend the prescription of HRT they do not ensure that women in the public health care system will actually have access to them. It is interesting to note that the Midwives Professional Association (Colegio de Matronas de Chile) fully supported this Hernando's bill, claiming that midwives must be allowed to prescribe HRT. In fact, in 2015 a bill to reform the Sanitary Code (Codigo Sanitario) to give greater therapeutic authority to midwives was presented. The bill states that midwives "will be allow to indicate, use and prescribe only those pharmaceuticals that the regulation classifies as necessary for the reproductive health care of the woman from contraceptive control, care for the pregnant and normal birth giving, climacteric woman, fertility regulation and general gynecological care according to established protocols" (Congreso de Chile, 2015; my translation).

However, this effort is not supported by the physicians' professional associations. The Society for Climacteric, formed mainly of gynecologists and endocrinologists, publicly expressed its disagreement (Camara de Diputados, 2017), claiming that midwives do not have sufficient training to deal with such therapies. The view of gynecologists is more aligned with the idea of having climacteric units at a secondary and tertiary level. As Salinas (2017) describes it, such units would include multidisciplinary teams that provide personalized care while focusing on a comprehensive management of the issues related to climacteric and menopause. He also points out that is "compelling to settle climacteric units at hospitals, which practically do not exist at all, so they can assume a guiding and supervising role regarding the work performed at the primary level of care which is mainly developed by midwives" (Salinas, 2017, p. 297; my translation).

An official discussion held by the Health Care Commission at the Chilean Parliament in 2017 addressed the issue of HRT access in the public health care system, inviting the president of the midwives professional association and the president and former president of the Chilean Society of Gynecological Endocrinology to give their expert opinion. Midwives argued that they are entitled to prescribe HRT on the grounds of their current involvement in sexual and reproductive care in the public health care system. They put forward their concaqerns for those women living in isolated rural areas, whose only access to medical care is the field visit performed by the midwives once or twice a year. They claim that those women would not have access to HRT unless midwives are allowed to prescribe and hand over the therapies when visiting isolated communities. Meanwhile, medical specialists oppose the measure, arguing that midwives do not have the necessary training to prescribe hormones and are not prepared to evaluate the potential risks and side effects for women with risk factors. However, when the issue of the medical specialists' shortage in the public health care system was brought up, medical specialists did not seem to have a clear recommendation. They tend to blame a "lack of incentives" for medical specialists to work in the public health care system, but do not describe what would be suitable incentives to solve this issue. Instead of giving more therapeutic power to the midwives, their proposal is to allow midwives to prescribe medicines under the monitoring of a medical specialist. This oversight of prescription was formerly used with contraception, until midwives were allowed to prescribe them in 2011.

It is worth noting that the debate became more controversial when the midwives made public that a considerable amount of replacement hormones bought by the Ministry of Health were about to expire, without being distributed, because of the lack of medical specialists to do such prescribing. Because of the highly bureaucratized procedures in

the public health care system, pharmacists are not allowed to hand over any medicine without the signature of a medical practitioner who is held accountable for it. There was no published information regarding the amount of prescription and acquisition of HRT in the public health care system. I made requests to the National Center for Medical Provision (CENABAST) and the Ministry of Health to obtain this information.[8] According to the health care network office (Subsecretaría de Redes Asistenciales) of the Ministry of Health, a total number of 4,240 women received HRT in the public health care system in 2017. Of them, 61% attended the public health care centers in the metropolitan region of Santiago (2,575 women) and 10% in the region of Biobio (where the city of Concepción is located). In the more isolated public health care centers in Arica (northern Chile) and Aysen and Magallanes (southern end of Chile), only three women received the treatment at each location. The therapies that are distributed correspond to micronized estradiol (1 mg. tablet and gel), micronized progesterone (100 mg. and 200 mg.), nomegestrol (5 mg.) and tibolone (2.5 mg.).

It seems unlikely that midwives will be authorized to prescribe HRT given the strong opposition of the medical establishment, which enjoys a considerable political strength within Chilean politics. And the idea of having more specialists engaged in climacteric units with the secondary level of public health care system seems unfeasible, especially given the critical shortage of specialists that the overall public health care system faces. This particular issue will be further discussed in chapter three.

In conclusion, there is a gap between the demographic facts and the way the Chilean state is dealing with the needs of its growing aging population. SENAMA has developed several programs and activities mostly aimed at improving the quality of life of those living in poverty. Its focus of action should be understood as part of the role of the subsidizing state which does not ensure universal rights but aims its work at those needing more support.

In the realm of health care, several actions to support aging women are found. The GES policy seeks to ensure access to health care in a limited number of health conditions or pathologies, but this accounts for only a partial view of women's health. Still, the coverage of prevention and treatment of uterine and breast cancer, and the psychological treatment of depression are important benefits for women in their middle age, especially those who use public health services. Within the realm of the public health services, what seems to be an emerging concern regarding aging women is the development of technical guidelines for the treatment of climacteric women, which stress the need for assessing and responding to issues that compromise women's quality of life.

As will be discussed in chapter three, highly specialized treatment for climacteric women seems to be in the hands of private practitioners, who prescribe "tailor-made" HRT as the best biomedical technology available for dealing with menopausal complaints. The development of this private practice of gynecologists and endocrinologists must be understood in the frame of the strong and deep privatization of health care in Chile,

8 Data obtained through the Public Transparency System, Ministry of Health. According to law 20,285 of the Chilean state, public services are obliged to provide public information to anyone who fills in a formal request.

which has led to greater consumer-oriented behavior and the logic of choice (Mol, 2008). The public health care system has not been able to ensure women's access to HRT and specialized care. Even though there are some initiatives under discussion at the moment, the power disputes between professional associations and the critical lack of funding make the success of such projects unlikely.

What also seems to be relevant is the absence of political representation for middle-aged women, whose needs are not met by public policy. The discussion seems dominated instead by a biomedical view that deems HRT as the most relevant care for women. In the face of this consolidation, the women's movement and the feminist organizations have failed to build a political agenda that represents the needs of aging women and there is no visible group able to advocate for them in the present. I argue that the needs of menopausal and aging women are considered so "natural" that they are invisible, and thus there is no vision of developing an organization like other patient groups focused on biological citizenship. The gender constructions that naturalize women's menopausal complaints "as inevitable suffering" have the effect of preventing the development of any political demand around it. In chapter three, we turn to those few who do seem to care, the medical specialists, who are very much focused on the use of HRT, leaving aside other non-medicalized ways of dealing with the needs of aging women.

CHAPTER 3.

THE BIOMEDICAL DISCOURSE ON AGING AND MENOPAUSE IN CHILE

In Chile, as elsewhere, the biomedical discourse dominates the social production of meanings around menopause and aging. Women's processes of aging have been understood as physiological decline strongly linked to the end of women's reproductive role. In biological terms, it is believed that menopause is something culturally produced due to the advancements in biomedical technology that allowed women to survive beyond reproductive life.

According to Austad (1994), evolutionary biology classifies theories of menopause into two categories, adaptive or nonadaptive. The first strand suggests that menopause offers a selective advantage, and is an evolutionary response to the increased risk of reproduction late in life. Therefore, it might be biologically more advantageous to concentrate reproductive efforts on caring for existing descendants once reproductive capabilities have ceased. The second strand contend that menopause is not an evolutionary adaptation, but the result of the relatively recent extension of human longevity due to cultural changes that help to prolong human life. This second interpretation is supported by the fact the majority of the mammals studied to date do not manifest a natural reproductive cessation, therefore, menopause may be attributed to human actions (Austad, 1994).

To understand the way menopause and female aging are constructed among Chileans, it is relevant to pay attention to what the biomedical field is saying about it. In order to do so, it is useful to turn to the concept of healthscapes suggested by Clarke (2010). I argue that in the Chilean case there are at least two healthscapes that have coexisted for the last decades: a medicalized one and a biomedicalized one.

The concept of medicalization has been widely used to describe medicine's increasing jurisdiction over issues that were not considered medical problems before. In this case, HRT are not only promoted as a form of coping with menopausal complaints but also as a treatment to improve women's performance particularly in the sexual domain.

In Chile, medicalization has been developing since the mid-20th century, when strong efforts were put in place to ensure universal access to health care, which required high amounts and social control and compliance. As Illanes (2010) describes it, in the mid-20th century the idea of a health care system strongly regulated by the state and the medical sciences was put in practice by making it compulsory for women to give birth in medical facilities. The medicalization of other social practices such as mourning and overworking was also implemented. The medicalization healthscape seems to have dominated the public and private health care systems since then. Simultaneously with the economic neoliberalization brought about by Pinochet's regime later on, an open market of medical commodities for personal enhancement became increasingly available

in Chile. In a very limited way, medical specialists are starting to see such medical services and technologies as a legitimate choice for women who want to improve their sexual performance or prolong their youthful looks.

Since gynecologists are the specialists assigned to deal with menopausal complaints, they have become a very strong voice when it comes to defining what menopause and climacteric are all about, how women can deal with menopausal complaints, and what comes afterward regarding health and health care. However, as this chapter shows, medical specialists seem to hold two different views at the same time, one regarding menopause in the public health care sector (where HRT becomes something that the suffering women need) and one regarding the upper-class women who use to HRT not only to cope with menopausal complaints but also to enhance their bodily looks and health.

The specialization in gynecology and obstetrics has a strong tradition in Chilean universities. According to Zarate (2001), gynecology started its development in Chile at the end of the 19th century. It was only in 1880, with the consolidation of both the university training in gynecology and the gynecological clinical service at the San Borja Hospital in Santiago, that complaints related to female reproductive organs started to be checked by trained gynecology specialists. According to Zarate (2001), proof of the growing interest in gynecology was the development of studies related to female body and physiology by the end of the 19th century.

Furthermore, *Revista Médica de Chile* (Medical Journal of Chile) published results of research on reproductive organs as well as clinical accounts of treatment and surgery interventions executed by the San Borja public hospital clinical service.

Zárate (2007) states that the Chilean medical school was from the beginning a male- dominated space where the presence of women was an exception. The law forbade women from applying to medical school until 1877 when a decree issued by President Amunategui allowed women to take free university exams and gain university credentials (Zárate, 2007). Within the field of gynecology, the presence of women was even more reduced: during the 19th century only five women studied gynecology in Chile. Most of the women who studied medicine specialized in neonatal care, patient care, and obstetrics, and worked as midwives and birth attendants. Doing so, they became agents of popular knowledge in a very different fashion from their male colleges who were more associated with scientific knowledge (Zarate, 2007).

According to the World Bank in 2009 there were 1,638 registered gynecologists in Chile, of which 73,87 were located in the central zone of the country (World Bank, 2009). Currently in

Chile, the path to becoming a gynecologist or endocrinologist is a difficult one. After seven years of medical school, general practitioners must apply to a specialization program that takes three years and includes a medical residency. Nowadays, along with the privatization-related crisis of the whole health care system in Chile, the specialization program is also threatened. Because of the development of private medical schools in private universities, it is now possible for each resident physician to pay for their medical residency with no exclusive dedication. To do so, some residents combine their residence with paid work somewhere else. This means that they have limited time to dedicate to

their practical training. Before the setting of private medical schools the specialization programs where run by public universities which supported by governmental scholarships the full dedication of the students. Additionally, informed stakeholders have denounced the lack of regulation regarding the quality of education, contending that some medical schools do not meet minimal requirements regarding trained teachers and medical facilities (Cuello, Oyarzún, & Wild, 2004; Armas & Goic, 2008; Guillou, Carabantes, & Bustos, 2011).

It is difficult to measure the extent of services provided by gynecologists and endocrinologists. In 2014, the National Health Care Fund (FONASA) financed 39,211 medical consultations in gynecology and obstetrics and only 290 consultations related to endocrinology (INE, 2014). In the private health care sector, in 2014, 110,986 consultations in gynecology and obstetrics and 944 endocrinology consultations were financed by ISAPRES, the private health care insurances.[9] That means that of every four consultations in gynecology and obstetrics, three are performed in the private health care sector, and the same proportion is found in the case of endocrinology consultations. Considering the fact that ISAPRES only provide insurance for 12% of women, whereas FONASA covers 84% of women (Ministerio de Desarrollo Social, 2012), meanwhile a 4% has another form of insurance (for example military healthcare insurance) or has no insurance at all. This data reflects a high level of social inequality in accessing health care in Chile.

Furthermore, according to Cuello, Oyarzun, and Wild (2004), 77% of gynecology specialists are located in the three most populated regions of Chile: Valparaíso, Bio-Bío, and the metropolitan region of Santiago. Sixty percent of all the registered specialists work in the metropolitan region. That means that there are 1.4 gynecologists per 10,000 women in Santiago, fewer than the recommended ratio of two gynecologists for 10,000 women. This figure becomes much worse in other regions with fewer gynecologists (Cuello et al., 2004).

It is worth noting that the gynecology and endocrinology specialists organized themselves in international and national associations. The International Menopause Society (IMS) was founded in 1978, during the Second International Menopause Congress in Jerusalem. Its aims are "to promote knowledge, study and research on all aspects of aging in men and women; to organize, prepare, hold and participate in international meetings and congresses on menopause and climacteric; and to encourage the interchange of research plans and experience between individual members" (IMS, n.d.). About 15 years later, in 1991, the Chilean Society for Climacteric was founded. Its main purpose is to promote the development of knowledge on climacteric and menopause as well as open up room for discussion and exchange of relevant medical resources. The Chilean society has 43 members, mostly gynecologists and endocrinologists, who hold regular meetings and congresses and organize specialization courses (Sociedad Chilena del Climaterio, n.d.). In 2006 the Chilean Society of Gynecological Endocrinology (SOCHEG) was founded, with the purpose of spreading knowledge of gynecological endocrinology, reproduction, and andrology. While the climacteric society focuses on a particular stage in the life of women, the SOCHEG is concerned with endocrinology processes in the longer

9 Data obtained through the Public Transparency Information System in 2016 at the Superintendencia de Salud.

human lifespan (Sociedad Chilena de Endocrinología Ginecológica, n.d.).

Discourses on Menopause and Aging in Academic Papers

As explained in chapter one, to analyze the biomedical view on menopause and female aging, I critically read academic papers published in the field of biomedical sciences in Chile between 2002 and 2017. I collected 40 scientific articles published between 2002 and 2017, most of them in journals such as *Revista Médica de Chile* and *Revista Chilena de Obstetricia y Ginecología* (Chilean Journal of Obstetrics and Gynecology). I summarize the content of the 40 reviewed papers in the following chart.

Table 3. Content of scientific papers reviewed

Topic	Number of papers	Publication year
Effectiveness and risks of HRT	12	2002, 2002, 2003, 2003, 2005 2005,2006, 2009, 2009, 2010, 2016, 2017
Biomedical research on menopause, climacteric, and quality of life	7	2008, 2008, 2010, 2011, 2011, 2015, 2017
Relationship between climacteric and other health issues (hypertension, depression, thyroid, skin)	6	2009, 2009, 2009, 2009, 2009, 2014
Relationship between clima-teric and cardiovascular health issues	4	2003, 2009, 2009, 2016
Other bioscientific research	3	2011, 2013, 2016
Relationship between climacteric and sexual dysfunction and/or sexuality	2	2006, 2009
Nutrition and dieting for menopausal women	2	2009, 2014
Physicians' attitudes and information regarding HRT	1	2008
Cancer diagnosis among menopausal women	1	2014
Other treatments for menopausal symptoms	1	2016
Health care services for menopausal women	1	2017
Total	40	

It is not surprising that most of the articles reviewed refer to HRT (or 'hormonal substitution' as it is called nowadays). The publication of the Women's Health Initiative (WHI) study in 2002, that assessed the effects of hormonal replacement therapies in women's health, discussed in the Introduction, has had a tremendous impact on the use of hormonal therapies because it posed questions about the safety of this treatment and its long-term side effects.

Reviewing the articles published since 2002, it becomes clear how worried the physicians were about the results of the WHI study. However, as the years have passed, they seem to have become more confident about the benefits of HRT. Once the WHI results were criticized for methodological shortcomings, the state of panic seemed to subside. Then, physicians started to think and publish the idea that under controlled circumstances women can greatly benefit from the use of HRT. The idea emerges of the 'tailor-made suit', which encompasses a complete medical checkup, the assessment of the possible individual risks, and the identification of the minimal dosage of hormones to attain a positive outcome. The gynecologist Italo Campodonico summarized the story of HRT thus:

> Let me compare the long story of HRT with the evolution of bipolar disorder. Women, physicians, and the media—we all have moved in a constant zigzagging from periods of euphoria and collective exaltation that is interrupted by periods of depression when everything seems dark and hopeless. A separate mention is needed for that aggressive group that I allow myself to define as "paranoids" who are declared enemies of the hormones; they are afraid of them, they hate them, and they feel persecuted and blame everything on the hormones. Currently, there is not an ideal HRT; we need to wait for the pharmaceutical industry to develop a "magic bullet" that concentrates all the benefits and does not carry the risks associated with the current conventional therapies. (quoted in Ruiz et al., 2002, p. 265; my translation)

Campodonico, like other specialists in menopause, openly criticizes those who fear HRT, because he believes that the right attitude is to keep an open mind and rationally assess the risks and benefits of the treatment. As it will become clearer in the following section of this chapter, some of the specialists interviewed even portray women who reject hormonal therapies as emotional, easily influenced, and superstitious.

Between 2002 to 2005 several studies were published. Some of them are quite favorable to HRT, stating that women who receive adequate HRT have a low incidence of malign endometrial pathology (Bianchi, Arteaga, & Villaseca 2002; Bianchi 2009). Also, Blümel and colleagues published in 2003 a research-based paper on the effect of HRT on the sexual life of menopausal women. The authors found out that women on HRT obtained a higher score in all of the tested domains of the Female Sexual Function Index (FSFI), especially in lubrication, orgasm, and sexual satisfaction. They conclude that female sexuality decreases with aging, and HRT users have a better sexual function than non-users (Blümel et al., 2003). Also, in 2006, a literature review concluded that hormone replacement lowers the deterioration of the human sexual response during the climacteric (Arena, 2006).

However, most of the papers published between 2002 and 2010 addressed questions generated by the WHI study. For instance, the paper "Recommendations for the Treatment of Menopause," published in 2005 by 12 distinguished members of the Chilean

Society for Climacteric, intends to give a practical guide to the treatment of the climacteric "due to the confusion produced by the WHI study in 2002" (Arriagada et al., 2005, p. 645). The authors assert that HRT must be only prescribed when a clear indication for its use exists, namely, distressing symptoms. Because there is no alternative to estrogens or estrogen/progestin in the effective treatment of symptoms and reduction of fractures, the recommendation of HRT continues. The indication of a prolonged treatment must be examined every year and requires close follow-up of the patient.

A later study on perceptions, attitudes, and practices of physicians and gynecologists regarding the use of HRT found a great deal of mistrust and fears (Pizarro et al., 2008). For instance, 67% of the surveyed physicians perceive mistrust and fear from patients, 70% feel that the media press coverage on HRT is negative, and 80% report that their own attitude towards the use of HRT changed after the publication of the WHI report (Pizarro et al., 2008). Also, 57% of gynecologists felt that HRT brings more benefits than risks (Pizarro et al., 2008). These results correspond with what other Arena (2005) found when reviewing international literature on this subject:

> even though there is no abundant bibliography on the matter, the impact of the study of WHI undoubtedly did exert a strong retraction to incorporating the therapy as well as a smaller compliance and a larger rate of giving it up. (p. 187).

There is no doubt that the publication of the WHI report in 2002 had a negative impact on the image and level of use of HRT in Chile. By the end of 2010, it appeared that the Chilean Society for Climacteric had at least partially regained their confidence in hormonal therapies with their declaration "The Official Position of the Society for Climacteric Regarding Hormonal Replacement Therapy." In this declaration the most prominent Chilean gynecologists of menopause state that HRT is highly recommended for women with a poor quality of life (QL) due to menopausal complaints. A proper evaluation, they assert, will identify those patients and those who are at a high risk for chronic disease. Therefore, standardized medical assessments must be used to identify women who require therapy. However, they do not focus exclusively on the use of HRT in their guidelines but include other practices:

> clinical management should include recommendations to improve lifestyles, increase physical activity, avoid smoking, and follow a low-calorie diet that is rich in vegetables and fruits. Hormonal therapy is the most efficient treatment to improve QL, and its risk is minimized when it is used in low doses or by the transdermal route. Tibolone is an alternative, especially useful in patients with mood disorders and sexual dysfunction. Vaginal estrogens are also a good option when urogenital symptoms are the main complaint. Some antidepressants can be an effective therapy in patients with vasomotor symptoms who are not willing to or cannot use estrogens. (Blümel et al., 2010, p. 645).

In this document gynecologists still support the use of HRT but are more cautious about recommending its extensive use. They acknowledge that HRT diminishes the frequency and severity of hot flushes by 80%, and that postmenopausal woman taking HRT have less depression, "hostile behavior, and aggression" (Blümel et al., 2010, p. 647). They sustain that women experience better lubrication, orgasms, and sexual satisfaction. Regarding the risks, they acknowledge that the use of estrogens increases the risks of endometrial cancer but indicate that adding progestin neutralizes this increasing risk. They add that the WHI did not prove a significantly increased risk of breast cancer, but, if

there was an increased risk, they suggest that medroxyprogesterone might be the cause of it. They acknowledge that starting HRT with elderly women can increase cardiovascular risks. Overall, they advocate for individually evaluating every climacteric woman's quality of life and risks of chronic diseases. They recommend the use of HRT and lifestyle changes only when there is "clinical deterioration" (Blümel et al., 2010, p.648). Lopez-Alegría and Soares (2011) argue that, as the result of the WHI study:

> health care given to climacteric women moved towards the direction of the quality of life. Currently, when suggesting comprehensive health care for a climacteric woman, even though there is still a consideration for the benefits of hormonal therapy, less invasive measures such as the encouragement of healthier behaviors are preferred. (p. 619; my translation)

In contrast, in 2017 two of the most prominent specialists in the hormonal treatment of menopausal women, Blümel and Arteaga, published an article titled "The Risks of Avoiding Hormonal Replacement Therapy during Menopause: Deterioration of Quality of Life," in which they call for ending the bias against HRT, which they believe has been based on misleading information regarding their risks. They advocate for the use of hormonal therapies as the most effective way to help symptomatic menopausal women improve their quality of life, and also mention the positive outcome that menopausal women on HRT will make less demands of the health care system. As the authors put it, "if we do not prescribe HRT to those women who need it, we could deprive them from several potential health benefits" (p. 760, my translation).

In the papers reviewed, I found that menopause was constructed as a troublesome stage in women's life and something that seriously deteriorates the quality of life of most women. Together with all the health issues studied in relation to menopause and climacteric (Blümel, 2003; Kunstman & Gaínza, 2009a, 2009b; Grant, Fasce, & Fasce, 2009; Trincado, 2009; Apt & Saavedra 2009; Jadresic, 2009; Danckers, 2009; Errandonea, 2009) a great deal of attention is paid to assessing quality of life in menopausal women.

One relevant study used the Menopause Rating Scale (MRS) to assess the extent and seriousness of menopausal complaints among women in Latin American countries (Chedraui et al., 2008). The authors surveyed 8,373 healthy women aged 40–59 years who were accompanying other patients at health care centers in 18 cities of 12 Latin American countries. They women were requested to take the MRS and a questionnaire aimed at gathering sociodemographic and personal information. Among other findings, the authors found that the prevalence of women with moderate to severe complaints regarding menopause was high (>50%) in all countries studied. Particularly, Chile and Uruguay had the highest percentages of menopausal complaints, with Chile the highest at 80.8%. Statistical analysis determined that reduced quality of life was linked to factors such as the use of alternatives therapies for menopause, the use of psychiatric drugs and being treated by psychiatrist, being in a postmenopausal condition, being 49 years old or older, living at a high altitude, and having a partner with sexual dysfunction, such as impotence or premature ejaculation. Lower risk for reduced quality of life was associated with living in a country with a lower average income, taking hormonal therapies, and having healthy habits and lifestyle.

Del Prado and colleagues (2008) published the results of the Chilean portion of the study led by Chedraui and colleagues. There were 370 women enrolled in this study,

who were contacted as they were accompanying other patients in three public hospitals in Santiago in 2007. The average score of the MRS was 16 points; in other Latin American countries, and in countries of Europe, North America, and Asia the average score is around 9 points. This gap is attributable to the fact that Chilean women score four times higher in psychological symptoms and twice more in somatic symptoms; in addition, of the studied countries, Chile was the country where women reported the worst quality of life. Del Prado and colleagues (2008) found that 41% of the women surveyed had serious menopausal symptoms, and concluded that menopause is the factor with the most influence on women's quality of life. But they also note that a larger number of offspring and lower educational level correlate with a poor quality of life (del Prado et al., 2008).

There are other less alarming studies that also made use of the Menopause Rating Scale (MRS). Lopez-Alegría and Soares study, published in 2011,[10] was based on a sample of 1,023 women between 45 to 64 years, who were attending primary health care centers and who were relatively healthy (women with chronic conditions such as diabetes, hypertension, and psychiatric medication were excluded from this study). The researchers found out that 56% of women did not have a paid job; 64% reported that they did not smoke, and 90% reported having sedentary habits, such as not engaging in any kind of physical exercise. The most frequent menopausal symptoms reported were muscle and joint complaints (85%) followed by mental and physical tiredness (80%). The worst quality of life score was associated with sedentary habits, smoking, and not having time for recreational and leisure activities. The study concludes that the high prevalence and intensity of symptoms have a negative impact on women's quality of life, which together with unhealthy lifestyle habits (such as smoking and having a sedentary routine) make climacteric symptomatology more severe.

A different approach was taken by Salazar, Paravic, and Barriga (2011), who interviewed 49 married, heterosexual couples between 40 to 65 years old, whom were contacted at a primary health care center in Concepción. Even though the researchers focused on comparing women's and men's perceptions and experiences of climacteric, this study also provides overall information regarding women's quality of life. Most women reported a moderate disturbance in their quality of life particularly in sexual, physical, and psychosocial spheres, reporting more deterioration in the sexual and physical spheres. Men were asked about their observations regarding how women experience Climacteric, and their account was compared to women's perceptions. One interesting conclusion is that men and women did not report significant differences in their perceptions regarding the alterations experienced in their sexual encounters. Men were aware of women's complaints such as vaginal dryness, changes of sexual desire and avoidance of sexual intercourse. Researchers found that women's perception regarding other dimensions of their quality of life during the Climacteric varies from that of their husband's. This finding leads the authors to hypothesize that women do not communicate their experiences regarding menopause to their husbands because of the traditional belief that menopause is something to be discussed only with other women. Regarding the sexual dimension, men are able to identify women's complaints because they have a direct impact on their

10 Lopez-Alegría and colleagues published partial results of their research in 2010. However, in this chapter I focus on the paper published in 2011 because it provides more data and a more extended analysis of the results.

own quality of life (Salazar, Paravic, and Barriga, 2011).

In sum, after analyzing the scholarly knowledge in the field of health care and menopause in Chile between 2002 and 2017, it becomes clear that menopause is conceptualized as a health issue, responsible for several complaints that appear in women's middle age, and a serious impact on their quality of life. After the publication of the WHI study in 2002, medical practitioners became more cautious about the use of HRT and started to consider other ways of treating menopausal complaints such as changes in lifestyle, including better nutrition and exercising. Still, much of this literature suggests that "menopausal disease" can be properly treated with HRT, which is considered the ultimate solution for all the issues women express in their climacteric.

It is striking the limited grasp that most of the analyzed articles have on social factors that influence the way menopausal complaints are experienced by women. For instance, even though their find important correlations between educational level and social practices that are more common among a better-educated population (such as better nutrition and participation in sports) and a better quality of life, there is not much discussion of how these findings can be incorporated in the treatment of menopausal complaints. In other words, even though menopausal complaints are described as a set of complex symptoms that affect women's quality of life, the ultimate solution seems to rest on the use of HRT and the individual treatment of associated pathologies such as cardiovascular disease and hypertension.

A special comment is warranted on the methodological shortcomings of several survey- based studies that took place with women in public health care centers, which in other words means that these studies are only addressing working-class and lower-middle-class women. Because social class such a significant variable in the way women experience menopausal complaints, it is difficult to know to what extent the worrying results of the MRS studies are explained by poverty and gender inequalities. As will become evident in the analysis of my interviews with gynecologists, they are confronted with two different realities. There is first the reality of working-class women, who are surveyed in public health care facilities and thus who were the respondents of the Menopausal Rating Scale. And there is also the reality of the upper- middle-class women that gynecologists meet in their private practices. They do not express much reflection on these differences, probably because menopause is for them fundamentally a matter of biology.

The analysis of the papers also empirically shows that the community of specialists in climacteric in Chile is strongly connected to international organizations. There are several joint research projects coordinated within the International Society for Climacteric, and several papers authored by Chilean specialists have been also published in prestigious international journals such as *Maturitas* or the *Journal of Obstetrics and Gynecology*. At a Latin American level, there is a notable level of coordination, which is not only visible in scientific symposiums and meetings, but also in the joint effort to write technical guidelines for the use hormonal therapies. It is plausible that laboratories and the pharmaceutical industry play a relevant role in bringing these specialists together and sharing their new discoveries with them. However, in interviews they did not acknowledge any such influence, claiming that they keep informed about discoveries and new developments in hormonal therapies through their own personal research and meetings with colleagues.

The Physicians' Perceptions on Menopause and Aging

In this research project, 13 interviews were conducted with physicians specialized in Climacteric, treating menopausal women and doing medical research in this field. The purpose of such interviews was to find out how they perceive menopause and menopausal women, what they think of HRT, and their perceptions of gender differences and female body. The fields of specialization of the interviewees were: endocrinology (3), gynecology (6), endocrinological gynecology (2), and oncological gynecology (2). It is important to note that the confidentiality of the interviewees has been protected and that is why their personal and professional features are not identified in their quotations. In the case of the female physicians interviewed, they are only identified as such in the case that this information proved relevant for the analysis.

One of the key areas of inquiry was how they perceive menopause. I first asked: how do you define menopause? Not surprisingly they tended to focus on a biological understanding of it. All the interviewees agreed that menopause is the biological effect of a decrease in hormonal production, which leads to several complaints defined as "menopausal." Therefore, the appearance of several menopausal symptoms is believed to relate directly to this lack of hormonal production. Generally speaking, there was no mention of other possible explanations for women's menopausal troubles, such as social devaluation of infertility or menopause as a sign of becoming old. At most, some physicians mentioned a few things they consider psychological issues related to menopause, such as empty nest syndrome and sexual dissatisfaction. However, sexual dissatisfaction is believed to be mainly caused by the decrease in hormonal production. One gynecologist defined menopause thus:

> The definition of menopause is the end of menses for more than one year, and a decrease in the hormonal production of the ovary, namely estrogen and progesterone. That makes women develop deficiency symptoms of these hormones, which make them feel sick and, generally speaking, are the main reason they seek medical help.
>
> *(Interviewee 7, female gynecologist).*

In addition, they established a distinction between menopause and climacteric, pointing out that the first refers to a specific event, which is the end of menstruation, while the second refers to a longer period that brings about several (negative) changes for women:

> A wider understanding of it is the concept of climacteric, because that starts when one is 40, 42 years, when the oscillation in the estradiol levels increases, which leads to changes in the general neurochemistry, and the hot flushes start, the mood changes appear, the memory disorders, the aggressiveness, the headaches, and then later the menses stop when someone is 48 or 49, when the uterus stops responding, but her brain-collapse [el colapso del cerebro] started when she was 43.
>
> *(Interviewee 5, male endocrinologist)*

In addition to a general definition of menopause or Climacteric, most of the physicians described menopause and its complaints as a sort of "general collapse" of the female body, which damages its brain function, having an effect subsequently on women's

cognition processes, mood, and behavior. The interviewees also clearly linked the effects of menopause to a decline in women's quality of life, with statements like:

"It is the beginning of getting old because several organs and metabolic processes start to fail." (*Interviewee 5, male endocrinologist)*

Finally, although some of the physicians emphasized certain aspects of this decline, others pointed out the comprehensive effect of menopause, noting a set of pathologies associated with menopause with direct effects on women's health in the short and the long term.

> Everyone focuses on the hot flushes and doesn't see the problem of mood changes, the problem of sexual breakdown. "I got old," says the woman, and just accepts it. The memory disorders and the bone aches appear, so women have a very, very hard time.

(Interviewee 5, male endocrinologist).

As medical anthropologists have pointed out, a mechanical view of the human body underlines the biomedical conception of the human body (Martin, 1986; Helman, 2001) and the physicians' view of the menopause tended to reinforce this conception. For instance, one of the interviewees compared the menopausal women's brain functioning to a broken car:

> But the major problem is the oscillation in women's estrogen production, which starts when they are 42 years old more or less. It leads to a general decay of the brain neurochemistry, in other words, the brain starts to fail. Thus, it is as when the battery fails: it has no acid. Therefore, there is no spark. The radio does not work, the lights don't work, which is why this is a multiple- symptom phenomenon. But it is a real serious problem.

(Interviewee 1, male endocrinologist).

I found agreement among the physicians in the view of menopause as a phenomenon resulting out of the development of culture. The increase of life expectancy is seen as the result of human intervention, which proves different where comparisons with other mammals are made.

> Menopause is not a natural stage, and it results from the prolonging of human life. [Other] Mammals do not have menopause. We made our life longer, and this phenomenon appeared as a result of it.
>
> Menopause did not exist more than one hundred years ago, women did not live longer than fifty, and, therefore, post-menopause, climacteric and all the issues that women older than fifty carry with them did not exist either.

(Interviewee 5, male endocrinologist)

The interviewees' strong association between old age and disease (and, therefore, youth and health) meant that the use of HRT was presented not only as a treatment for menopausal complaints but also as an anti-aging treatment. They asserted that HRT helps to maintain women's health and characteristics that are considered "beautiful" such as the absence of wrinkles:

> The individual who takes hormones keeps herself younger for a longer period. She keeps herself energetic, she can perform more physical activity, with more enthusiasm.

> Sexually she keeps herself better, there are fewer libido disorders, the vagina keeps wet and stretchy. The skin does not get that wrinkled, the hair does not fall out that much, the gums don't recede, the eyes do not get dry, so you prevent many things.
>
> *(Interviewee 7, female gynecologist)*

One of the issues constantly brought up in the interviews was the sexuality of menopausal women. Physicians mentioned vaginal dryness and declining libido as the main sexual issues that caused complaints among women.

> The vagina deteriorates [*se deteriora*], gets dry [*se seca*], which leads to painful intercourse, the sexual desire gets low [*baja*], and that is something that appears in the long term. It is not an immediate effect of menopause.
>
> *(Interviewee 12, male gynecologist)*

On the other hand, most of the interviewees pointed out the need for a holistic medical response, which implied the involvement of diverse medical specialties in the process of diagnosis and treatment of menopausal complaints.

> If you see a patient, and you want to have an integral approach, you need to evaluate arterial hypertension, you have to look into cholesterol issues, to check on depression symptoms, you have to ask about sexuality, and, you know, when you touch upon this subject is when women start talking for hours and hours… And you need to check on depression, you see, because it is a serious issue, so there are many things involved.
>
> *(Interviewee 5, male endocrinologist)*

I noted some devaluation of "women's complaints," for instance, in how this interviewee mocked women's need "to talk for hours and hours." From their point of view, most women's issues can be easily cured with the use of hormones.

Even though the interviewees acknowledged the fact that several social factors are involved in the experience of menopause, hormonal replacement therapy remained the ultimate solution for it. One of the interviewees compared the effectiveness of hormonal replacement therapies to other treatments such as psychotherapy, and asserted that hormonal therapies have a faster effect:

> They [menopausal women] spend so many years in psychiatric treatment. I remember one patient that wanted to sue her psychiatrist, because she spent ten years in a treatment for depression and we made her better in one and half months. I just gave her hormones and the job was finished!
>
> *(Interviewee 5, male endocrinologist)*

Such statements make clear that they believed that the origin of menopause is biological and so is its cure.

I did not find significant differences in the discourses on menopause according to the interviewee's gender. Still, among the female specialists, I found a sort of identification with the patients, which led them to recognize a different dimension of menopause beyond the strict biomedical view. For example, one female gynecologist described it as a time of taking stock of one's life:

> There are patients that say that menopause is like the New Year's celebration in their lives, because at the new year, you sum up your life, you look at the past, you look towards the future, you laugh, you cry, you celebrate, who knows, but you analyze your life, and when the menopause crisis comes about your identity is already formed, and you know what you wanted for your life.
>
> *(Interviewee 13, female gynecologist)*

Another interviewee referred to the social devaluation of women who reach the menopausal stage:

> There is a stigmatization of women, this idea that menopausal women no longer have use, they are not sexually active, they are no longer attractive, that is something is decaying, and if you can prolong that hormonal life that is something that makes women feel better.
>
> *(Interviewee 7, female gynecologist)*

On the other hand, some interviewees held a more positive view of menopause, and explained that it would be helpful for women to see motherhood in a larger perspective. One interviewee said:

> It is the best period in a woman's life because, first, she has accomplished her role as mother— their offspring must be grown into adults by that time. During menopause the woman does not get pregnant, and therefore does not need contraception any longer, and that implies a reunion with her partner. This is a very important moment for [a menopausal woman], and that is why I think it is crucial to be able to explain to a woman that this is not the end of her life, that the mother role is just a stage, but it is not something transcendental.
>
> *(Interviewee 10, male gynecological endocrinologist)*

The interviewees mentioned the fact that the Chilean population is growing older, which in turn is generating new challenges for public health, such as the prevention and treatment of cardiovascular diseases, osteoporosis, and Alzheimer's disease, among others. Furthermore, they expressed concern about the Chilean government's lack of effective responses, particularly when it comes to providing effective medical treatment for menopausal women. They noticed the opposite when it comes to government attention to younger women's needs, who receive a greater deal of medical attention through governmental programs focused on fertility and reproduction.

Many of them also acknowledged the existing gap between upper- and middle-class women who have access to medical treatment and HRT in private consultations, which are lacking in the public health care sector. In the case of the private sector, they pointed out that the services provided are aimed at marketing HRT and making a profit from it.

When talking about the access of women to menopausal treatments in the public health care system, the specialists recognized the need for a stronger public policy on this matter. Some of them mentioned that they receive patients who are covered by FONASA, the state health insurance, who can afford the co-payment to access the private health care system. This option is only available for those with higher incomes within the public insurance system. They also wished that the public health care system provided

specialized menopausal health care. Some of them participated in the writing of the technical guidelines for menopausal treatment developed by the Ministry of Health, and hoped they will be fully implemented in the future.

> In my opinion, here in Chile there is no state view on the issue of menopause. If you go to the Ministry of Health and health care you will see that there is no plan to act on menopause.
>
> *(Interviewee 4, male gynecologist)*

This situation is also characterized by the lack of specialists who can provide comprehensive medical care to menopausal women, as well as the shortcomings in the training of gynecologists who are mostly prepared to deal with obstetric issues and know little about the climacteric and its complaints.

> In the short term there should be people trained to deal with menopause issues, which is what some people as defined as the *menopausologist*, that is, someone who knows about the issues women face at this stage, from a comprehensive point of view, someone who doesn't only know how to treat the hot flushes.
>
> (*Interviewee 4, male gynecologist*).

Another of the interviewees envisioned a wider way to treat menopause, which, they argued, should also encompass cultural and structural issues:

> A healthy process of growing old should have three axes: the medical practitioners and the health care, the society—and I mean specifically avoiding gender stereotypes, etc.—but also the role of the state welfare to ensure a good retirement plan and a good health care system.
>
> *(Interviewee 10, male gynecological endocrinologist)*

Most of the interviewees declared themselves in favor of HRT. Since they defined menopausal complaints as the result of declining hormonal production, it seemed reasonable enough to restore hormonal production through biochemical therapy. They saw this therapy as a necessary step for women who suffer several menopausal complaints that sometimes become unbearable. As long as there are no risks involved, the specialists reasoned, women usually obtain benefits and improvements in their quality of life as the result of this therapy.

> I think it should not be called "hormonal replacement therapy" but "therapy of hormonal restitution," because that is what you do, you are not replacing anything but restoring something that is missing. And I think it is good option because it allows the maintenance of those organs that stop receiving the natural hormone. But with these, let's say, external hormones you have the chance to keep the body functioning in a very similar way to what it was when the ovaries were alive, when they were working.
>
> *(Interviewee 4, male gynecologist)*

All of them were aware of the negative publicity that HRT has encountered, particularly after the WHI report was published in 2002. They blamed it on the media, stating that newscasters often misinform the population by broadcasting scientifically inaccurate information and spreading fear about the presumed association between

hormonal therapies and cancer. In their opinion, most patients are reluctant and fearful about HRT because of this misinformation and sometimes decide not to take the therapy even if they badly need it.

Even though they discounted the WHI report because of its methodological shortcomings, they acknowledged that it started a debate that proved necessary in the long term. In particular, the WHI report pointed out the fact that HRT should not be universally recommended. One interviewee summarized that finding:

> Hormonal therapies are not good for everyone. In some cases it carries more risks than benefits, therefore, it is no longer as it was thought before, that it would always be good to use it, that it would bring always more benefits to using it than not to use it, and it has been proved that it is not the case.
>
> *(Interviewee 9, male oncological gynecologist)*

They also pointed out that the physicians' perceptions of HRT have changed over the last years, not only because of the need for an accurate assessment of the patient's needs before recommending it but also because the therapies have been improved in the last decade, reducing their side effects. They also point out that the transdermal route for hormones offers pharmacological advantages over the oral route and improves patient acceptability and compliance.

When it comes to evaluating women's need for hormonal treatment, the specialists identified at least two factors: the severity of the menopausal complaints women face and the extent to which their quality of life is affected, and second whether or not there are cancer- related risks involved. They emphasized that HRT is not recommended for everyone, and the cost-benefits ratio must be individually assessed before any prescription.

It is relevant to note, that when medical specialists talked about women's needs they mostly referred to the situation of women they saw in their private practice. A few interviewees had actual experience seeing women at the public health care centers. When they talked about their patients they described women looking for information and advice on whether to start HRT. Some patients had a positive opinion about HRT and were favorably disposed to start a treatment. Others were reluctant and were described as difficult to deal with.

> There are two groups: the patient who is looking for a treatment, and reacts very well. She feels she is being understood, one can put words to their feelings that she can't express herself. You conduct a friendly interview, in confidence, which produces much more effect than just the prescription of a hormone. … If someone presents the facts in an organized way, to show you the real dimensions and risks, facing all of them, without avoiding to mention any of them, and in addition gives a name to your symptoms, which you did not know how to express, the patient that already was sensitized finishes the consultation feeling grateful and happy. In contrast, we have a huge group of women that have different analysis capabilities. I would describe them as patients with an emotional association ability—very little logical depth, little critical sense, great predisposition to associate emotionally with what is in fashion, superstitious as well—they are reluctant to receive the]hormonal) therapy. … It is very difficult that those patients understand the whole thing. You need to take at least an hour to make a proper and accurate presentation that does not sound like fanaticism, on the contrary, to put it in a reflective perspective…

> There you have the two groups.
>
> *(Interviewee 2, male endocrinologist)*

Some of the interviewees strongly criticized women's resistance against HRT. They called it "superstitious," "ignorance," and "a lack of reflection." They blamed the WHI report and what they considered misleading information published in the media. A considerable percentage of women who specialists believe would benefit from HRT are not willing to take it:

> 20% of women, which coincides with the number of women under treatment in the world, are women who are clear about this issue, they worried, they were motivated because of their symptomatology, and additionally are symptomatic. A[nother] 20% more or less, or 30%, require the treatment, but they are influenced by misleading information, disinformation, and it is really hard to get them focused. Approximately another 20% would have partial advantages, in which the cost-benefit ratio could be arguable or not, but they could have some advantages although it is not strictly necessary. … And there remains another 30%, roughly estimated, that do not need treatment at all, and the only action one can perform is to make sure that the integral management of the case has been well conducted, that is more or less the proportion.
>
> *(Interviewee 2, male endocrinologist)*

There is no agreement regarding proper prescription of HRT. Some interviewees spoke of "tailoring," which means to prescribe according to the specific needs of the patient:

> The more symptoms expressed due to hormonal insufficiency, more the benefits of the therapy. So, that is a concept that we have been promoting. In English it is called "tailoring," that is, the therapy is a tailor-made suit. When we physicians talk about developing tailored treatments, it sounds somehow empty, but it conveys that you must evaluate the patient's conditions, try to assess how much she has and how much she needs, what is the balance between prescriptions that will bring a clear benefit—for instance eliminating hot flushes, improving the sexual response, improving semantic and cognitive abilities, or fixing the urinary symptoms—or even improving other things that are less well known, such as the locomotor system, postural balance, and other things that have been little explored.
>
> *(Interviewee 2, male endocrinologist)*

In the opposite corner, a senior specialist in menopause claims that such tailored therapy is not possible, and the only way the prescription of HRT can be regularized is by clearly defining the steps to be taken under different scenarios. In their view, generalization is a necessary step to regulate the way HRT are prescribed.

> I have criticized a lot those that argue for a tailor-made suit. I have not met anyone who can tell me how you get to measure that. That is just a made-up thing. I just wrote the official stance of the Chilean Society for Climacteric, and I just did it as a very simple guidebook: one, two, three steps. Because the physicians don't read that much, they have to work, and we need to regulate this thing. I find that thing of the "tailor-made suit" a lie as big as a ship, because you just need to say the climacteric brings one, two, three things, and you treat it with one, two, three things, and you follow up by taking one, two, three

> steps. I mean, you could write a Junior Woodchucks guide book for hormonal replacement therapies in two pages.
>
> *(Interviewee 5, male endocrinologist)*

As it was mentioned before, HRT is believed to be a necessary ethical medical response. Therefore, specialists think that part of their professional responsibility, in the logic of care (Mol, 2008), is to provide women with HRT:

> Not using the therapy is a lack of ethics. Not to use them if they are right there. If you think from God's perspective things are given to us, if someone had the intelligence to develop them, then we can use them with prudence and based on medical research. One starts narrowing down his research, to whom you prescribe it, to whom you should not to, for how long, what is the right dosage, how you maximize the improvement whereas you minimize the costs and side effects, that is what you are constantly trying to analyze.
>
> *(Interviewee 1, male endocrinologist)*

> There are people who do not want to take it because they are afraid mostly of cancer, and, well, in that case, you have to evaluate her symptoms. If she goes to consultation because of vaginal dryness I say to her, "look this is the best solution we have," but she says, "no, I'd rather stay with vaginal dryness," well then she will continue with vaginal dryness. Each person has to evaluate what is best. If she is all right, I am not going to prescribe her hormonal replacement therapy.
>
> *(Interviewee 9, male oncological gynecologist)*

They also mentioned the role played by new formulations of HRT, claiming that before the therapies that were too concentrated and had more side effects, and the dosages now have fewer undesired effects. They also referred to the new transdermal preparations that have several medical advantages and are more appealing to women as they look like beauty products:

> For instance, look at this, aesthetically this jar is very beautiful. I am behaving like a salesman… [he laughs]. This is estradiol made in France, but it looks like some kind of beauty product, you see? Then they apply it in the morning just like they use a body cream, this is something women are liking, and it has the advantage that it is very good quality.
>
> (*Interviewee 3, male gynecologist)*

In sum, among the interviewees, we find a highly medicalized view of menopause, where all the troubles of middle-aged women are explained in relation to their decreasing hormonal production. In this view, HRT appears as the ultimate solution for menopause issues. Also, menopause is perceived as a process of a generalized decline of women's bodies, and therefore of their health. In this regard, the interviewees mentioned several disorders, mostly related to psychological and sexual issues. They also mentioned the long-term negative effects of menopause as well such as cardiovascular problems and osteoporosis that can be prevented through timely use of HRT.

Because menopause is not considered a natural stage in women but the product of human intervention, therefore, they see it as their ethical responsibility to help women to cope with menopause, using all the available knowledge and biotechnology. Further, growing old is perceived as a negative event, associated with disease and decline. The

effects of growing old are believed to start with menopause and must be fought against. This fight is perceived as a necessary condition for attaining a good quality of life.

Their view regarding menopausal treatment is mostly a medicalized one, as they argued that menopausal women's complaints may be solved with the use of hormonal treatments. For instance, they attributed issues such as depression and lack of sexual desire to estrogen deficiency, with no regard for other social factors that may play a role. They also acknowledged the possibility of enhancement, mentioning new hormonal preparations (for instance with testosterone) that improve sexual desire and performance. They asserted that women have the right to choose such prescriptions as they have a positive impact on their quality of life.

An analysis of their scientific production and discourse shows their high level of connection with the international scientific community. They published technical guidelines on a regular basis, which are aligned with the international scientific community. They acknowledged the need to keep informed about new discoveries and developments regarding HRT, even though in Chile "everything arrives two years later," as one of the interviewees stated. However, the influence of the transnational forces in the HRT market does not completely shape the healthscape in Chile. The way the health care system works, especially the limited access to specialized consultation and to hormonal therapies, somehow limits the expansion of biomedicalization. The use of hormonal therapies as an enhancement technology is restricted to a confined social group, those with a high income, higher level of education, and full access to private health care. Also, the persistence of fears and mistrust regarding the use of hormonal therapies constitutes a strong barrier to the promotion of HRT. Based on the interviews with working class women, I would argue that cultural values regarding suffering and resignation, and the idea that women must endure the troubles of femininity, seem to play an important role in women's resistance to HRT. While the medical discourse is a dominant way to understand women's aging, women are not that willing to embrace HRT as the ultimate solution to their menopausal or middle-age complaints.

MASS MEDIA REPRESENTATIONS OF FEMALE AGING

It was a rainy day in Concepción when I went with my friend Vania to watch the movie *Gloria*. The cinema was full of people waiting to see the most popular and Hollywood-made movies, so, despite waiting in a long line, it was easy to get two tickets. These were the last days *Gloria* was being screened, so we were worried about not being able to get in. The cinema is in one of the huge commercial centers, or malls, in the city, which many Chileans love and visit religiously every weekend. Even if they do not intend to buy anything, they love going to walk around, to "*vitrinear*" (window shop), watch other people, take part in one of the free activities that take place there, and eat some fast food in the food garden. I do not much like those places, where I tend to feel trapped in a sea of people. Sometimes there are so many people that one just has to follow the flow, without being able to sit or enter the place where one wanted to buy something in the first place. When there are celebrations such as Mother's Day or Father's Day, it is almost impossible to get there. I remember, on the eve of one Father's Day, hearing on Radio Biobio in Concepción a kind of emergency message: "Please do not go to the Plaza El Trebol mall. It is full. You will not be able to get in. There is a long line of cars because the parking lot is completely full. We repeat, do not go there, and if you must go in that direction try to take alternative routes, otherwise you will stay trapped in the traffic jam for several hours."

But if you want to go to the movies in Concepción, there is no alternative but to go to one of the three malls of the city, which have several movie theaters. The independent movie theaters disappeared one by one in the city since the 1990s, as people preferred the fancier and bigger ones in the mall.

When we entered the theater, we looked around to find our seats, and Vania told me, "You see, we came to see a movie for old people." In fact, most of the people seemed to be middle aged or older, and there were few young people in there. I ignored her remark. I was excited to see the movie that had been awarded many international prizes and good reviews. Vania, however, seemed very concerned with the issue of getting older. Just before, as we were having a coffee, she tried to convince me to go with her to get a face treatment for wrinkles. She had just sold her car because her husband gave her a new one, so she had some money that she wanted to spend on a beauty treatment. She did not want to go by herself, and said, "Come on, it will be fun." I replied that I found it scary, and that I did not feel that I had that many wrinkles to worry about. I said I was afraid that my face would stay red and puffy for a long time and that I could not go to my work that way. She insisted, though, so I told her that I would think about it and that maybe over the summer holidays we could go to get a face treatment together. That never happened.

I met Vania some years ago. When I met her, she was a single professional woman working in the public service, but she told me once that she knew that her beauty (a pretty face, a sort of blonde hair and green eyes, which are always very valued in Chile) would help her to have "a great marriage." In fact, later on, she married a wealthy man from from a "traditional family" in the city of Chillán (close to Concepción), so she moved there, and I saw her less often. Her husband belongs to a wealthy family that enjoy the priviledge of

being well known and respected. I remember my surprise to realize that Vania had become some sort of celebrity in Chillán just for being someone's wife. She enjoyed the everyday privileges that came with it, such as being served first in a restaurant, getting all kind of special treatment at various venues, and being allowed into places that were closed to other people. Not to mention her frequent appearances in the "social event pages" of the local newspapers that reinforced her image of local celebrity. Since her marriage, she had become more worried about her appearance and how she presented herself in public, and getting older started to be a source of worry. It was common in our conversations to talk about how to lose weight, what kind of sports one can practice for staying fit, or some beauty tips.

As discussed further later on, Gloria portrays the life of a middle-aged divorced woman who has romantic and sexual encounters with several men. One of the controversial aspects of this movie in Chile were the sex scenes in which one can see the lead actress's naked body. After watching the movie, I was very curious to hear Vania's reaction and also wanted to share mine. To my disappointment she was not that happy with it, saying that the film "was funny but unrealistic." I said, "What do you mean 'unrealistic'?" She replied, "It is impossible that a woman in this country can behave that way. I mean, look around, do you see any Glorias here?" I said, "Well, you never know what women are actually doing in their private life." I added that sexual behavior is changing in Chile, particularly among older people. She replied that such change may be happening in Santiago, but not in the south of Chile. The discussion went on. I asked her what she would do in Gloria's shoes, and she answered, "I would try to stay married in the first place." My enthusiasm about the possibility of changing meanings on women's aging, which I saw in the film, was crushed by my friend's resistance.

In the following days I asked other friends and acquaintances who were getting into middle age what they thought about the movie. Because it was an independent movie, not everyone had seen it, but I got some positive feedback. An acquaintance told me that she enjoyed the movie and that she wanted to be like Gloria as she got older, saying, "it gives me hope." Another told me that she went to see the movie with her teen daughter, and remarked that in the theater there were young people that just laughed at the sex scenes, thinking they were funny. She added, "I can't believe it, what is so funny about older people having sex? And you know what is the worst part? My daughter told me that Gloria has a better body than me! Can you believe it? I am ten years younger than the actress and my daughter thinks that she looks better than me!" In any case, the movie raised different reactions as it brought about a new perspective on aging and sexuality. In this chapter I examine some of the meanings that female aging has within Chilean society by analyzing how it is represented in the media.

Analyzing mass media representations is a way to explore what different social actors say about aging women. I elaborate here on the concept of the politics of representation, as developed by Stuart Hall (1997), which breaks apart the idea that an empirical reality exists separate from representation. On the contrary, Hall asserts that the meaning does not exist until it has been represented and can only be traced by studying the language of representation. In this view, representation is part of the event to be studied because it participates in its development. According to Hall (1980), two critical concepts help explain the process of meaning creation and interpretation: encoding and decoding. He redefines the classical distinction between denotation and connotation;

according to him denotation in any language community is a "literal" meaning taken from the other associative meanings that a sign generates (connotation). Hall (1980) asserts that "codes are the means by which power and ideology are made to signify in particular discourses. They refer signs to the 'maps of meaning' into which any culture is classified; and those 'maps of social reality' have the whole range of social meanings, practices, and usages, power and interest 'written in' to them" (p. 132). But he cautions that polysemy is not synonymous with pluralism, because connotative codes are not equivalent among themselves. Each society or culture attempts to force its own classification of the world. This gives shape to a dominant cultural order, though it is neither homogeneous nor unchallenged. According to Hall there is a hierarchical organization of dominant or preferred meanings, though encoding and decoding do not necessarily correspond with each other. The process of decoding can be either transparent, negotiated, or contested. This means that the subject has the agency to process the message she is receiving.

In this chapter, the representation of female aging in Chile will be unfolded by analyzing the way the Chilean media portrays such experience. For that purpose, I collected and analyzed 209 articles published between 2008 and 2017 in six online newspapers widely known in Chile. I also analyzed a popular soap opera broadcast in Chile in 2013, the Chilean film Gloria, and a popular self-help book published in 2014 by a prominent Chilean author. As mentioned before, the main criterion for selecting these sources was that they were produced in Chile and had some impact on public conversations at the time.

Press Review

I reviewed 209 articles published between 2008 and 2017. Six online newspapers and magazines were selected by their influence on public opinion (they are part of the mainstream media) and also because they are fully accessible on the internet. The selected online newspapers were Emol, the website of Radio BíoBío, La Tercera, Terra, La Nación, and Revista Paula. Through content analysis, the articles were grouped into twelve 12 categories. These categories were identified after reading and classifying the notes, that is, they were emerging categories.

1. Scientific discoveries
2. Quality of life
3. HRT
4. Sexuality
5. Beauty and aging
6. Natural and alternative therapies
7. Male menopause (andropause)
8. Menopause symptoms
9. Menopause and entertainment industry
10. General Information on menopause
11. Motherhood and fertility
12. Others

Table 4 displays the frequency and percentage of topics addressed in press notes in Chile (2008-2017) according to my research. The first finding to be noted is that most of these articles related to scientific information and were presented as recent discoveries (21.1%). The second most covered subject had to do with HRT, which accounted for 19.1% of the reviewed articles. The third most mentioned subject was quality of life, in 18.2% of the articles. The media that gave more coverage to aging-related issues were: Emol (29.2%), Terra (28.2%), and La Tercera (19.6%)

Table 4. Frequency and percentage of topics addressed in press notes in Chile (2008-2017)

Category	EMOL		TERRA		LA TERCERA		LA NACIÓN		BIO-BIO		PAULA		TOTAL	
	F	%	F	%	F	%	F	%	F	%	F	%	F	%
Scientific Discoveries	12	5.74	11	5.3	13	6.2	3	1.43	4	1.9	1	0.5	44	21.1
Quality of life	9	4.3	18	8.6	8	3.82	3	1.43	2	0.95	0	0	40	19.1
HRT	12	5.74	13	6.2	7	3.34	3	1.43	2	0.95	1	0.5	38	18.2
Sexuality	8	3.82	5	2.4	0	0	6	2.9	3	1.43	1	0.5	23	11
Beauty and aging	3	1.43	2	0.95	1	0.5	1	0.5	1	0.5	5	2.4	13	6.2
Alternative therapies	4	1.9	4	1.9	2	0.95	0	0	0	0	0	0	10	4.8
Andropause	2	0.95	1	0.5	2	0.95	1	0.5	3	1.43	0	0	9	4.3
Other	11	5.3	5	2.4	8	3.82	3	1.43	3	1.43	2	0.95	30	14.4
Total	61	29.2	59	28.2	41	19.6	20	9.6	18	8.6	10	4.8	209	100

4

Table 5. Examples of headlines on menopause and aging in Chile (2008–2017)[11]

Category	Headline, newspaper, and date of publication
Scientific information	"Scientists discover the origin of menopause," La Tercera, 10/12/2008
Hormonal replacement therapies	"Warn that hormonal replacement therapies for menopause increase breast cancer risk," La Nación, 05/02/2009
Sexuality	"Sex: When the golden years become glorious," La Nación, 27/12/2009
Natural and alternative therapies	"Soy supplements reduce menopausal symptoms," Terra.cl, 2/05/2012
Menopause symptoms	"How to get relief for menopausal symptoms?" Terra.cl, 4/06/2012
Menopause and entertainment industry	"Madonna gives advice on menopause," EMOL, 28/02/2009
Quality of life	Chilean women lead the Latin American ranking of worst quality of life facing menopause," EMOL, 22/10/2008
"Andropause	"The first symptoms of menopause in men were discovered," La Tercera, 17/06/2010
General information on menopause	"Strategies for a good climateric," Terra.cl, 30/08/2011
Beauty and aging	"Menopause brings changes and trouble to the skin," Terra.cl, 27/12/2011
Motherhood and fertility	"Motherhood after 45," Revista Paula, 7/03/2012
Others	"Getting old… something that we are afraid of," Revista Paula, 22/01/2008

11 I translated the original headlines (in Spanish) into English.

In table 5, I present some examples of headlines on menopause and aging in the period 2008-2017. According to the data collected, most of the issues regarding menopause and aging in the press are represented as recent scientific discoveries and cutting-edge findings. Even though they tend to be repeated after a short period of time and presented once again as “new” topics, it is common to read in the headlines phrases like “recent discovery shows that,” and “scientists conclude that.” Several science-related articles have to do with the origin of menopause, explaining for instance why humans and whales are the only species that reach a menopausal stage, or relating discoveries regarding the association between menopause and other health issues such as Alzheimer’s disease and osteoporosis. In 2013, a press note was published in several newspapers stating that “according to a scientific research published by The Public Library of Sciences Computational Biology, menopause is caused by men because they prefer younger women” (los hombres serían la causa de la menopausia según estudio, June 14, 2013; my translation). The note mentions that scientists used a computer simulation to show how male mating preference for younger females could lead to mutations that had a negative impact on female fertility that ended up producing a menopausal period. They concluded that mating selection and preference for younger women as a reproductive advantage can be an explanatory cause in itself for the later development of menopause in older women.

As can be noticed in the previous table, many of the articles were focused on the use of HRT. Most of them present a positive view, and HRT are represented as the best way to deal with menopausal complaints. Some of them deal with the issue of risky side effects, such as breast and ovarian cancer, but they tend to conclude that the benefits of HRT surpass the risks. However, in this regard there are several contradictions in the scientific information provided by media.

Usually, the press notes regarding HRT include short interviews with Chilean gynecologists and endocrinologists who strongly support the view of HRT as a safe therapy, whose risks are slight and can be properly controlled by specialists. They also portray any criticism of HRT as a result of misleading findings from the WHI research in 2002. As wias discussed in previous chapter, this view reflects the current biomedical view on hormonal replacement therapies which commonly find resonation in the news media.

Regarding sexuality, it is interesting to note that in the last four years, the number of articles addressing this topic increased. They usually acknowledge the importance of having a satisfactory sexual life but tend to stress the difficulties women face when reaching menopause. Particularly, vaginal dryness and diminished sexual drive are presented as the result of estrogen deficiency and are described as the main sexual issues women face in their late 40s and 50s. HRT therapies are once again presented as the best available solution for this problem, as well as the use of lubricants and sex therapy. A few articles address the idea of the changing meaning of women’s sexuality and how the main problem could be related to cultural beliefs rather than actual physical complaints.

Menopause and aging are represented as a negative process that brings about trouble and sickness. Women are advised to take measures to counteract the negative effects of aging, such as dieting, working out, and in some instances natural therapies and

HRT. This perspective is very much related to the biomedical discourse. Therefore, it is not surprising that the most frequently used terms are women (914), menopause (677), years (507), life (300), study (284), woman (231), risk (220), symptoms (214), age (202), cancer (194), sexual (175), therapy (158), hormonal (157), treatment (149), stage (142), hormones (114), health (113), estrogens (101), breast (94), problems (91), changes (89).

Figure 1. Word cloud of press review 2008-2017

It is also worth noting that there are no independent journalists' research on topics of menopause and aging, and the newspapers are just reproducing what is published by the international news agencies. The news agencies gather and provide newspapers with information regarding a wide variety of topics.

The press can be seen as an actor that plays a role in reproducing scientific controversies, in this case with a very sexist and androcentric approach. Therefore, the topics selected to be published tend to undermine menopausal women's image, neglecting their own capability to control their condition. In other words, the articles tend to recognize as involved actors "scientists," "physicians," and "experts," portraying women as objects of (male-dominated) biomedical power and in this way reinforcing it. This way of approaching the issues of menopause and aging seems to be very powerful in producing the reality it is representing and there are no other contesting discourses in the media except for that found in a few alternative feminist media.

Representations of Menopause and Female Aging in a Chilean Soap Opera

"*Socias*" (business partners) is a Chilean soap opera, classified as an evening program, which according to Chilean legal regulations allows for the inclusion of sex, drug use, and violence in its content. This successful soap opera was broadcasted in 2013 by the National Television Chanel, a state-owned television channel that in practice works just like a regular privately owned channel. The soap opera is the Chilean version of the homonymic Argentinean soap opera that portraits the vicissitudes of three successful female lawyers who are partners at a legal firm. With the main characters aged between 35 and 45 years old, the opera shows the difficulties of women who despite their professional success continuously fail to form a happy love relationship.

The main character, Ines Ventura, is a well-known lawyer mother of a teen girl, well organized and perfectionist. She is always about to collapse because she tries to solve everybody's problems: her workmates', friends', daughter's, and family members'. At the beginning of the story, she gets married to Ricardo Ossandon, an older millionaire who owns an important newspaper. She does not know that her new husband has just hired Alvaro Cardenas, an adventurous journalist, to be the new director of the newspaper. Alvaro was Inés's first love, and they had a long relationship that ended 15 years ago when Alvaro decided to travel around the world and became a battle-field journalist. Because Alvaro is back, and Ines will have to work with him, her new life is all of a sudden turned upside down, and she can't manage to keep her past love out of it. Eventually, she ends up a widow, after finding out her husband was a criminal and held many dirty secrets from her. After being freed of the guilt of infidelity, she has another chance with Alvaro and starts a happy new life with him.

The second partner is Dolores Montt, an independent young woman who is ambitious and also a perfectionist in her work. She doesn't believe in love nor in marriage. When it comes to relationships, as soon as things get serious, she runs away. She hates having her privacy invaded, and she seems not to need a man's support.

However, she is secretly having an affair with Pablo Ventura, Ines's brother, who is married and publicly declares to hold very conservative Catholic beliefs regarding marriage and family. Pablo seems to impersonate the so-called Chilean double standard that combines conservative Catholic beliefs with liberal social practices (Blofield, 2001). Dolores enjoys having casual sex and "friends with benefits." Along the way, she develops a relationship with Mariano, her office assistant with whom she will eventually abandon her "wild life" as a young single woman, and ends up married and having a baby.

Monserrat Silva has been married for 15 years to another successful lawyer, Federico, and together have a ten-year-old son called Mateo. She loves and admires her husband. But she is wrong about him: he has been unfaithful to her all along their seemingly happy marriage, and she has been blind to it. Later on, she starts a relationship with a young journalist called Cristobal who seems to have deep feelings for her. Nevertheless, Monserrat has unsolved issues with her ex-husband and never takes her relationship with Cristobal to a deeper level.

Here I focus on Monserrat's character, who in the plot faces premature menopause. In the first episode, she appears as an emotionally unstable woman who finds out that her husband has been having an affair with his secretary when she finds them having sex in her bed. This event causes her to fall into a period of depression and unwillingness to live. She is also very insecure about her looks; she constantly remarks on the fact that she is getting older, and that she wishes to get her breasts enlarged because says that the only thing men care about is whether a woman has small or large breasts. In several episodes of the soap opera she seems obsessed with other women's breast sizes and this obsession only ends when she gets plastic surgery to enlarge hers.

What becomes interesting for this research is the fact that Monserrat seems to embody upper-middle-class women's issues about aging. Even though I did not plan to analyze a soap opera at the beginning of my research I came across this one during the writing process and I realize how meaningful this character was to understand the way female aging is being represented in Chile.

In episode 75 Monserrat thinks she is pregnant because she has not had her period for a long time, and she has several medical exams done. She was so nervous about the exams that she asked her good friend Dolores to go with her to the appointment with her gynecologist. Once in the doctor's office, she finds out that she is not pregnant at all but going through early menopause. She is shocked; she did not expect such news. She feels devastated, crying and yelling that her life is over. In order to analyze further the way Monserrat's early menopause is represented, I have transcribed the dialogue from this scene:

Doctor (female gynecologist): Did you bring the exam results? Please give them to me.
Monserrat: Please whatever it is, just say it to me with no preambles, I am too nervous.
Doctor: It is clear, you are entering menopause.

Monserrat: Excuse me, can you repeat the diagnosis, please? (starting to cry)

Doctor: According to the exams, what you have is an early menopause.

Monserrat: That is, it is the same: I have menopause.

Doctor: Look, the process can be reversible, 50% of patients have their period again in

an intermittent way… Let's do something: I will go to my secretary and ask her for some medical samples of hormones that will be great for you, you will see. (She leaves the room.)

Monserrat (to Dolores): I can't believe this, I got old this fast. (crying)

Dolores: I can't believe you are reacting this way.

Monserrat: And what do you expect? I mean I am very close to the third age.

Dolores: Please don't exaggerate; see the positive side of it.

Monserrat: What is the positive side? Please!

Dolores: Well, that you can have sex without worrying. You are so lucky!

Monserrat: This can't be happening, can't be happening to me.

Dolores: No, no, you are not old. Please don't react that way. Look at yourself, you look gorgeous; don't try to fight nature because this thing is going to happen to all of us. It is just a natural thing.

Monserrat: You are telling me this because it is not happening to you. Please don't say that because this strikes anyone's ego.

Dolores: Besides the doctor says this can be reversible.

Monserrat: Yeah, but because of the bad luck I have got for sure I will be part of the 50% that doesn't get better.

Dolores: Please look at yourself, you look gorgeous. Don't be so dramatic.

Monserrat: And I was thinking that I was pregnant and I am just menopausal! How stupid!

Dolores: I would understand your reaction if you wanted to have more kids, but that is not the case. You already have one; that is enough.

Monserrat: You are telling me all this because it is not happening to you, because if that were the case, you would be dead, devastated, you couldn't believe it. This is the worst thing that could ever happen to me. I can't believe it, I am a fucking old bitch.

Later on, she tries to hide her health condition from her boyfriend. She is afraid of him finding out that she is undergoing climacteric and thinking she is too old for him. But because he suspects she is hiding something he sneaks into her papers and finds out. They talk about it. The relationship goes on and, apparently, he does not care about the age gap. But once Monserrat's menopausal is revealed she starts having mood swings. She becomes irritable; she yells at everyone, cries about everything, has hot flushes all of a sudden, and becomes someone difficult to deal with. From being an insecure but still successful put-together-woman at the beginning she becomes more and more out of control. Her body and behavior seem to deteriorate continuously. In addition, she has to put up with her ex-husband visiting her office, where he tells her how happy he is with the new relationship he is having. He tells her about his plan to live with his new younger partner, to get married, and have kids and so on and so forth. The visual content of these exchanges suggest that he is just annoying her and trying to make her feel jealous. There is some sort of competition going on between them. As Federico tries to show how happy he is, Monserrat pretends to be just as happy as him and she does not succeed in hiding how bad she feels about his whereabouts. In one episode, after finding out that Monserrat

has broken up with Cristobal, he brings her a cat as a present, because he says he has noticed how lonely she is, and the cat will be great company for her. This present brings about all Monserrat's fears of becoming a lonely single old lady with a bunch of cats, but, at the same time, she seems to accept her fate, stating that she is condemned to loneliness. In the conversations she has with her girlfriends, she constantly repeats how hard it is for a woman of her age to find a good partner, and she expresses her fear of ending up all by herself. But at the same time, her behavior is portrayed as moody, because she goes from sadness and deep pessimism to excitement at finding new potential partners through an internet dating website. Her friends seem not to understand her behavior and express concern about her state of mind.

Later on, after breaking up with Cristobal, she starts looking for a date on the internet. But she does not succeed in her quest. Her ex-husband once again gets in her way. He pretends to be a new internet date and arranges to meet her. She is very excited about the date and thinks it will be a new beginning for her. When she finally arrives, she realizes that the perfect virtual mate was really her ex-husband. She gets angry and disappointed. After learning that their divorced was legally finalized, they have a last conversation, and she tells him she does not trust him anymore. As he leaves her office, he says to her, "Good luck, I hope you will be very lucky in the second half of your life." This sentence seems devastating to her. She looks shocked.

Later, she has an emotional breakdown, and tells one of her girlfriends, crying:

> I am a failure. Why is this happening to me? … I am alone; I am a bitter single old woman. Why do I get this punishment? I am so optimistic, I have such good vibes, and life brings me this punishment, this paper [referring to the divorce papers]. Life wants me to start all over again, but I am old and ugly.

After a few days she finally talks again with Federico. He says he is still in love with her and asks her for another chance. Despite her initial hesitation, she eventually admits to being in love with him as well, and decides to give the relationship another shot.

This soap opera conveys the general opinion regarding menopause and female aging in Chile: it is just a curse. No woman wants to reach that point in her life. It means being devalued and loneliness unless one has been able to stay married. The story of Monserrat is disempowering; it does not allow women to believe that changes are possible, and the soap opera tells women that there is no chance for a new life. On the contrary, it seems wiser and safer to be back with an unfaithful husband than run the risk to grow old in solitude. As the popular saying goes, in Chile and elsewhere, "better the devil you know than the devil you don't." In this saying, there is a taste of resignation, a pessimism implied in the idea that women cannot change their fate.

Monserrat depicts women's fear of getting old. In Monserrat's words, "That's it. It is over." Youth is associated with freedom, joy, opportunities, the chance to enjoy love and sex; all those things seem to vanish for women as soon as they get to the menopausal stage. It is interesting to note that in the Argentinean version of the series, things go otherwise. The Monserrat character (named Mia in the Argentinean version) tries to restart her relationship with Federico but he develops erection problems. After looking for medical treatment to reestablish his sexual performance, he slowly becomes aware of the fact that he likes men. At the end he assumes a homosexual identity and starts a new

life with another man.

Comparing both "happy endings" makes clear that each society seems to confront issues and public debates according to its own state of affairs. After legalizing homosexual marriage, the public conversation in Argentina seems to be much more focused on sexual diversity and civil rights. In Chile, even though there recently was passed a law that legalizes both homosexual and heterosexual partnership contracts, such a public depiction of "coming out" seems still unthinkable. Chilean society is still debating about the place of women in society and the boundaries of women's independence. According to Vidal (2013) the Chilean soap operas in the last decades reflect the changes Chilean society has experienced. They range from a very conservative agenda to an increasingly open and progressive representation. Some of the changes featured in soap operas are the more democratic relations established between adults and kids, the open display of sexuality and sexual practices, and the displacement of a traditional model of family by a new model that is called "reunited family" (or in Chilean terms "your kids, my kids, and our kids").

I do agree with Vidal's description of the actual content of Chilean soap operas but I am not so optimistic as he is. In my opinion, the way that "*Socias*," a so-called progressive soap opera, finally solves the issues it poses is in a very conservative fashion. If we assume that soap operas comply with a classic narrative structure: a setup where the main characters, and their goals and obstacles, are introduced; a development where we see how these characters overcome or face their obstacles; and a resolution. I argue that this last part is important to understand the whole content that is being represented: the way the conflicts of the plot are solved is a key element to interpret the meanings produced in the visual text. So, although this soap opera can be defined as "progressive" because it portrays new family models and liberal sexual behavior, the way it solves the central conflicts of the plot is very conservative and reinforces traditional gender models.

The Counter Example: The Film *Gloria*

Gloria is a Chilean film that premiered in 2013. It reflects the everyday life of a divorced woman, 58 years old, named Gloria, who looks for occasional sexual meetings by attending parties for people over 60. In this process she faces several adventures. As the movie starts, we see Gloria dancing in a club, where she gets to meet Rodolfo, a 60-year-old man who claims to be in the process of divorce. Later, we get to know Gloria's adult children: her son Pedro who is taking care of his new baby (apparently the baby's mother is not around) and her daughter Ana, who works as yoga teacher and gets engaged to a Swedish man with whom she will move to Sweden.

The film portrays Gloria's liberation from social taboos against aging women, as she learns to enjoy her life and being single with joy and vitality. She expresses an attention to romance in her practice of listening and singing 80's love songs on the radio while she is driving. She tries to live her life in a gratifying way, including by going to these parties for third-aged people.

Gloria's relationship with Rodolfo does not work out well because he is still quite connected to his former wife and daughters. They usually call him just in the moments

he is sharing with Gloria. But Gloria likes being with him, likes the sexual encounters with him, and seems to be getting more and more involved. After their intimate moments are interrupted a couple of times by phone calls from Rodolfo's daughters, Gloria asks him why he does not tell them he is busy with his girlfriend. Rodolfo answers, "They will tell me, 'So, you have a girlfriend, you silly ridiculous old man, how could you even think of dating at your age?' They would make fun of me, and why give them that chance? I don't want to get them involved in our relationship. They don't care about me. It is an absolutely loneliness."

The movie slowly shows the differences between Rodolfo and Gloria. Rodolfo has a parental relation based on dependency and overprotection while Gloria continuously has to face the meager attention of her children who do not seem to worry much about what their mother thinks. The initial enthusiasm of Gloria and Rodolfo's relationship gets overshadowed by the problems both face. It is worth noting how the director Sebastian Lelio portrays sexuality and pleasure among aging people. The film engages with sensuality, eroticism, and nudity in an intimate way. It succeeds in showing that desire and pleasure are fully present in the life of a middle-aged woman such as Gloria.

Gloria portrays an active and desiring model of female sexuality, one that looks for and finds pleasure. This liberation is represented by Gloria's naked body that is shown without shame and hesitation. After several attempts at enjoying her time with Rodolfo, which did not go well as he had the tendency of leaving her to respond to his daughters' needs, Gloria decides to break up with him. At the end of the movie, Gloria succeeds in reaching liberation by ending her relationship with Rodolfo and starting to enjoy being by herself, which is represented by her dancing by herself at the end of the film.

Lelio, the director, explained in an interview that *Gloria* reflects a society that wants to break with social barriers and produce a change from within. The film had an overwhelmingly positive reception not only in Chile but also in other countries all over the world. This film speaks about a universal phenomenon: the way older women are redefining their role in modern societies. At the same time, the film conveys a great deal about Chile and its current contradictions. It portrays the confrontation between conservative ideas and people's need for more progressive practices. According to the director, *Gloria* vindicates this generation's rights to keep living, dancing, and its believing that there is much more to come for them ("Sebastian Lelio: en Gloria está presente una sociedad chilena en proceso reivindicativo," *Revista NOS*, April 2013). The middle-aged Chilean columnist Susy Hernandez (2013) published a column sharing her identification with the film:

We are women in our fifties, getting very close to the sixties, who are reconciled to our age, with no need to show anything to anybody, we don't care about failing anymore, we just want to live what is left the best way we can, on our own terms. (my translation)

The liberating image of a middle-aged woman that *Gloria* provides seems to resonate and give optimism to many Chilean women who are looking for new models of aging. However, it does not represent a general change in the state of affairs.

No Quiero Envejecer (I don't want to get old) by Pilar Sordo

Pilar Sordo is Chilean psychologist and writer who since 2005 has become very famous and influential in Chile and other Latin American countries, thanks to her books on family and wellbeing. Her books are best sellers and have been taken as authoritative sources when it comes to learning how to discipline kids and how to endure pain and loss. She also gives lectures and conferences, writes columns, takes part in TV programs as special guest and advisor, especially for the so-called *matinales* (TV miscellaneous morning programs aimed at capturing the attention of housewives and maids). Her internet videos where she performs a sort of stand-up comedy, talking about topics such as consumerism and the difficulties of educating kids these days, become viral on Facebook and other social networks.

Her book *No Quiero Envejecer: Las Claves para Vivir Plenamente y Disfrutar del Paso de los Años* (I don't want to get old: The keys to living fully and enjoying the passing of the years) was published in 2014 and it is part of a considerable list of publications in which she addresses a variety of issues, such as how to endure pain (*Bienvenido dolor*, 2012), seduction (*Lecciones de seduccion*, 2010), how to raise teenagers (*No quiero crecer*, 2009), and gender differences (*Viva la diferencia*, 2005). *No Quiero Envejecer* was the best-selling book for eight weeks in Chile in 2014. Sordo also reflected on the success of the book in several interviews with television programs, magazines, and newspapers in which she explained the basic ideas of it.

Regarding the objectives of the book, Sordo explains:

> What does aging mean today? When is someone considered to be old? What is the meaning we give to the word old? Is it important to ask those questions or we should just accept that time goes by without much analysis or social discussions? … I wonder what happens with issues such as partners, mourning, sexuality, family, friends, work, health, technology, or those topics that were brought about by all the people that took part in the research that I try to summarize for you in these pages. (Sordo, 2014, pp. 20–21; my translation)

She begins by analyzing the sentence "I don't want to get old," which she heard many times while doing her research on aging in Chile. She does not describe the methodological steps of her research but implies that she conducted many interviews with men and women in several Latin American countries to find out what they think about aging. She later presents the keys for getting older successfully and enjoying that stage in life.

It is difficult to assess Sordo's statements on aging. She claims that the ideas she presents in her book are part of a research and "have been told by her informants" (Sordo, 2014, p. 17). Therefore, the author is not to blame for transmitting those views as she is recounting what is "common sense." For example, she provides a definition of aging that emphasizes the loss of independence as a sign of getting old:

> Everyone agreed that the clearest expression of what getting old is about is to lose independence, in physical and mental terms. It seems that the major indicator that one has become old is the loss of autonomy. In any event, many people agreed that even though those signals are inevitable, other people's attitude is decisive to evaluate whether

> one is socially considered old or not. (Sordo, 2014, p. 28; my translation)

However, sometimes she expresses her own opinions, talking as a psychologist and based on her own experiences, usually about the 'dos' and 'don'ts' of getting old.

Sordo's book can be rightly classified as a self-help handbook, but it is not presented as self-help tips from an expert, coach, or an illuminated guru, as she presents herself as a common- sense woman, someone who asks people, learns what they think of aging, and also brings to the book her own experiences. What makes her books so powerful and explains their great success is the idea that she brings back common sense. According to Sordo, being happy is a matter of having the right attitude and planning a successful life. For instance, she states that aging people should value the spiritual aspects of life more than the material ones:

> With one's financial situation solved, aging should be a stage of consolidating goals and affections that we have reached during our previous living. It should be a moment to thank and appreciate details and give more value to the spiritual aspects instead of the material ones. (Sordo, 2014, p. 37; my translation)

In this framework, the problem of aging is a matter of perspective. Sordo explains that because people are so involved in the capitalist quest to become rich and successful they are not able to value what really matters in life, and thus risk ending their lives in loneliness and despair. She offers what she calls the "keys to living in plenitude and enjoying the coming of years" as states the title of the book. I summarize those keys in the following list:

> People must get prepared for getting older in physical, psychological and spiritual terms. People must work out to stay healthy.
>
> People must accept the fact that years pass by with dignity but also with self-care. People must take care of their eating habits.
>
> People must invest in affection when they are younger, so they will have "savings" for the future.
>
> Men must learn to express their affection and women must learn to let negative experiences go, quitting the search for being always needed.
>
> People must maintain sociability throughout their lives. People must learn how to live alone without being lonely.

The book also conveys an essentialist view of aging, particularly when it comes to describing gender differences. Sordo reinforces an analysis developed in her earlier book *Viva la Diferencia* (Long live difference!), in which she states that there are fundamental differences between men and women that should be valued and taken into account. In *No Quiero Envejecer*, she asserts that aging women should learn to modify certain behaviors that are considered negative:

> We are designed by biology to retain things and this gets worse with the years. It becomes more visible and pathetic. The water retention increases, and all our metabolism works as slow as a turtle. … Our retaining behavior goes beyond the physical aspects and that is why we keep so many memories, and we are askers, pushers, and repeat ourselves so much. We need to stop doing things that aren't good for us. To be able to stay with the

> things that are good seems to be the key for enjoying the coming years. In this way we won't become complaining ladies and won't become victims of the things we have faced in life. (Sordo, 2014, pp. 93–94; my translation)

Critically reading her book, it becomes clear that author focuses on the situation of upper middle-class people. Because she does not seem aware of it, this focus on upper-middle-class issues becomes a serious bias. Sordo talks about the search for success, for material accomplishments, for having a good car and a nice house, but says little about those who are far from reaching such comforts in their lives. Generally speaking, the keys for successful aging according to Sordo are placed in a logic of choice, and lack a historical, political, and cultural analysis. Even though the author refers to "other cultures," "non-western cultures," and "past times" to acknowledge cultural differences, the information she provides is superficial and very close to stereotyping.

4

According to her, successful aging is a matter of having the right perspective: being able to enjoy affection and love, finding a way to spend time with the loved ones, actively resisting consumerism and superfluous interests. In other words, being a successful elderly person is a moral matter. Her reflections on aging seem to reinforce the idea of successful aging as an individual responsibility, something people must prepare themselves for. *No Quiero Envejecer* is a text that intends to rule the way people should face aging, complying with the economic and social structure of capitalism, emphasizing autonomy and independence.

Alongside relating "healthy aging" to eating habits and exercise, Sordo adds the concept of "emotional investment," which refers to caring for relatives (particularly children) when being young, which will establish ties that will last and help the elderly in the last years of their lives. She stresses the idea of not being an overdemanding and complaining woman but also advises men to pay attention to their emotions and to care about others when they are young. Sordo's focus on "the right attitude," though, neglects the power of gender relations, in suggesting that both men and women must accept their differences and learn to understand the opposite gender.

Despite Sordo's popularity, which is evident in her frequent appearances in mainstream media in Chile, she also has attracted enemies. In Argentina, in 2014, when she appeared on a popular TV show, the lead personality on the show read a tweet sent by the well-known Argentinian TV script writer, Carolina Aguirre, attacking Sordo, describing her as "a reactionary, guilt implanter, male chauvinistic, homophobic, who hates everything that is different. She is not harmless. She is a public danger." This public critique ignited a media controversy around Sordo's work and thoughts. Nevertheless, her work has encountered little scholarly critique, as I myself experienced at the Chilean Sociology Congress, where I presented part of my analysis on her work on aging (La Serena, 2014). I realized her work is little known by those who disagree with her views because she is perceived as part of the "uneducated" popular culture. The numerous questions and reactions that my analysis raised made me realize the importance of closely looking at the popular discourses that are being produced on gender and aging these days by influential authors such as Sordo.

Generally speaking, the mass media represent a negative view of female aging, suggesting that any troubles can be compensated for by the use of technologies and biomedical treatments or can be prevented through "the right way of living." In that sense,

the articles reviewed reflect to a great extent the concerns and recommendations of the biomedical specialists in menopause and aging. This is also visible in the soap opera, where the character of Monserrat is immediately advised to start hormonal replacement therapy, as soon as she finds out that she is undergoing menopause. The way she deals with the process of aging reflects the idea of biomedicalization as a way of enhancing the body against aging, which seems to represent the dominant view of upper-middle-class women in Chile. This subject will be further discussed in the following chapter.

Even though the media seems to give predominant voice to the biomedical view on menopause and aging, in a limited way they also put forward the fears associated with potential deleterious side effects of HRT. However, the information they publish is unclear and does not fully help the case of the medical specialists who want to encourage Chilean women to use HRT.

At the same time there are conflicting discourses that talk about accepting aging as a natural process but at the same time suggest that aging requires self-care and taking responsibility for oneself. This discourse puts many demands on women who are encouraged to change what are considered negative behavior patterns. This discourse is very much in alignment with the biomedical discourse since it conveys the idea that aging is a disease that can be prevented and turned into a "healthy successful aging" with the help of medical care and other self-care technologies.

There is an emerging new view on women's aging that breaks traditional patterns regarding the expected behavior of aging women, particularly regarding sexuality. This discourse portrays the idea that aging women have sexual and affective needs that should be satisfied. This discourse acknowledges women's autonomy and breaks with the idea that women must confine themselves to the private domain as they get older.

CHAPTER 5.

SOCIAL CLASS AND THE BODILY EXPERIENCE OF AGING

On the 18th of October, the International Day of Menopause is celebrated worldwide. It was created by the International Menopause Society (IMS) with the purpose of raising awareness about the health needs of menopausal women. The IMS is a UK-based international non- governmental organization joined by medical specialists in menopause. It was founded in 1978 and has developed into a global society that includes national and regional menopause societies (International Menopause Society, n.d.). In Chile, on the International Day of Menopause, press reports appear in the media as a way to call attention to the health care needs of aging women.

What seems interesting is the emphasis placed on sexuality and active sexual life as a main source of wellbeing for menopausal women. The Chilean Society of Obstetrics and Gynecology wrote an opinion editorial that was published in several newspapers on the 17th of October 2011 ("Specialist Says It Is Possible to Enjoy Sexual Life after Menopause"; my translation). This editorial stated that all the sexual-related problems that appear as a result of menopause, such as vaginal dryness and lack of genital sensitivity, might be solved if menopausal women would dare to discuss those issues with their doctor. The gynecologist Manuel Parra representing the Chilean Society of Obstetrics and Gynecology states in this text:

> First, we need to take into consideration that a good sexual life takes place in a healthy body and mind. That is why we need to start by facing the situation because many women do not even dare to ask about it. Therefore, if one as a doctor does not ask the patient straightforwardly how she is doing regarding libido, vaginal dryness, or whether she experiences pain during sexual intercourse, she is not going to tell you. Unless her relationship with her partner is endangered or her husband has sent her to your practice to ask about it. ("Especialista afirma que tras la menopausia," 2011; my translation)

At the time I read this statement, I was already doing interviews with menopausal women from both upper-middle-class and working-class backgrounds. I noticed that the way the menopause was being represented by the media (which mostly replicates the biomedical discourse on menopause) did not necessarily account for the concerns expressed by women.

Women's View on Menopausal Complaints

The interviews I conducted with women showed that the emphasis on sexuality displayed by "the specialists" seems to be closer to the experience of upper-middle-class women; still, they also placed this worry in a wider context that included their feelings of aging and lack of energy to perform their daily activities. In contrast, working-class women did not give much importance to their sexual activity, even though many admitted having sexual issues with their partners. They tended to accept having less sexual encounters as part of what aging means to them.

Some women experienced serious menopausal complaints while others said that menopause came unnoticed. What seems to be a common experience was that women started to feel older, and that they observed some physical changes which made them aware of the time going by. The way they coped with these feelings varies according to their perceptions of life and their available resources to carry out certain practices. Nevertheless, they all seemed to care about their image, looking for ways to present themselves in a fashion that is socially acceptable.

A study published in 2017 also shows that menopausal women who attend a public primary health care center in Santiago, Chile see menopause as a normal stage in life, one which involves uncomfortable symptoms and even suffering (Dois Castellon et al., 2017). Women report that sometimes cannot carry on with their normal activities but still see that condition as "normal." In other words, the study found out that women see negative symptoms and alignments as part of what it is to be menopausal and not as something that can be cured or dealt with. The authors conclude that women face menopause with a stoic attitude, patiently waiting until the transition is over, which could be linked to social representations of female identity in Latin America, such as suffering and dependency (Dois Castellon et al., 2017).

In this chapter, I will explore the class differences in the perceptions that women have about menopause and aging, in terms of their body image and the strategies they adopt to care for their appearance. As explained in chapter one, I conducted in-depth interviews with 24 working class women and 13 upper-middle-class women in the cities of Concepción and Santiago. I started by contacting women in neighborhood associations and other social organizations with which I had contact before. The number of total interviews conducted was higher, as in the process of the analysis I decided not to consider interviews with women older than 70 years, as their problems, interests, and views proved to differ from those of younger women. Upper- middle-class women proved difficult to contact, therefore, the process of identifying interviewees was slower and I had to resort to personal contacts (contacting friends of a friend and acquaintances) and snowballing. Also, doing ethnographic observations in therapeutic groups such as bio-dance and yoga provided me with other contacts from whom I could solicit interviews. I stopped carrying out interviews when I realized that no new information was emerging from the interviews.

Based on the analysis of the collected data, I argue that the distinction between "middle aged" and "elderly" does not exist among Chilean women, at least not in the terms it has been documented in other cultural contexts. Menopause means becoming elderly while being "middle aged" is something that must be fought for. Exercise, alternative therapies, cosmetic surgery, and HRT are the means available for upper-middle-class women to remain "middle aged," a category still under construction in Chilean society. The fact that "middle aged" can be seen as constructed category not only helps in understanding aging as a cultural phenomenon but also, and more importantly, it poses the analytical challenge to identify and understand how different factors play a role in such construction. This process cannot be carried out without taking a theoretical stance on how social behavior and ultimately culture is interpreted.

In this chapter I explore to what extent social class can be used as a meaningful category for understanding the differences in the way women perceived aging. While

upper-middle-class women seemed much more concerned with being a middle-aged woman, working-class women tended to accept the idea of getting old and seemed much more worried about the everyday maintenance of their families. Some of them had a sense of accomplishment linked to the wellbeing of their families, whereas others regretted that they had not fulfilled their own wishes and expectations in life. Sometimes they worried about their appearance but taking care of it was not a priority in their everyday lives. That does not mean they did not care about their looks, but beauty was something they felt they could no longer achieve. Instead of worrying about it, working-class women thought that one must age with dignity, taking care of oneself in a moderate manner.

As described before, the definition of menopause as a medical condition caused by estrogen deficiency or ovarian dysfunction, by the western biomedical literature, has led to it being considered as physically and psychologically detrimental to wellbeing of aging women. (Beyene, 1986). Cultural research challenges this biological view of menopause; if it was principally a hormonal event, one would expect that women throughout the world would experience menopausal symptoms in the same way, which is not the case (Beyene, 1986; Lock, 1986). Comparisons of menopausal experiences of women from different industrialized and non- industrialized societies demonstrate a great deal of variety regarding the physiological, social, and cultural manifestations of menopause (Beyene, 1986; Hunt, 2000; Lock, 1986). Anthropologists thus claim that menopause is not a universal fact, but is signified and experienced by women in a variety of ways. It has been pointed out that gender constructions, body politics, and ideologies and practices related to sexuality influence the way menopause is constructed as a cultural event (Lock, 1993a).

I found a variety of symptoms and experiences with menopause in both groups studied. Upper-middle-class women's experiences tend to differ from each other. For some, menopause went unnoticed, while others experienced pain and discomfort. Those who had severe menopausal complaints went on HRT under the advice of their gynecologists.

At the time of our interview, Joan was 56 years old. She worked as the manager of a company owned by her husband, to whom she had been married for 32 years. She was living with her husband and youngest son, who was still in college. Her menopausal symptoms were noticeable, and she decided to use HRT.

> My first symptoms started when I was 44 or 45 years old. The truth is that I started to get worried because I started to feel the things I had heard about, the hot flushes, the vaginal dryness, and then I said, "I am finished, the menopause has come to me." Generally speaking, the symptoms were bearable, nothing to get traumatized from, and I believe being optimistic helped me a lot because that helps you overcome things. I believe the mental aspect has a lot to do with it as well. I think that now that I am in the next stage of being without [hormonal replacement] therapy, I will start experiencing some issues because now I am older. I was 45 when I started with therapy. Maybe it won't happen, but I am fighting against it.

Among working-class women, I also found variable perceptions of menopause. For some women, it was a difficult process to endure while others said they did not notice it at all. Among those who declared having menopausal complaints, the main issue they faced was to get proper medical treatment, because (as described in chapter one) HRT

or even medical specialists in menopause are not available in most of the primary health care centers in Chile.

When we met, Rosa was 57 years old. She had three children, two of whom still were living with her and her husband, to whom she had been married 37 years. Her son, who was divorced, had two daughters who also lived with Rosa. She used to work in domestic service and also as a shopkeeper, but was now mostly busy taking care of her granddaughters and doing the housework. She also led a neighborhood association even though she did not have much time.

She remembers having had several complaints that were not properly addressed in the primary health care center she attended:

> I do not remember when I got the menopause; I think I was about 50, maybe 52, something like that. Since then I have been fine, but the menopause was terrible because I had all the hot flushes and the troubles. You go to the Poli [health care center] and they say , "Well, you have to endure it because it is normal." In other words they give you no solution. I know some people get hormones but in my case I did not because within my family there are cases of breast and womb lumps … and that is it. I went there for nothing, I went early several times, trying to get an appointment with the doctor, going from one place to another, and when I finally got to see the doctor she did not give me anything; I was left the same way I was before.

Rosa had several complaints that she related to aging. Her account of her health issues is inseparable from the bad experiences she had when looking for health care:

> I have these horrible headaches, last year I had no idea what was happening to me, and had to go from one place to another. In the end I got the girl who measures blood pressure to do that for me, because the doctor did not have the time, so there was nobody to look at the results of my exams, and this and that. And in the end, it turned out that it was not a blood pressure problem, because I got dizzy—I couldn't stand up because of the dizziness. Later, I got an appointment with another doctor who sent me to take blood exams and everything, and they found out that I have problems with cholesterol. But when I went back to the doctor to get some medicines for cholesterol she did not have time for me. Then I was in the same place than before. I wasted a lot of time,so what did I do? I took the medicines that my husband gets for cholesterol, and I started taking those as well.

Anthropological studies have shown that the experience of menopause may vary according to how a culture perceives aging women. In this research, I have also found differences according to social class in the way women perceive growing older. In the case of upper-middle-class women, they seem more concerned with entering a middle-age status, which is not seen as the ultimate stage in their lives. On the other hand, working-class women tend to view the post-menopausal stage as an inevitable process of becoming old, something that must be accepted with resignation.

Generally speaking, upper-middle-class women said they still felt young. Even though they noticed body changes related to aging, they believed that taking care of these changes and having a positive mental attitude could help them stay young. They identified a social pressure that led them to think that they were getting older, but it was something they refused to accept. Keeping fit, dressing as young women, and taking care of wrinkles and gray hair were the strategies they used for looking younger. One

interviewee commented:

> You notice that—I mean, if I go back and look at the photos, I see that one starts dressing in a way that looks older, wearing a haircut for older women, I don't know. But I said to myself, I want to be different." (Joan, 56 years old)

For Joan, menopause was something to be fought against. If it brings about feelings of getting old, that is something that must be counterbalanced:

> As far as I am concerned, talking as a woman older than 55 years, when all the menopausal changes start you must fight against them. But also you have to win because I have realized that all this process is a psychological thing. You need to reinvent yourself, move on, try to feel young, not to make a fool of yourself, but feel young, because a 50-year-old woman is still young, she has a lot to give yet. If you are on bad terms with your partner and the menopause has affected you, you have to try to reinvent yourself with him again, with your children, with your family. If you need to go out to dance, then go out to dance, go to the movies, travel, you don't need to go to Europe, you can also go somewhere nearby. The worst thing a woman can do is to lock herself up and feel old; that means she is finished.

Joan also said HRT helped her to fight the feelings of aging: "I said to myself, 'I must keep being the same, I am going to fight against it, and it is not going to defeat me, and with the help of hormones, I am going to overcome this.'"

Body Perceptions on Aging

Perceptions about aging were also linked to women's body image. In the case of upper- middle-class women, their major worry was not to get fat, which was something they constantly fought. For them, staying thin was a matter of not giving up. All the upper-middle-class women interviewed worked out in gyms or attended workshops such as yoga or Pilates that helped them keep fit and active. Others also used alternative therapies for fighting weight gain.

Laly was 58 years old at the time of our interview. She held several academic degrees in education and philosophy, and owned a business in the center of Concepción, which was her main source of income. She defined herself as feminist, and was involved in local feminist activism mainly related to the struggle for the legalization of abortion. She was living with her husband, to whom she was married when she was 20; they had a daughter and two sons, none of whom still lived with them. Despite her husband's infidelities and the fact that he had beat her when they were younger she was still married to him.

In the case of Laly, as with other interviewees, it was clear that her main motivation for taking care of her body was her relationship with her husband. She was worried about her husband meeting other women, and felt she needed to be attractive to him:

> Well, I am a little fat, and that is something I don't like because I feel bad. On the one hand, I get tired, and the other thing is that I don't like being a fatty. I do care about my body because I know—because I know that my husband has—he travels everywhere; he is just coming back from Asia, and he goes to Uruguay next week because he gets invited

> to seminars. Even though I can tell he is a Casanova but also I know women chase him, and, of course, I want to look pretty and to match up with him, because he doesn't have a paunch and he dresses very well. I am not going to be the fatty standing beside him. Thus, I want to feel good first and then that he feels good too, because I know he has never liked fatties, that is something very clear to me. But he says that I am not fat, that only here I have a bit [she touches her belly], that is the thing that Cristina, my biomagnetism therapist, is working on, because she says that I have a problem with my pancreas that doesn't work properly.

Working-class women also worried about aging, and noticed body changes, wrinkles, and weight gain. Some of them said that if they had the money they would also take care of themselves in the way rich women do. However, they seemed much more worried about their health issues. Most of the working-class women interviewed had problems such as diabetes and high blood pressure which caused them several complaints. Their health problems were not only the result of their hard life experiences and lack of opportunities, as they also tended to get worse due to the lack of proper health care. Particularly, when it came to losing weight they regretted not having proper professional support for carrying out this goal.

Marta (56) was aware that she was overweight, but she found it difficult to diet and lose weight. Marta and her husband had four daughters, and two of them still lived at home. She worked as office cleaner in the evenings, and during the day she took care of a grandson and participated in community activities in her neighborhood. Because of her work shifts she was getting little sleep, but she said that it was fine with her. She was aware of her health problems related to being overweight, but instead of complaining she chose to value the good things she had in her life, such as her daughters' accomplishments:

> I am not happy with my body, not at all. But it is difficult; you need to have a lot of willpower to lose weight. I don't know how I got to this point. But at the same time, I am very happy, I am happy with my daughters, one is going to be a kinesiologist and the other gave me two grandchildren. Everything is going OK. I think I fulfilled the first part of my life.

Later in the interview, she explained that her main obstacle for losing weight was the fact that she did not have proper professional support. She compared the bad experiences she had had seeking help at the primary health care center with the kind of support she thought she would have if she went to a private practice:

> The doctor told me how to take care of myself, but it is so hard to stop using salt. In fact, I am consuming much less now, but there are a lot of things you need to quit eating, a lot, a lot, and when you get proper medical checkups it is easier to keep focused . . . . It is not the same when you go to a nutritionist's private practice: they make appointments every 15 days, then once a month or once per week, you get a checkup, you get to tell how things are going with you, you get help, it is not the same when you go once every 3 months.

Working-class women also cared about their appearance. Dying their gray hair and wearing makeup were the most common practices they used to keep looking nice. But more than fighting aging what they seemed to care about was looking "decent," that is, to look nice according to their age, in consonance with what was socially expected of them. As Rosa put it, it was a matter of following one's "age pace" (*el ritmo de cada una*). It was also a matter of attitude; not complaining, not showing ailments was a way of aging in a

dignifying manner:

> I still care about my looks, because I have always been this way. Not much now, but I still take care of my appearance. I don't like gray hair, to go out I use makeup, I take care of my gray hair, my haircut, everything, and even though I like eating I try not to cross the line. I don't want to be terribly fat because that looks ugly. I see my sister and she is fat, she has a lot of gray hair, and she still wears long hair. I mean, she doesn't follow the pace of each one's age, because it is OK to have long hair and things like that when you are young, that looks pretty, but when you are getting older the best thing to do is to have a nice haircut, and look like a more decent lady, so they [my sisters] are still living in the past. They are always complaining a lot, they complain about everything as if they had too many problems, too many ailments. (Rosa, 57 years)

This notion of aging with dignity seems to include two kind of behaviors: not complaining unnecessarily or being "*achacosa*" (someone with too many ailments), and taking care of one's appearance. It is not a fight against age to keep young but to show that one cares about her image:

> I started to feel many ailments [*achacada*], I don't know, older, uglier, a lot of things, then I say, "One has to take care of oneself," to use a little make up, that is what you can resort to, right? I doesn't matter that you have more wrinkles, but you have some dignity, you look cute. Because there are different kinds of old women, some don't care at all and look shabby, and others go out very well dressed and with makeup [*amononaditas*], and that way you show that you love yourself. I find that everyone has to live her own age with dignity. (Rosa, 57 years old)

When working-class women thought about their bodily changes, they seemed to accept them better than upper-middle-class women. It was not that they were happy with them, but they believed that such changes were part of their lives. Perhaps it has to do with the fact that they had less available resources to fight aging. Some of them went to gym classes organized by the neighborhood association or took part in occasional workshops on different subjects. These activities were seen as recreational opportunities that life offered them; it was not something they had control over. While upper-middle class women identified the kind of leisure activities they would like to do or alternative therapies they would like to try, working class women thought more in terms of wishes, things they would like to do if they had the opportunity.

Enelda was 55 years old, and living in a poor neighborhood in Pudahuel, Santiago. She and her husband, married 36 years, had five children; three of them still lived at home, together with a granddaughter. Enelda worked in a small hairdressing salon in her house. She said she felt older, but she found that aging is something that has to be accepted. She saw aging as a process of bodily decline, saying, "your body starts to fall apart" (lit. fall down; *se te va cayendo el cuerpo*).

> When this whole thing started I was like 53. One day I started looking myself at the mirror and oops! I saw that I had become old, I saw all these crows' feet around my eyes, and I said to myself, "Well you will have to settle for it, because that is how the stages in life are." Now I just don't often look at the mirror, just to avoid tormenting myself. I care about myself. I use lotions, and I try not to eat things that make you fatter.

Working-class women did worry about becoming older and losing their

attractiveness, but they dealt with this preoccupation differently than upper-middle-class women. Some said that they would turn to plastic surgery and other beauty technologies if they had the money, but that was something completely inaccessible to them. As some women commonly said, "there are not ugly women, only poor women." Unlike the situation described in other Latin American countries such as Brazil (Edmonds, 2010) working-class women do not have the means to obtain beauty technologies such as plastic surgeries and other beauty procedures.

Upper-middle-class women seemed much more worried about the consequences that aging would have on their marriage or relationships with men, and working-class women did not seem to believe that getting older would jeopardize their relationships. Perhaps this has to do with the fact that those who were married at the time I did the interviews had experienced several conflicts with their partners (infidelity, violence, alcoholism, and economic constraints) in their life together, and that, at some point, they had made the decision to stay with them despite the troubles. Most of them said that, because their partners were also getting older, they have changed: they are calmer, they go out less, they drink less than before, they seem now more focused on their family life. Therefore, menopause is a time when they can enjoy a more pleasant family life.

At the same time, working-class women seemed busier with taking care of their grandchildren, in comparison to upper-middle-class women. Some of them still had precarious jobs that they combined with their "duty" as grandmothers. Due to economic constraints, multigenerational homes were common, and as grandparents they could help with the parenting, not in an occasional way but with a great deal of responsibility. While upper-middle-class women typically relied on daycare or had nannies at home to take care of their children, working- class women mostly relied on their mothers and mothers-in-law to perform this task so they could work. Older women saw this duty as an extension of their role as mothers, to help their children in their everyday life by taking care of their grandchildren.

An example of the way older women worried about their grandchildren is what Marta (56) said about having more grandchildren. She was taking care of the first one, but did not know how she would deal with taking care of several grandchildren at the same time.

> Now I am focused on taking care of my grandson. But I have thought, "What am I going to do when each of my daughters has a child? What I will do, where should I go first? That is the issue, where I will go. Because they are going to say, "My mummy is there, and she doesn't help me." I told them the other day, and they said, "Come on, you are joking." But I really think that now we are all here because there is only one baby, but when another one has a baby then I will have to be everywhere, I will have to take this baby and go where the other baby is.

Marta's words express how working-class women saw taking care of their grandchildren as their primary responsibility and fundamental role. In such a scenario, taking care of themselves was seen as a secondary worry, something that can be postponed. Being a grandmother was a source of satisfaction and happiness for them, no matter how hard it sometimes was. This role also allowed them to find a new place in the family structure, which somehow put them at the center of the family everyday activities.

Aging and Sexuality

According to Foucault (1976), sexuality is a modern construction, which began to be defined as part of the human nature only in the 19th century. The understanding of sexuality was elaborated in order to define normality and its limits, and therefore to make possible the labeling as pathological of any behavior classified outside those limits. Foucault (1976) argued that the elaboration of sexuality allowed the organization of sex as something natural instead of a social construct.

Social theory on sexuality has developed extensively since Foucault's work. The critique of psychoanalysis has allowed the development of a fully constructivist perspective that acknowledges the historical, cultural, and social factors that shape how sexuality is experienced in contemporary societies (Weeks, 2003). According to Giddens (1993) contemporary ideas about sexuality, as the relationship among sex, love, gender, and intimacy, are a direct result of modernity. Giddens (1993) contends that the rise of the modern global and democratic society fundamentally changed the shape of all human interactions, from sex to love to companionship. A "pure relationship," he argues, is built on the idea of sexual and emotional equality, and implies a change in terms of power relations between men and women (Giddens, 1993, p. 93).

Giddens (1993) also coined the concept of "plastic sexuality" to describe a sexuality freed from procreation; it is the result of the emancipation of women, the emotional emancipation found in the pure relationship, and women's demand for sexual pleasure. Giddens has defined plastic sexuality as a "decentered sexuality," freed from both reproduction and submission to a fixed object for pleasure. Plastic sexuality is also the result of the reflexivity of the self that comes out of modernity (Giddens, 1993).

If modernity is represented by the search for a pure relationship and pleasure through a plastic sexuality, more traditional ideas remain associated with romantic love. Among the interviewees, I found a concern for sexual pleasure that was mostly framed by the importance it held in their relationships. Most of the interviewed women, regardless their socioeconomic status, said they were encountering problems in their sexual life after menopause. Most of them felt less sexual desire, and that made it difficult to have sex with their partners. Others say that because their partners were getting old and sometimes sick too, they were less interested in sex. However, the difference between the two groups is the fact that upper-middle-class women had the means to seek help. They looked to professional sex therapists or solutions in alternative treatments. Some of them tried several treatments and argued that that one must persevere to find the right treatment:

> Now I am looking for another treatment because I refuse to have sex with my husband; I want to keep feeling that connection, as long as I can, because there were some periods—we had long periods of time without having sex; maybe it was due to the same, I mean the mind has a lot to do—I reinvent myself with him, for him, because what is the point in living with someone who does not make me happy, someone with whom I don't want to be if I don't want him to touch me…? What for? I mean I felt in love with him because I love him, I want him to be with me, I want him to touch me, that we both enjoy life together, that we go out together, and if I am well physically and psychologically as long as possible,

5

> it is better. (Joan, 56 years)

Working-class women also faced problems in their sexual lives. Unlike upper-middle- class women, they did not see possible remedies to their situation, and tended to accept things as they were. Some studies carried out in other Latin American countries (Ramírez, 2006) found out that sexual relations seem to be less important for women in traditional communities, since their source of identity and power is in the role of mother and grandmother. Based on my own research findings, I contend that in the case of working-class Chilean women, it was not that they did not care about having sex, but because of a lack of means they developed an attitude of resignation, accepting that their sexual life will become less active as a natural and irreversible process. Unlike upper-middle-class women, they did not have access to a sex therapist or alternative treatments, and when seeking advice in the public health care system, they usually were told that at their age sexuality is not that important. This view was reinforced by health care workers and the health care system that does not acknowledge a satisfactory sexual life as part of the "quality of life" of working-class women.

Maria (64) lived in Pudahuel with her husband and daughter. She had first married at 19, and had two children. After a long period as divorcee, she remarried a widower, and they had another daughter. She also raised the five children from her husband's previous marriage. She has worked since she was 14, and had a little shop of candies and sodas in her house. Her story reflects how women who live in poverty face difficulties in finding sexual health care. When attending the primary health care center Maria complained several times about not having sexual desire, and the response she got was that it was normal, and there was no harm in not having an active sexual life.

> I don't feel anything at all. He knows that and says it doesn't matter. He is 60 years old now. He neither, I mean with all the sicknesses he has, he no longer—but I don't feel anything at all. I have been complaining about it for six years. Do you know what the doctor told me at the hospital? "What else do you want? Just don't have sex anymore." What a solution! No, and here I have complained too; [referring to the health care center] the gynecologist laughs at me, and even the doctor I saw, and the nurse told me, "No, but how old are you? That doesn't matter; it doesn't harm you." And I said to her, "Really, do you think so?" Sometimes my husband complains about it with me, not every day, but sometimes, and I said, "What can I do? So far nobody has told me anything useful, I don't know where else I can go." (Maria, 64 years)

Experts assert that "it is possible to enjoy sexual life after menopause," though this does not apply to every case. It appears that when speaking about sexual life after menopause medical experts are referring to upper- middle-class women who look younger. Maria does not comply with the expected image of a sexually active old woman. She does not take care of her body in a way that makes her look younger, and does not seem to worry about looking old. Maybe the idea of a sexually active woman is acceptable until she hits 60, and so Maria just appears too old to her medical interlocutors. Perhaps the reason her sexual health care needs have been neglected is because she is poor. Living in hard conditions and having barely any medical attention does not make sex therapy seems like a priority. Perhaps the professional staff at the primary health care center think that she would do better worrying about preventing high blood pressure or diabetes, the goals that the National Health Ministry has set as priorities for primary health care.

Are There Emerging Views on Female Aging?

According to the data collected, it seems that there are two different pathways women face for aging in Chile, which are fundamentally shaped by social class. When I was doing the press review on menopause, I came across an interesting concept. Old age ("*tercera edad*" in Spanish) is now being renamed as "*maduritud*," a play on the words *madurez* (maturity) and *juventud* (youthfulness). The concept is being promoted by a multinational company that sells intimate body care products for menopausal women such as pads and vaginal lubricants. The press release was titled "Maduritud, the new stage of women after the 40s." Its first paragraph states:

> It is well known that every woman over 45 starts the experience of the climacteric period when the menopause appears. Nowadays this cycle in life is no longer something to be ashamed of or something that makes women look emaciated or old, on the contrary. The term "maduritud" has been created. It is a play on the words youth and experience of maturity which perfectly defines this stage in the life of every woman. The brand Poise has brought about this topic of conversation. (Maduritud la nueva etapa en la vida de la mujer despues de los cuarenta, 2012).

5

The term "*maduritud*" conveys the new meanings that the aging process is acquiring for women and for society as a whole. *Maduritud* is being represented by the image of a white, upper-middle-class middle-aged woman who has some wrinkles, but still looks young. She is thin, well-dressed, and active. She is happy with her life. She has a successful career and she has the means and time to take care of herself. That is a social class-biased image, one which seems to represent the market niche that the brand Poise is seeking to attract, but, of course, does not resonate with many Chilean women's experience.

If the term "*maduritud*" is the response to the development of a new imaginary about aging women, the local biomedical sphere is also searching for new ways of representation. The concept of a middle-aged woman (*mujeres de mediana edad*) is newly being used in Spanish, mostly within the academic domain. This term was first used in an academic paper published in Spanish in 2003.[12] Since then, the concept of *mediana edad* has frequently appeared in medical sciences publications (and to some extend in social sciences as well) as well as internet magazines and blogs that communicate and comment on scientific findings.

The fact that the concept of *mediana edad* is not commonly used in Spanish does say something about the way aging has been perceived in Hispanic cultures. In Latin America, traditional gender arrangements have defined motherhood (and therefore reproductive capabilities) as the main source of female identity (Montecino, 1990; Lagarde, 1990). In this paradigm, becoming "elderly" means a new social role: guardian of tradition and the wellbeing of the entire family (Montecino, 1990). The global changes that have taken place in gender relations in the last decades have weakened these traditional meanings attributed to womanhood, and a new stage in women's lives has appeared, a transitional stage between young adulthood and old age. However, the meanings of this stage are

12 According to my own review of the two main academic repositories for Spanish scholars www.scielo.org and http://redalyc.uaemex.mx/. I reviewed all the articles published on both sites for the period 1993 to 2012 in relation to the concept of middle age..

now a matter of dispute.

The upper-middle-class women I interviewed were seeking the status of "middle-aged women," which meant showing their willingness to keep looking young and to care about their sexuality and relationship in times of the "empty nest." To a great extent their search for remaining young implied resorting to enhancement technologies within the biomedical system as well as the treatments offered by the beauty industry. For working-class women, that was not much of an option, even though they cared about their image and most of them were not happy about getting older. They were much more concerned about the wellbeing of their families, and taking care of their children and grandchildren. Material conditions seemed to play a major role in the way both groups experienced aging.

Analyzing the interviews, I found that, on the one hand, women tended to reproduce in their bodily experiences the traditional norms attributed to women, particularly when it came to sexuality. Even though they claimed their right to have sexual pleasure they framed this claim as part of the requirements for a harmonious marital relationship. At the same time, they acknowledged their own neglected needs and wishes even though they did not have the means to fulfill them. In both groups, upper-middle-class and working-class women, what seemed to be at stake was the impossibility of breaking the gender rules that obliged them to undermine their own personal needs for the sake of family harmony.

I contend that, despite the differences that superficially appear when comparing the experiences of aging among upper-middle class and working-class women, they did not differ that much. In both cases, women worried about aging and feeling physical decline; the fundamental difference was that they had different sorts of strategies to deal with those feelings. While upper-middle-class women could resort to medical technology to fight aging, working- class women tended to accept aging as something inevitable and found ways to be grateful with what they had in their lives. Religious values and traditional ideas about motherhood were as important source of satisfaction for working-class women. Social class did shape and constrain the options these women had for dealing with aging. My analysis does not support the existence of a social class "distinction" (Bourdieu, 1988) related to aging, but the difference seems to relate to social practices around it.

In addition, upper-middle-class women seemed very much constrained by the traditional gender prescriptions that base woman's value on their physical attractiveness and beauty; in that sense they did not appear more emancipated than working-class women. Still, through the use of technology, women seemed to gain greater control over their bodies. Particularly, HRT can be seen as an ally in the search for wellbeing. Therefore, gender is still a fundamental category for analyzing how women experience aging.

I am very much concerned with the question of social reproduction in times of change. Aging seems to be an evolving cultural phenomenon. An anti-aging medical practice seems to be replacing the traditional gerontology approach, which looked to provide palliative care to the elderly (Mykytyn, 2006). New meanings are being attributed to aging subjects. In the case of Chile, the production of those meanings seems to have as cornerstone the biomedical view, which advances the idea that aging is in fact a disease that can be dealt with through HRT. But this biomedical discourse on aging does

not correspond to what the public health care system offers to women. Insofar as HRT access is not guaranteed, and there is no comprehensive and multidisciplinary medical treatment, working-class women are left with the idea that aging is a natural process that must be faced with resignation and stoicism. And upper middle-class women are expected to "fight" aging with the help of private medical services and the consumption of whatever is offered on the anti-aging market. In the next chapter I discuss yoga as a way to overcome this dichotomy.

CHAPTER 6.

LOOKING FOR ALTERNATIVE PATHS: WHY AGING WOMEN TURN TO YOGA

In this chapter I describe and analyze the way some of the women I encountered along my research project looked for answers to menopausal complaints in so-called alternative therapies. I argue that women who fully engaged in alternative treatments, such as yoga, tended to give particular meanings to their health complaints and to the process of aging. In this chapter I give an account of how women gave meaning to their health complaints in ways that went beyond physical problems, including psychological and spiritual aspects of wellbeing. This gave them the capacity to accept their aging process in a way that seemed easier or less conflicting to them. I argue that yoga provides a set of bodily experience that helped women elaborate a definition of aging as a positive process, as something that must be valued.

During the development of my fieldwork I met several women, especially those belonging to the upper-middle class, who explained that they sought help in alternative therapies. The most widely used treatments were: bio-magnetism, Bach flower remedies, yoga, and bio- dance. At the beginning of my fieldwork I participated in a bio-dance group for the elderly. It was a fruitful experience that gave me insights into the way this therapy works and some of the issues that upper-middle-class elderly women confront. However, later I decided to focus my research on middle-aged—rather than elderly—women and therefore did not continue with this participant observation.

In a later stage of my research I had the opportunity to attend a yoga class at the invitation of one of my interviewees. When I started practicing yoga I realized that my own experience could be helpful to understand why aging women turn to the practice of yoga and why they develop such positive perceptions and feelings about this experience. In the first stage of my fieldwork I came across several interviewees who mentioned the practice of yoga as something that helped them to face health issues. I took those perceptions into account in my analysis, noting that women who turn to alternative therapies seemed to have more positive meanings about aging. Later I realized I was missing something: an actual ethnographic account of what one feels when practicing yoga and why that experience could be rewarding.

This chapter is based on six months of ethnographic and autoethnographic observation in a yoga group for women in the city of Concepción, Chile. I held casual interviews with women who practiced yoga and had different trajectories and experiences with it, and I also analyzed the in-depth interviews I carried out in the first part of my fieldwork, in which some women accounted for their experiences of doing yoga and the meanings they attributed to it in relation to their process of aging. In addition, I also analyze several studies in the field of the anthropology of body and yoga, considering their findings with my own reflections on the subject. In this chapter I attempt to triangulate those three

sources of information—interviews, autoethnography, and scholarly research—in order to explain why aging women turn to yoga as source of wellbeing in the process of getting older.

Yoga was developed by the Indus-Sarasvati civilization in Northern India over 5,000 years ago, but only started to expand to the Western world in the late 1800s and early 1900s, when yoga masters began to travel to the West, attracting attention and followers (Strauss, 2005). According to Strauss (2005), "over the past century the practice of yoga has transformed from a regional, male-oriented religious activity to a globalized and largely secular phenomenon" (p. xix). In December of 2014, the United Nations declared 21 June as International Yoga Day (resolution 69/131), in order to raise awareness worldwide of the positive effects for wellbeing that derive from practicing yoga. This resolution was proposed by India and endorsed by 175 member states. India's prime minister Narendra Modi ,in his address at the opening of the 69th session of the United Nations General Assembly, stated:

> Yoga is an invaluable gift from our ancient tradition. Yoga embodies unity of mind and body, thought and action ... a holistic approach [that] is valuable to our health and our well-being. Yoga is not just about exercise; it is a way to discover the sense of oneness with yourself, the world and the nature. (United Nations, 2016)

In Chile, according to a study carried out by Lizama (2015), there were 137 yoga centers in Santiago alone, the first founded in 1965. Based on the number of lessons and estimated attendants, Lizama (2015) calculated that approximately 16,300 people in Santiago practiced yoga, or 0.2% of the population of that region. She also found that 85% of yoga practitioners were women and 15% men, that most belonged to the upper and middle class, and that most of the instructors were male. I identified 16 yoga centers in the city of Concepción, which led me to estimate that at least 700 to 1,000 people were practicing yoga in Concepción on regular basis (0.5% of the total population of the city) at these formal institutions (there could be more people practicing yoga in informal settings). Several centers in Concepción also offered yoga instructor training (in several branches of yoga) and there is also an EcoYoga Park where people with different kinds of new age interests meet. Also, at least 16 yoga festivals have been held in a public park in the city of Concepción. As in many places in the world, Concepción has fallen into the global yoga trend.

As I mentioned before, what drove my attention to yoga at the beginning of this research project was the fact that several women expressed positive feelings when they talked about the effects that yoga had on their lives, especially when they had to face challenging moments. Elsy, one of the women I interviewed in 2012, during the first part of my fieldwork (2012) lived in Concepción and had been practicing Kundalini yoga for more than 10 years. In fact, she was one of the first interviewees to tell me about the positive effects of yoga and how it helped her undergo the difficulties of getting older. Elsy was a housewife, married to a successful engineer who worked for mining companies and therefore traveled a lot, and mother to two daughters.

One of them was married and lived also in Concepción, the other was deeply religious and became a nun, and was often away on mission trips for long periods of time. When I met Elsy, she had just overcome a challenging breast cancer treatment, and she talked about her illness and how yoga helped her through the process.

> When I found out that I had cancer, everything felt apart. I started to think in my whole life, I saw the whole movie. My daughters, the time we lived in the south, everything. And I became aware of the lot of suffering that I did not ever express. So, I realized that this thing is just a result of something that you have not dealt with in the right way. Yoga helps a lot, a lot, you realize what is really upsetting you, because one lies to oneself a lot, you try to be understanding, to understand everybody except yourself. (Elsy, 57 years old)

Elsy also explained that yoga helped her to understand things, to reconsider her relationship with one of her daughters, making her also realize that she was herself creating her own pain.

> You know I used to have so much resentment against my daughter, because she just left, she decided to go far away, she never thought of us, she never thought about her sister, the way she has to cope alone with everything. But with yoga I started to realize that everyone has their own destiny, that Marcela did not mean to make us feel bad. It was her decision. She was following a call. I created that pain for myself, because I did not accept that in the first place. Now I see how things are. I miss her a lot. It is a pain you learn to live with, it does not go away, but I know she is happy at least.

In the interview Elsy explained how comforting yoga was during her illness and treatment, and when she could not practice yoga (because she felt too weak) it was difficult for her. Also, she referred to the importance of belonging to a group of women that has been practicing yoga together for several years with the same yoga instructor. They had become a group of good friends, going together to spiritual retreats twice per year, organizing dinners, visiting each other, and taking care of those who are sick. They also went together to special events in Santiago, whenever an outstanding yoga master came to Chile or there was a relevant national or international yoga or meditation gathering. Some of them have travelled together to India, but because of her health issues Elsy had not joined those trips yet.

Elsy did not seem that concern about becoming older. She said she was happy with her life, and her only worry was to stay healthy, so she can see her grandchildren growing up. She intended to take care of herself and practicing yoga on regular basis was part of her self-care.

The women I encountered during fieldwork did not only practice yoga as a spiritual quest. Some of them said that they started because they thought it was a good way of working out.

Fabi, who was 45 years old, told me that she started to practice Ashtanga yoga because she knew that it could help her with losing weight:

> I guess I started practicing yoga because a friend of mine lost a lot of weight thanks to yoga, and I thought maybe I should try it also. But that was 3 years ago. A lot of things happened, I feel good now, I take care of myself a lot. Because your body asks for the food it needs, now I eat properly, a lot fruits and healthy food, I just eat meat twice per week, I drink a lot of water, things like that.

She explained that for most of her life she had been concerned about becoming thinner. She talked about the pressure women felt and how sometimes it was difficult to realize that all women are suffering about their weight:

> For a long time, I think I hated myself. I wanted to be thinner. I remember the first time I wore a bikini and my sister told me, "You look awful, look how fat you are!" Since then, I realized that I was fat, I have done so many diets, I cannot tell you. The lemon diet, the watermelon diet, no bread, no fatty meat, I don't know. I did so many stupid things because I wanted to lose weight.

She also talked about the pressure women felt especially when single or divorced, like herself. She had divorced when her only son was three years old and since then had had some short relationships. She explained that yoga had helped her to reconnect with herself, making a distinction between taking care of oneself out of hate (because you don't like yourself and you want to be someone else) and taking care of oneself out of love. She said that even though she hated herself when she started yoga, after a couple of years she feels better and happier:

> It helps you to connect with your body, you listen to it and it doesn't lie to you, so you can identify emotions that have been kept in your body. Sometimes when doing an asana I felt like crying, I mean a lot, and then those emotions start to unblock. Anyways for me yoga helps you live well [*buen vivir*]. It is not only about being physically fit, because if you want that you better go to the gym.

It is interesting that Fabi emphasized that yoga activates inner changes, which are not necessarily visible. One may see many people practicing yoga because it is "in fashion," but nobody knows what is going on with those people, how yoga is affecting them. Therefore, the same external and observable actions can have different meanings and consequences at a subjective level.

Fabi was a successful businesswoman, who, after many years in the property market, started her own business. She bought and sold properties, and she made considerable profits. She said she had "a good eye" for business. She was financially independent and self-sufficient, and enjoyed travelling around the world for vacations. A couple of years ago she and her son went to India with her yoga group. At the time we met, her son was about to start college; Fabi stated that she was experiencing more freedom as her son was becoming more independent. She worried about not having a fulfilling relationship, and said that she always chooses "the wrong one." Fabi is one of the interviewees who had tried several alternative therapies. Apart from practicing yoga on regular basis, she had psychotherapy (together with her son to improve their relationship), followed a treatment with Bach flower essences, and also tried acupuncture. She explained that all these treatments were part of her search for wellbeing, and helped to escape the pressure she felt in her everyday life specially stress from work.

It is difficult to grasp the sense of wellbeing that women who practice yoga describe. Looking again at the interviews and what women whom I have observed said about this experience, I suggest that all shared the idea that yoga helps. They saw the practice as a way of taking care of themselves, as a therapy that helped to overcome physical, mental, and spiritual troubles. What I found interesting is that the yoga-practicing women I met did not seem as concerned as others about their physical appearance and looking younger.

The Experience of Doing Yoga

Here I describe my auto-ethnographical experience of doing yoga, and by producing a description of my own feelings, I attempt to approach to pre-objective experiences of doing yoga. The overall goal of such exercise was to find out why yoga seems to provide a sense of wellbeing to aging women. As mentioned in chapter one, I reflected on the difficulties and limitations of participant observation when it comes to writing an ethnographic narrative that accounts for the way body-mind-emotions are intertwined in the practice of yoga. I suggest that autoethnography is a way to describe the integration of the self in the practice of yoga, which requires a commitment and reflexivity around the dilemmas of being at the same time partaker and observer of such practice.

The concept of experience has been to some extent taken for granted within the realm of social sciences. It has been assumed, particularly by anthropologists, that experience constitutes a sort of recalling made by someone over an event that has happened in the past. Scott (1991) has analyzed the problems that experience represents for the field of historical research, where experience has been taken as historical evidence. Scotts points out the need for studying the created nature of experience, which relates to the way subjects are shaped as different insofar as their perceived experience is structured variably according to their language and history.

Scott (1991) asserts that experience taken as clear-cut evidence reproduces rather than challenges given ideological systems, especially when researchers attempt to make experiences "visible" without analyzing the notions implicated in the invisibility of some experiences in the first place. She stresses the need to pay attention to the historical processes that, through the elaboration of discourse, position subjects in certain places and fabricate their experiences. When studying subjects' experiences there should be no assumption that individuals have experiences but on the contrary that subjects are constructed through experience. In this formulation, the experience is not the origin of the explanation or the authoritative evidence that supports a finding, but rather it is what must be explained. Experience needs to be historicized with the identities it produces.

However, the definition of experience that relied on cognitive and linguistic analysis has been criticized by phenomenological anthropologists, who point out the limitations of signs to account for what have been called "pre-reflective experiences." A key concept that has informed the understanding of enculturation in anthropology is the concept of "natural attitude," coined by Husserl (1948). Natural attitude means the attitude in which the world is given to our senses and taken for granted (Husserl, 1948). Throop (2005) explains that the mental operations that support the formation of natural attitude, which include operations of interpretation and judgment, are built on "pre-predicative" experience, which is based on a synthesis of constituted precepts resulting of acts of consciousness patterned by past experiences.

Therefore, the distinction between language-influenced experience and pre-linguistic experiences seems to be critical in the understanding of this concept. Throop (2005), drawing on Csordas's definition (1990), states that there are at least two basic modes of experience that must be cautiously demarcated: "pre-objective" and "objective." Traditionally anthropologists have been more inclined to focus on investigating those

experiences encoded in cultural scripts and taken-for-granted conceptual frames that are easier to access through their informants' discourse and reports (Throop, 2005). However, there are experiences that escape the reach of cultural categorization and organized patterning.

Even within the realm of linguistics it seems to be acknowledged that in everyday life people confront experiences and mental processes that are not mediated by language whatsoever. The concept of "thinking for speaking," coined by linguist Slobin (1987), draws a useful distinction between those experiences that are not to be described and do not required utterance:

> the activity of thinking takes on a particular quality when it is employed in the activity of speaking. In the evanescent time frame of constructing utterances in discourse, one fits one's thoughts into available linguistic forms. A particular utterance is never a direct reflection of "objective" or perceived reality or of an inevitable and universal mental representation of a situation. (cited in Slobin, 2003, p. 157)

Slobin's understanding of the relationship between language and thought is described as a relativization of the Sapir-Whorf thesis. Slobin ascribes to Boas's suggestion that there is a complete concept existing in the mind, in the form of mental imagery. The grammatical categories of a particular language force the speakers to determine which aspects of the mental image are realized in the form of grammatical language (Slobin, 1996). Therefore, language influences the way a particular experience is described but it does not affect the actual perception of it. Slobin (1996) adds:

> Boas was probably wrong, though, in supposing that all speakers within and between languages have a common "complete concept," he was right however in suggesting that any utterance is a selective schematization of a concept—a schematization that is, in some way, dependent on the grammaticized meanings of the speaker's particular language, recruited for purposes of verbal expression. (p. 76)

For the purpose of my research framework, what seems relevant in Slobin's thesis is the possibility of leaving aside experiences that are not culturally encoded as relevant and therefore are not spoken of. Such an assumption poses a great challenge for anthropological research, in terms of how to access those experiences that are not schematized into language. Quoting Alfred Shultz's work, Throop points out that there are "ineffable experiences that can only be lived but never thought and are in principle incapable of verbalization" (Shultz, 1932, p. 53, cited in Throop, 2005, p. 503). Throop (2005) argues that despite the fact that there are a number of differences among the various definitions of pre-objective experience given by authors such as Dilthey, Husserl, and Merleau-Ponty, they share the belief that "there is an important distinction to be made between experiences which are articulated according to various explicit conceptual modes of categorization and those experiences that have not been so conceptually parsed" (p. 503). He identifies three distinctive varieties of pre-objective experience: perceptions where the mind is initially confronted with the unmediated flux before cultural categorization, experiences that seem to lack objectification even when individual focuses reflectively upon them, and experiences that constitute the basis of the "natural attitude" that is the individual's everyday experiences of the world that are taken for granted. Throop (2005) argues that Levy's (1973) ethnographical work in Tahiti was pioneering in exploring these three varieties of pre-objective experiences through the Tahitian's classificatory schemes for

feeling states (particularly "the sense of uncanny," "feruri," and "hypocognized emotions"). These bring to anthropology a sensitivity to the complex relationships existing among culture, cognition, meaning, and pre- objective experiences. Throop (2005) emphasizes that a microanalytic approach aimed at a detailed descriptive phenomenology of the life-worlds of informants may provide access to people's pre-objective experiences. I argue that in the study of aging and body experiences, autoethnography may constitute a key methodological strategy to access such pre-objective experiences.

With all these theoretical and methodological concerns, I got involved in the yoga lessons.

This brings me to another point that I feel needs to be mentioned: the question of being "one of them." Doing anthropology in a colonized society such as Chile, it is not easy to follow the methodological rules of ethnography. As Ellis and Bochner (2000) write, "as bicultural insiders/outsiders, native ethnographers construct their own cultural stories … raise serious questions about the interpretations of others who write about them and use their dual positionality to problematize the distinction between observed and observer, insider and outsider" (p. 742). Viveiros de Castro (2013) sheds light on the fact that anthropologists stand in a knowledge effect produced by anthropological discourse, which results from the relation between the meaning of this discourse and the natives' meaning. He adds:

> even when the native and the anthropologist share the same culture the relationship of meaning between their respective discourses serves to differentiate them. … What makes the native a native is the presumption, on the part of the anthropologist, that the native's relationship with his culture is natural, which is to say, intrinsic, spontaneous, and if possible, non-reflexive, or, even better, unconscious. (Viveiros de Castro, 2013, pp. 474-475)

The author proposes to overcome this by denying strategic advantage to the anthropologist's discourse. This denial could be implemented by admitting that we could be all anthropologists; in other words, the native may be also an anthropologist in her own terms.

Viveiros de Castro (2013) suggests "an equivalence de jure between the anthropologist's and the native's discourses taking them as mutually constitutive of each other, since they emerge as such when they enter into a knowledge relation with one another" (p. 486). His position on the "relativity" of the anthropologist's and the native's position is that any boundary between them can be erased or at least disturbed in order to explore the anthropologist's own cultural setting.

The school of Purna yoga where I did participant observation was located in a middle- class neighborhood (where I had been living for two years), and which can be properly classified in Chilean terms as an "aspirational neighborhood." The aspirational neighborhood purports to offer comfort and wellness, and because it exists within a context of profound inequalities it has been separated physically and symbolically from the poor, who are perceived as a threat to it.

The inhabitants of this neighborhood are mostly professionals or well-paid technicians who work the long hours that Chilean have to work, most of them returning home between 7:00 and 8:30 pm.

Most of women attending the yoga classes I observed worked every day, and yoga class had become a way of taking care of themselves in a sustainable manner. The classes were conducted every working day except for Thursday. There were two sessions: one from 7:00 to 8:10 pm, and the second one from 8:30 to 9:40 pm. The participants could choose the day and schedule more appropriate for them, as well as how many times per week they wished to attend. As I have observed, most of the participants were women; I saw only one man in attendance, who came with his wife to the class. Women usually got to the class just in time, rushing after work and passing by home to coordinate a few things (how are they kids doing? did they do their homework? Is everything ok?). Because of this pattern, the instructor allowed the participants to make last phone calls and send messages before starting the class, so the students would be calmed and ensured that everything was fine at home.

Because the instructor used the first floor of her own house as a yoga classroom, the classes were held with small groups of three to five people. The place was turned into a sort of little temple. Several mandalas made of wool by the instructor herself were hanging on the walls, and a very small shelf for the materials (mats, blankets, and cushions) was placed in a corner. On this shelf there was computer with speakers that the instructor used for playing music. The music seemed carefully selected, because it matched what one should be feeling with the different postures and exercises, for instance, a song that conveys strength for the hard part of the lesson or calm when relaxation is needed. The instructor also used incense and aromatherapy to create a particular atmosphere, and was very strict about not entering the room with shoes on, turning cellphones off, and making sure we would not be interrupted during the lesson.

For six months I took several classes, and was able to meet most of the participants. Before starting the class there were a few minutes for free conversation. The students continuously complained about how much they have to work and that they do not have time to work out and take care of themselves, and they complained about their physical pain (mostly back pain) and tiredness. Each yoga class lasted around 70 minutes. It had a clear structure. We started with a relaxing routine that involves focusing on breathing and singing the mantra "om" three times. Afterwards, we performed either the "sun salutation" or the "moon salutation" several times. Then we sat on the mat and performed several breathing exercises that involve controlling breath and coordinating it with different body movements. Depending on the exercises, the neck, arms, belly, or legs would come into consciousness. Several exercises, including breathing and neck movements, were performed in every class. As someone who was not particularly fit for yoga, I would say that this was the easy part, not physically challenging. Even so, the first times I performed these exercises I felt a little dizzy, feeling that my body was not actually used to receiving so much oxygen. Sometimes I can even feel as the air I breathe reaches the back of my head.

We then would begin the "asanas," which I call "the difficult part." The asanas are yoga postures meant to unify body and mind. The instructor once explained to me that according to yoga master Patanjali, an "asana is a simple posture that must be kept until one gets into communion with the spiritual essence of life." Therefore, asanas encompass staying still, duration, and relaxing. Because most of these postures are difficult, it requires a great amount of concentration to keep them. Sometimes, when I am practicing yoga I think, "Ahh, this is an easy one, just flexing your legs a little bit, keeping your arms flexed in

front of your chess, no pain, does not seem challenging." But after several minutes in the same posture it becomes unbearable. During the first lessons I took, I entertained myself, thinking, "Ok, who is going to be the first one to give up the posture?" But as I became more committed to what I was doing I started to pay attention to my own feelings. What do I feel? Why is this so difficult? During the lesson, the yoga instructor urged us to keep focused on the present moment, where we are right now, what we feel in the moment. She repeated, "Look with no attachment at any thought that goes beyond the present situation and then let it go."

This command proved very difficult to practice. When doing yoga I would constantly think about many things beyond the present moment. Because I was also observing what was going on sometimes I found it really hard to let those thoughts go. However, I have discovered that when I really focus on what I am doing, if my arm is in the right position, if my back is straight as it is supposed to be, if I am breathing according to the pace—all of a sudden, it works. I get to disconnect my mind from the external world and just feel my body. It is hard to describe such a feeling. I would say that it is a sort of alignment, when you feel that your body and mind are attuned. I would describe it as exactly the opposite experience that you have when you are driving or walking and pass a traffic light. All of the sudden you remember or come to the realization that there was a traffic light, and you have passed it. Was it green or red? You did not notice, you did not think about it. Your body just acted because your mind was busy with something else. This alignment is the opposite experience: the feeling that your body and mind are deeply connected, that you are aware of everything that is going on in your body, insofar as there is some feeling or possible perception involved. In those moments I feel like the time stops going by, and probably what seems to be a long time is just a couple of seconds.

What I am describing is what happens to me in some of the more meditative exercises involved in yoga. However, because I do not intend to portray myself as an "illuminated soul," I must admit that most of time I worry about my performance (as it could be seen by an external eye). "Do I look too stiff? Does anybody notice that I can hardly do this movement? I remember when I was younger I could do this. How come at some point one stops being able to support their own weight?"

Smith (2004), who carried out ethnographic research on an Ashtanga yoga practice in Australia claims that:

> Western Ashtanga practice might be understood as the conflict between two forms of spirit manifested in the embodied selves of practitioners. The first of these is the spiritual experience of balance that the practice is explicitly intended to foster. The second is a spirit of capitalism, first identified by Max Weber (1958), which drives us towards individual achievement, success and self-regarding status. (Smith, 2004, p. 9)

According to Smith (2004), these two conflicting forces confront each other during the yoga practice and yoga practitioners and "their quotidian selfhood" find ways to either bare or resolve such conflict (p. 10).

In the case of the group I did participant observation with, I did not perceive much concern with individual achievement, at least not in terms of competition with the others. On the contrary, what I observed and I also felt myself was a sort of collective sense of failure or not being good enough to practice yoga. Perhaps this had to do with the fact

that we were all beginners and the type of yoga we were practicing was not Ashtanga yoga but Purna yoga, which gives less importance to physical performance. Therefore, comparison and search for personal achievements seem to have different meanings in the context I am describing. Smith (2004) states that:

> it is clear that even fairly committed practitioners find themselves drawn to compete or push their own practice in order to achieve poses and improve their performance. Conversations with many serious students indicate that they often watch others' practices during classes and measure their own practice through comparison. (p. 9)

I do believe that in the classes there seemed to be some sort of inter-watching and comparison, and even the instructor repeated that everyone should focus on their own performance. One of the rules published on the Facebook page of the yoga school says: while on the mat: keep your attention and concentration only on your mat. Do not help others, do not compare with others, do not distract your classmates, you are only allowed to interrupt the class if it is for making a joke; [ask] any kind of help and questions directly to me, be conscious about your own body.

6

However, I do not feel this class was as competitive and achievement oriented as it could be in other social groups. On the contrary, I feel that there was a sense of all being in the process of learning, and not completely fit for it. This was noticeable in the constant remarks that everyone made about back pain and other physical complaints. They also made jokes about how difficult some postures were. The instructor often remarked that one should not feel pain when practicing Purna yoga, and we were all encouraged to stop when feeling pain or to switch to easier versions of each pose.

Luckily after the asanas, there were more breathing exercises and then the relaxing part. That is something I really like. The lights were turned off and just a few candles provided light. We all lay down on the mats, covered with a blanket. The teacher adds some additional aromatic oils to scent the room. With our eyes closed, we listened to the voice of the instructor, who told us to relax and to focus on our bodies. She then mentioned, one by one, the parts of our bodies we should pay attention to (feel your feet, feel your legs, feel your belly, your chest, and so on). Very softly there was the sound of water falling, part of the music the instructor played during the yoga lesson. It was common that in this part of the lesson some people would fall asleep.

Sometimes, when the relaxing moment was over, the instructor would approach them and tenderly touch their legs to help them wake up. The instructor then struck a stick against a Tibetan bowl, producing a deep and long-lasting sound (similar to a bell or a small gong), that somehow, as a ritual artifact, gave an intense spiritual meaning to the moment.

After this part, we meditated. After asking us to sit and close our eyes, the instructor described what she called "visualizations," which are basically a set of instructions related to something we should imagine while breathing. For instance, we were asked to visualize that when we breathed in we were doing so through a channel that connected ourselves to the universe and when we breathed out the breath was deposited deep in the earth through a channel that connected us to it. Of course, to use the term "imagination" is not quite accurate, because visualization means that we are creating the image we are visualizing: somehow it becomes real and is actually happening because we are thinking

it. For that reason, concentration is very important, and it is also needed to feel that what one is doing is real. It is pointless to fake that one is doing this exercise and just playing along with the others, because in that case the visualization will not work, it will not bring any effect. I found it really hard to keep the visualizations, but sometimes I was able to return my focus to the moment. When that happened, I felt better afterwards. I felt connected to the world in way that is difficult to convey. I felt that I become more aware of the surroundings, of other living beings. I could perceive things that usually I do not notice, for instance, shades of color, if the flowers are fading, if a tree has more leaves than yesterday.

Finally, the lesson ended up with a moment of gratitude. We were asked to sing another mantra: "*Om shanti hari om*." The instructor once explained that the word "*shanti*" is repeated three times to bring peace to yourself, peace to others, and peace to the world. The instructor asked us to be thankful for that day's practice and to dedicate it to the world, so it will multiply. At this point, I usually felt very good, energized and happy. I sang the mantra loud and enthusiastically. When we were asked to dedicate the yoga practice to others, I usually saw in my mind people with whom I had some sort of problem, for instance an argument at work, or people I knew who are suffering, and I also thought about my loved ones. This was a very special moment for me because I felt very grateful and loving. I felt like everyday problems were not that important, that everything could be seen from a different perspective, and that the problem and the troubles were dissolved thanks to the power of the mind. Of course, such an optimistic feeling did not last long (I guess it is not sustainable in everyday life) but it helped. It made me feel better. Yoga changed something and had healing effects.

Usually the yoga lesson was carried out in complete silence. The students just listened to the instructor's guidelines and the music that was played. We did not speak unless the instructor asked something or gave a specific recommendation. For instance, she once said, "You, Dany, because you have pain in your arms do this exercise like this." We usually talked to each other before starting the practice, while waiting for delayed participants to arrive. Sometimes, some of us stayed longer after class talking about different topics. I enjoyed those moments that allowed me to do my "casual interviews."

There were also moments of discomfort and frustration. When I felt too tired and unable to focus on the practice I just went along, pretending that I was doing things seriously. Other participants seemed to have also these moments of discouragement and some of them expressed them openly. One day, one of the participants, Cecilia, said loudly, "I can't do this anymore, I am just a failure" (*estoy fallada*). A few weeks before that, she mentioned that her husband went to the gym every day and she had to wait until he was back home, so their children were not left alone. Because of that, she usually arrived right on time or sometimes a few minutes late. She said that also wanted to do some working out. She was 45 and working as an accountant for a gas company, but she said that wanted to quit her job, because she needed a break. Once she came in commenting that she had had to leave their kids alone for a few minutes because her husband was trapped in a traffic jam. I gave her a look intending to empathize with her feelings, and she said, "Well, it is not a big deal. The oldest is 13 so he can take care of his younger brother." But we all noted she was preoccupied. She kept looking at her cellphone and sending messages until the class started.

Another day, after the lesson, I asked if Cecilia if she liked doing yoga. She said, "Well, not that much. I was told by someone to try it out, because I have these horrible back pains. She said it will help. But I see I can't do most of the exercises, so I don't know what the point is of coming." I tried to comfort her, telling her that she was just starting, and it is common to feel frustrated at the beginning. One day she did not show up. I asked the instructor about her absence and she said that Cecilia had withdrawn, adding that she was not in the right moment for doing yoga.

One of the participants who was very open about the positive effects that yoga has given to her was Ana María (47). The first time I saw her I thought, "She must be a successful professional. She looks and behaves like she is the boss in her job." I was not wrong at all. She was a nurse in charge of a department in a private clinic. She defined herself as an "organizer": "I have to manage a lot of things, to arrange things at work, make sure everybody is doing what she has got to do. I do the same at home." In the yoga lessons she looked very focused, like she was always trying her best. She explained:

> You know what, for me it is difficult to practice yoga, especially all the meditation. I just can't stop thinking about all the things I have to handle. Sometimes I remember something that I forgot to do at work. But at the same time I get to clear my mind.

She did not seem worried about aging. In fact, that was something I found interesting about her. She did not look like most of women I had met from this social group: she did not get her hair dyed or ironed (something very common in Chile among the upper-middle class), she did not use make up, and she preferred to wear comfortable and unfashionable clothes. That look added to the image of confidence she projected. When I asked about how she took care of herself, she said that she tried to eat healthy food and that yoga helps a lot. She did not have menopausal complaints, only sometimes headaches that she did not link to climacteric. When I asked about what she thought about aging, she said:

> Well, I don't think much about that. I feel good now, you know. I feel that my children are growing, my husband is doing very well in his work, we are all happy. Of course, sometimes you feel fed up about everything, about work, about how ungrateful people are when you are just trying to help, with good intentions, but then I say to myself, "Forget about it, don't pay attention to it, you have so much to be happy about."

I find it hard to covey how positive feelings after doing yoga may influence self-perception regarding aging. I believe that practicing mindfulness is a powerful tool to reshape the perception of time, one that brings about a different way of experiencing time. It is not about feeling the anguish of time flying by but enjoying a deep moment and a sense of eternity. What I call "the yoga moments" help one to submerge in timeless space in which the everyday worries of an aging woman seem to fade away.

Another aspect that I feel it is relevant has to do with the body perceptions that yoga brings about. To explain this idea, I rely again on my own experiences of practicing other workout activities, such as aerobics, running, and swimming. I used to practice such activities when I was younger, and I now believe that the main motivation of working out in those days was to stay thin (under Chileans' standards), healthy, and fit, in order to project a centered and successful image. In other words, in my previous experience of exercise, my body perception was mainly framed by the idea of building a socially

accepted (and rewarded) external image. In such a quest, suffering (for instance through a too-demanding routine of swimming or running) was seen as necessary to succeed in building a desirable body image. After being pregnant twice within a short period of time, I had the opportunity to experience overweight myself, and could experience on everyday basis how society punishes women for the "sin" of being fat. After such experiences, yoga was a sort of relieving space in which I felt that working out was not about shaping or reshaping my body image but connecting with myself, relaxing and moving in irregular ways. I feel that yoga has helped me to reach a different level of body consciousness, going beyond the level of social/external image, making me feel my own body not as something for others to see but as part of myself. I contend that it is also the case when accepting aging, as part of a body process that influences the subjective identity.

Atkinson (2010) characterizes yoga as one of the late-modern "post-sport" physical cultures, which are defined as:

> subaltern forms of existential truth, subjectivity, desire, authenticity and purpose through a variety of non-traditional, boundary-crossing physical cultural practices that might loosely be called 'post-sport athletics'. Stated differently, the looseness of cultural meaning contouring late modernity may indeed allow for a mass destabilization of many mainstream sport forms. (p. 1250)

This destabilization is featured by their de-institutionalization, diversification, moralization, and structuring around ideologies of egalitarianism. Therefore, a post-sport physical culture exalts spiritual, physical, and emotional expressions of alternative sports that do not engage in performance competitions (Atkinson, 2010). Atkinson (2010) further contends that Ashtanga yoga can be defined as "heterotopia," a term elaborated by Foucault, that describes:

> a space that is potentially outside traditionally normative, or hegemonic, institutional zones of power and order. In this sense, heterotopia is a zone which has the power to suspend prefigured cultural identities, maps of meanings, relations of power and technical uses. (p. 1252)

Therefore, Ashtanga yoga brings about the suspension of social categories that define the individual and her subjective identity (Atkinson, 2010).

A different interpretation of yoga as social practice is developed in the cosmopolitan multi-local ethnography carried out by Strauss (2005) in India and several Western countries. She contends that yoga becomes an individual or personal strategy for adjusting oneself to the conditions of modernity, as yoga entails the idea of "unlimited progress" through the recognition of the complete freedom of the mind and the extraordinary potential of the healthy body (Strauss, 2005). In other words, the practice of yoga becomes functional to modernity insofar as it does not require "the practitioner to abandon life as a middle-class (or any other class) householder; rather, they provide a way to navigate modernity's dangerous waters without succumbing to the undertow of materialist excess" (Strauss, 2005, p. 31). Therefore, practicing yoga in modern Western societies does not aim at challenging modernity but correcting it, helping overwhelmed individuals to fit in.

Strauss (2005) also argues that yoga practice is part of the wellness trend, which represents a shift in the perception of what it means to be healthy, now understood as the ability to simultaneously achieve a state of wellbeing and fitness. Drawing on her

ethnographic work, Strauss also remarks that yoga helps people to manage their stress in a way that ensures they will be able to carry on with their work and social obligations. The Western yoga practitioners that Strauss met in the Rishikesh yoga center in India were looking for a temporary break from their everyday busy lives:

> They hoped to be able to develop a discipline that they could take home with them, a strategy that would help them get through their stressful work weeks in a less frenetic way. The practice of yoga was a way to create a separate space, both temporally and emotionally, but not geographically. (Strauss, 2005, p. 68)

Lizama (2015), in her doctoral research on the yoga practice in Santiago, concludes that the yoga practitioner enacts new ways of social expression and possibly new ways of social mobilization. She describes those who practice yoga as counterhegemonic subjects, because they challenge some of the capitalistic assumptions, particularly consumerism. She describes the yoga phenomenon in Chile as an attempt—inspired by a socially rooted tiredness, trouble, and hopelessness—to find a way toward human emancipation. Coming from a sociological perspective, Lizama's (2015) research looks for the "yogi social subject." In this depiction yoga is seen as a refuge and way to individually fight back against everyday capitalist oppression. According to Lizama, yoga practitioners are trapped in a contradiction because they are looking for a non-capitalistic liberating path but at the same time they are joining the yoga trend, which makes yoga a profitable commodity. Late capitalism fights back by attempting to invade yoga with market-oriented dynamics.

6

It is interesting that Lizama (2015) also links the practice of yoga to gender issues. She points out the economic and social changes that have led to the "emancipation" of women (what she describes as the transformation from a patriarchal order into a patriarchal capitalist order) have brought about a great deal of discomfort to women. She says that "women must practice yoga to contain the suffering produced by the demands exerted upon them as workers, mothers and housekeepers" (Lizama, 2015, p. 277).

Strauss (2005) states that women seeking equal rights need to reform themselves and engage in bodily practices that give them power in other arenas of their lives. She describes yoga as a strategy of (self) "connection rather than domination" (Strauss, 2005, p. 78). In other words, women gain power through being able to control their own body.

Fajardo (2009), in his study of the practice of Hatha yoga in Colombia, concludes that yoga and meditation are liberating mechanisms for people, because sustained involvement in such spiritual rituals positions the body in poses, actions, and places in a culturally unusual way, creating new bodily habits. Through repetition, this practice brings about a deep change in self- perception. When repeated three or four times per week, it is no longer a meaningless bodily experience, but it becomes a "lifestyle" (Fajardo, 2009, p. 45). This change is experienced through "a continuous process of building the own body in several dimensions: material, emotional, mental, and spiritual, which in turn transforms a person's world view, relationship habits, and practices of consumption" (Fajardo, 2009, p. 45; my translation).

The performative dimension of yoga seems relevant in several ways. It seems that the development of unusual bodily practices and their repetitions can help women re-build their self- perceptions and the way they relate to their world, leading to an experience

of empowerment. I argue that, together with facilitating the process that Strauss defines as "reconnection," yoga helps women to experience a different perception of their own body.

The maximum yoga accomplishment is not a physical one but a state of alignment that is ageless. Also, the practice of yoga can be understood as counterhegemonic or resistance because it allows women to develop a different understanding of their wellbeing, which has nothing to do with appearance or beauty but with an inner state. The wellbeing then comes from a state of quietness, acceptance, and understanding of life circumstances, producing a state of joy located in the present moment. Somehow yoga practice breaks with the Western epistemology of a nonexistent present that is always looking forward to the future and regretting the past. The search for a spiritual wellbeing has to do with an inner state of joy and acceptance of the world as it is, just because it has a meaning. What I call "the yoga moments" give the practitioner the sense that all the problems one faces in everyday life are self-created and the effect of the mind, and that it is somehow possible to activate within oneself a different way of enjoying life.

In this experience, complaints related to aging, feeling sick, ugly, or fat just fade away, because they appear as mere creations of the mind and their meaning can be modified. That is why the women I interviewed emphasized as part of their inner wellbeing the acceptance of age and self-care. What I observed in the yoga practice was not that the body did not count—there was no rejection of the physical body as in the traditional Christian philosophy (Scheper-Hughes & Lock, 1987)—but that the body could be experienced in a different way. This new way of experiencing the body had an influence in how the self was perceived and the meanings that one gives to their own identity.

Women who practiced yoga also recounted several practices of self-care. The effects of yoga in overcoming health care complaints and improving quality of life have been well documented (Coelho et al., 2011; Lopez Gonzalez & Díaz Páez, 1998). Women I interviewed talked about significant changes in their diet, saying that they started to eat more properly thanks to yoga. They also mentioned avoiding unnecessary stress, and coming to terms with relatives and with those whom they are having problems. It is interesting to note the importance that Chilean women gave to having good relations with others as part of their concept of health. Whenever we talked about health they referred to their family issues and the need to reach harmony with their relatives. I did not find a similar preoccupation in the literature on yoga practitioners from modern Western countries (Strauss, 2005; Smith, 2007; Lea, 2009; Atkinson, 2010). On the contrary, those studies presented a concept of health that is deeply linked to individual achievement and self-development. I argue that Chilean women also seek self- development, but they too establish the need for being themselves, so they can "reunite" with their relatives in a more harmonic way. So, there is an important second stage in the search for health and wellbeing, which is the ability to reconnect with others in a way that brings happiness and reward.

Another point that I think needs further development is the question of spirituality. Atkinson (2010) asserts that, for North American yoga practitioners, the allure of Ashtanga yoga has to do with its Eastern philosophical roots, which makes it exotic, mystical, physically rigorous, and decisively alternative to mainstream Western sports. While this sense of spirituality as embedded in yoga seems to be exotic for Westerners, in the case of

Chilean women it seemed more familiar. Most of the women I interviewed talked about their religious beliefs; most came from a Catholic background and had faced a crisis in their faith. It seems that yoga, in the way it is mostly practiced in Chile, has a spiritual character, since it explicitly refers to a superior, non- human, no-material order that can be reached through its practice. Women also referred to other traditional beliefs that linked indigenous and popular beliefs, and seemed to be at ease with mixing beliefs and practices of health care. For instance, in the Facebook groups of several yoga groups that I joined, there were several posts on the International Day of Yoga (June 21) referring to the "Wetripantu" (Mapuche New Year celebration), which is celebrated with the winter solstice, the International Day of Yoga and also popular sorcery traditions referring to the Feast of Saint John (June 24). I contend that, in the case of Chile, as occurs in other Latin American countries, indigenous and mestizo cultures together with popular Catholicism provide a substrate in which New Age beliefs and practices mix in particular ways. Therefore, in Latin America, New Age as a global movement is not concerned with a "search for the exotic" but with adding new elements to already existing syncretic practices.

One of the questions I intend to address in this chapter is why these women turned to yoga in their search for wellbeing. Of course, it is a difficult one to answer. When I posed this question to my interviewees, they simply said that they liked it. They usually tried yoga because they heard from someone who had positive results from it. I can only account for the results they reported regarding their practice of yoga and what I have myself experienced. They referred to a sense of accepting their aging process, learning to take of themselves in different ways than before, and feeling that their spiritual needs were being fulfilled. They elaborated a definition of aging as a natural process, something that must be accepted, but at the same time they acknowledged a need for care and preparation. They talked about "knowing how to get older," which implied at least three components: acceptance, self-care, and inner wellbeing, which did not necessarily correspond to externally measurable aspects. Sandberg (2013) coined the concept of "affirmative old age" to describe holding positive feelings regarding one's aging. Affirmative old age" in contrast to successful ageing, does not aspire to agelessness or attempt to reject and fight old age, but instead seeks a conceptualization and acceptance of old age in all its diversity, from active to sedentary, from sexually vibrant to sexually indifferent. Affirmative old age is as such ultimately a political force and empowering strategy (Sandberg, 2013, p. 35).

Sandberg (2013) relates this idea of affirmative old age to sexual practices of old Swedish men and women who recalled sexual encounters when they did not feel worried about their body appearance but submerged themselves in a deep experience of pleasure. I argue that the concept of affirmative old age describes the positive meanings that yoga has for aging women as a concrete bodily experience. Affirmative old age is a "non-teleological concept which focuses less on the outcomes in terms of health, well-being and avoidance of aging and more on the unbounded production of desire" (Sandberg, 2013, p. 32). This concept helps us move away from the predominant Western thinking on time and aging to look into body experiences and subjective perceptions that can help people escape values that undermine old age.

Certainly I am aware of the risk of romanticizing the practice of yoga as well as the risk of neglecting other cases and experiences of women who may have not experienced such positive outcomes. Additionally, because yoga only exists in practice, it has effects that only exist when it is performed. That is something interesting about yoga, because it

forces us to rethink the relationship between practices and perceptions or, in other words, the relationship between body and mind.

CONCLUSION

The purpose of this research was threefold: first, to understand the way menopause and aging have been constructed in Chile in different social groups. Secondly, it explored how women gave meaning to their experience of menopause and aging, and, finally, analyzed how those meanings related to ideas held by other actors, such as the biomedical system, alternative treatments, the media, and public policy. Therefore, in terms of its methodology, this research was a multi-sited ethnography, and thus did not focus on one specific community or social setting but focused on the role played by different actors in the cultural construction of female aging in Chile. I did not follow a straight line, but approached the issue of female aging from different angles including my own experiences and perceptions in the process of getting older.

Doing this medical anthropology research in Chile involved the exploration of two different worlds: the private health care system, with its many resources, and second the highly underfunded and overburdened public health care system that most Chileans use to find relief for their health complaints. The issue of social inequalities in health care proved relevant throughout the process of fieldwork and data analysis.

In the last 40 years Chilean society has faced major social and cultural changes. The fact that after Pinochet's military coup in 1973 the country became a laboratory for neoliberal policies explains why Chile currently faces many challenges in terms of aging, gender, and health care. Menopause and aging have become highly medicalized issues in Chile. The biomedical discourse dominates what is said in other social spheres, such as the media and governmental public policy. Public policies for aging women have focused on preventing a limited number of diseases, such as obesity, hypertension, and climacteric complaints, and most of these efforts are undertaken in the domain of public health care services. No comprehensive definition of "quality of life" has been offered, and the involvement of public services has been so far very restricted. In contrast, upper-middle-class and middle-class women have access to climacteric specialists in private services and HRT, while working-class women must deal with their "natural complaints" only with resignation. Even though there are initiatives aimed at ensuring access to proper health care for menopausal women, little has been accomplished and, judging from the current public debates, it does not seem a political priority.

When exploring policies on aging it becomes evident that efforts have focused on the social issues of elderly living in poverty. The National Service for the Elderly (SENAMA) is a disjointed program that focuses its action on short-term initiatives such as workshops and leisure activities for elderly and takes limited action to ensure minimal care for those who do not have someone to count on. There is no specific program for middle-aged women beyond primary health care and thus no comprehensive response to the issues that women face. In the realm of policy, it is worrisome that middle-aged women are expected to care for their older parents and have little security regarding their future retirement. They also face gender-based structural discrimination in both the private and public health care subsystems. Unfortunately, there is no political subject able to represent middle-aged women's needs in the public debate, since the feminist movement has been mainly focused on the sexual and reproductive rights of younger women. In addition, because of the limited research conducted, there is not much information about

women's feelings, experiences, and expectations, and much of what is being said does not represent their voices.

The guidelines for the treatment of menopausal women elaborated by the Ministry of Health reflect a very medicalized view that is centered on the diagnosis of complaints and the offering of medical treatment. The limited way that the guidelines have been implemented in the public health care system reflects the fact that it has not been able to ensure access to medical specialists to prescribe HRT. The ambiguous position of the medical associations regarding their own role and involvement in the public health care system, and their rejection of the possibility of the midwives prescribing HRT in primary health care, have not helped to overcome the issue.

Regarding the view of the medical specialists on menopause and aging, I found that they still hold a highly medicalized understanding of menopause, where all the troubles of middle- aged women are explained in relation to a decline in hormonal production. In scholarly publications, in 40 articles published between 2002 and 2017, the most addressed topics are: the effectiveness, side effects, and risks of HRT; the relationship between Climacteric and health issues such as hypertension, depression, thyroid, and skin; menopausal women's quality of life; and the relationship between menopause and cardiovascular health issues. Among the papers devoted to HRT, some explicitly address the issue of sexuality and the positive outcomes of such therapies in enhancing women's sexual satisfaction.

In our interviews, physicians defined aging as a process of a generalized decline in the female body. They described several disorders, mostly related to psychological and sexual issues. They also mentioned the long-term negative effects of menopause, such as cardiovascular problems and osteoporosis, which can be prevented through timely prescription of HRT. Therefore, HRT appear as the ultimate solution for menopausal issues. The effects of getting old are believed to start with menopause and are something that must be fought against, which is perceived as necessary for attaining an acceptable quality of life. Even though they pay attention to the fact that HRT is seen as "dangerous" and associated with cancer (an effect of the WHI report in 2002), they remained strong advocates of HRT.

My analysis of their scientific publications shows these specialists are well connected to the international scientific community. However, the influence of the transnational forces in the market of HRT does not completely shape Chile's healthscape. The medical specialists reported that their patients show a high level of resistance towards HRT. This is consistent with the fears and doubts regarding HRT that women expressed in the interviews. The structure of the health care system, the persistence of fears and mistrust concerning the use of HRT, and the cultural values regarding suffering and resignation all seemed to play an important role in such resistance. To the medical specialists' disappointment, generally speaking, women were not very willing to embrace HRT as the ultimate solution to their menopausal or middle-age complaints. In that sense, the way the biomedical system deals with menopause and aging can be described as a particular mix of medicalizing and biomedicalizing views. On the one hand, medical specialists' efforts to make women more inclined to engage in HRT can be seen as a regulatory attempt, part of their medical responsibility to provide their patients with the best treatment available. On the other hand, upper-middle-class women also looked to

HRT as an enhancement technology.

In order to understand the medicalization-biomedicalization continuum in Chile it is necessary to pay attention to how the medical system was historically organized. It has evolved from a national unified system (in which the medical practitioners held a great amount of power in decision-making) to a fragmentary and highly privatized system in which women who can afford private medical services gain power in decision-making as consumers or clients. Medical specialists still shape views on menopause and aging in the public health care system, but their involvement is limited since they are more involved in the lucrative private system. The lack of resources and economic incentives for menopause specialists in the public health care system has resulted in their absence in the provision of services for working-class aging women.

The dominant biomedical view on menopause and aging strongly influences and dominates other social fields such as the media and governmental policies. In media representations of women's aging, there are at least three discourses. The prevailing one presents a negative view of female aging, suggesting that becoming old is a tragedy for women because it implies devaluation and loneliness. This view is consistent with a patriarchal gender order in which women are expected to please men as sexual objects and reproduce. Because these two "tasks" are perceived as fundamental for women, they face an identity crisis when changes indicate that they are no longer useful for these purposes. As the character of Monserrat in the soap opera dramatically shows, some women's subjectivity is defined by these gender norms to an extent that their life after menopause may become unbearable. Turning to plastic surgery and beauty technologies becomes a strategy to maintain a youthful looks. This representation seems to resonate with middle- and upper-class women; there was no particular portrayal of working- class women's issues regarding aging. Based on what the media presents, it seems that aging troubles affect women who have the resources to pay for some market solutions and who exercise their agency in this matter.

A second discourse regarding female aging is found in the work of psychologist Pilar Sordo. Her book *No Quiero Envejecer* seems attuned with the discourse on successful aging. As Sordo explains it, successful aging is an "investment" that must be made when young, which implies a set of preventive steps in order to ensure a peaceful and satisfactory old age. This discourse accords with the notion of the individual modern subject who is expected to solve on her own the social issues of aging. In that sense, Sordo's stance on aging reflects the overcoming of traditional ideas on aging in Chile, in which family ties were believed to be strong enough to ensure love and proper care for the elderly. The idea of successful aging developed by Sordo assumes the end of the traditional model and asks individuals to face and solve by themselves the issues of wellbeing and care. It is particularly relevant to note her idea of "investing in affection," which Sordo defines as a key for successful aging; in this analysis love (and elder care) must be earned by creating and maintaining a proper relationship with one's children and other relatives. In this way, one can expect "favorable returns" in the future. It is also noteworthy the patriarchal view that underlies Sordo's advice. Even though she advocates for breaking gender-patterned behavior, such as women being too complaining and men being less affectionate, the very way she portrays those patterns seems to reinforce them as natural.

The third discourse comes from new representations that account for changes in

Chilean society. The film *Gloria* conveys an emerging discourse that breaks traditional patterns regarding the expected behavior of aging women. It conveys a new model that involves freedom for aging women, who no longer must depend on her relationship to a man nor on her servitude to her children and grandchildren but can find an inner state of wellbeing by herself. The way Gloria deals with her life suggests there is an "inner wellbeing" to be reached by enjoying oneself with no expectations regarding what others do. Even though I found all three of these discourses in the press review, the first dominated the way menopause and female aging was spoken about.

Regarding women's perceptions of menopause and aging, I found out that both upper- middle-class and working-class women tended to reproduce in their bodily experiences the traditional norms attributed to women, particularly when it comes to sexuality. Even though they claimed a right to have sexual pleasure, they framed this claim as part of the requirements for having a harmonious marital relationship. They also expressed a wish to improve their sexual life and saw getting old as something that undermines it. For both upper-middle-class and working- class women, what seemed to be at stake was the impossibility of breaking the gender rules that obliged them to postpone their own personal needs for the sake of what is defined as "family harmony." In both social groups, women worried about aging and feeling a physical decline, but they had different strategies to deal with those feelings. While upper-middle-class women resorted to biomedical technology to fight aging, working-class women tended to accept aging as something inevitable and found ways to be grateful for what they had in their lives. Religious values and traditional ideas about motherhood and grandmotherhood were an important source of satisfaction for working-class women. Social class shaped and constrained the options women had for dealing with their aging process.

Upper-middle-class women were also very much constrained by the traditional gender prescriptions that relate a woman's value to her physical attractiveness and beauty; in that sense, they did not appear more emancipated than working-class women. On the contrary, they seemed "trapped" in the struggle against aging and they were very concerned that their marriage might break apart (namely their husbands might leave and start a new relationship with a younger woman). Still, women gained some control over their bodies with the use of biomedical technology and felt their quality of life was improved because of it. Particularly, HRT were seen as an "ally" in the search for wellbeing. I found a more liberating discourse among women who practiced alternative health care therapies, such as yoga and other spiritual-oriented practices.

They seemed to have found new meanings for the process of aging and felt happier and more satisfied with their experience and wisdom.

Thus, when studying the meanings that aging women who practice yoga give to their experience of aging, more positive perceptions are found. They refer to a sense of accepting their aging process and growing spiritually. They elaborate a definition of aging as a natural process, something that must be embraced but also requires selfcare and preparations. They identify three key components of knowing how to get older: acceptance, self-care and inner wellbeing.

Yoga is a body technology that offers a sense of naturalness and reconnection to women. I contend that the women who turned to yoga were looking for counter-hegemonic ways to face their process of aging, since yoga is seen as a natural way to deal

with physical, psychological, and spiritual complaints, and it is an alternative to seeking relief from biomedicine or the beauty industry. I borrow the concept of "affirmative old age" to better describe the effect of yoga on aging women. As Sandberg (2013) suggests, this way of experiencing the process of aging is empowering and challenges the assumptions of what has been called "successful aging." However, among the sites I studied, yoga was also a socially shaped practice that required certain conditions of "social capital." It was not widely accessible to working-class women.

Further, the women who practiced yoga were still subject to the constraints of modern life and were not freed from the worries and obligations that other aging women face in Chile.

Chile is facing an important cultural, social, and demographic change for which it is unprepared, both at a structural level and at the level of social practices. Chilean society does not seem equipped for the idea of individual successful aging and lacks community organizations that could effectively promote comprehensive health care for the aging population. Because of the subsidiary state policies in health care, there is no comprehensive approach to elderly care.

As families start to see elderly care as a burden, there is no community response, and individuals are expected to solve their aging needs on their own. We can expect that the crisis of elders lacking care will increase in the next years.

Even though one should be critical of the health care policies that are based on moral views on what successful aging should be, there is a need for proper wellbeing policies for aging women. It is not about following the "dos and don'ts" of aging, but about providing women with the means to take care of the issues they feel are affecting them. As I have argued here, women face several issues that affect their wellbeing, in the realms of health, sexuality, family relations, and economic and work constraints.

Fully aware of the risks and shortcomings of the path I have taken, this piece of work nonetheless offers an understanding of the complexities of the contemporary world, in which anthropologists need to describe the interplay between social structure, subjectivity, and cultural meanings. I decided not to focus on one perspective, but to draw a general picture that shows the intersections of different dimensions, and, at the same time, provides a closer view on particular issues that women face. I also sought to balance my attention to two main purposes of anthropology. First, there is the need to account for social inequalities, particularly those affecting women, and to offer a view that can be useful to the quest for social justice. In that sense, I intend to make my research work as applied as possible, trying to translate (and sometimes simplify) key concepts to make them accessible to a non-academic audience. Second, I seek to contribute to the development of anthropology as discipline, in theoretical and methodological terms.

B

BIBLIOGRAPHY

Agee, E. (2000). Menopause and the transmission of women's knowledge: African American and white women's perspectives. Medical Anthropology Quarterly, 14(1), 73-95.

Amezcua, M., & A. Galvez Toro. (2002). Los modos de análisis en investigación cualitativa en salud: perspectiva crítica y reflexiones en voz alta. Revista Española de Salud Pública, 76(5), 423-436.

Anzaldua, G. (1987). Borderlands. La frontera. The new mestiza. San Francisco,. CA: Aunt Lute Books.

Apt, P., & Saavedra, P. (2009). Piel y climaterio. Revista Médica de la Clínica Las Condes, 20(1), 84-91.

Arena, J. (2005). Incorporación y cumplimiento de la terapia de reemplazo hormonal del climaterio femenino antes y después del estudio del WHI: revisión de la evidencia. Revista Chilena de Obstetricia y Ginecología, 70(3), 186-195.

Arena, J. (2006). Influencia del climaterio y la terapia hormonal de reemplazo sobre la sexualidad femenina. Revista Chilena de Obstetricia y Ginecología, 71(2), 141- 152

Argote, L., Mejía, M., Vásquez, M., & Villaquirán de González, M. (2008). Climaterio y menopausia en mujeres afrodescendientes: una aproximación al cuidado desde su cultura. Aquichán, 8(1), 33-49. Retrieved from http://www.scielo.org. o/scielo. php?script=sci_arttext&pid=S1657- 59972008000100004&lng=en&tlng=.

Ariztía, T. (2014). Housing markets performing class: middle-class cultures and market professionals in Chile. The Sociological Review, 62(1), 400–420.

Armas, R., & Goic, A. (2008). Informe sobre la situación actual de la educación médica en Chile. Santiago: Academia de Medicina del Instituto de Chile. Retrieved from: http://www.institutodechile.cl/medicina/publicaciones/Educacion_Medica.pdf

Arriagada M., Arteaga, E., Bianchi, M., Brantes, S., Montaño, R., Osorio, E., Pardo, M., Arteaga, E. (2016). Menopausia y riesgo cardiovascular. Revista Médica de Chile, 144(11), 1375-1376. https://doi.org/10.4067/S0034-98872016001100001

Atkinson, M. (2010). Entering scapeland: yoga, fell and post-sport physical cultures. Sport in Society: Cultures, Commerce, Media, Politics, 13(7-8), 1249-1267.

B

Austad, S. N. (1994). Menopause: an evolutionary perspective. Experimental Gerontology, 29 (3-4), 255-263.

Avello, M., & Cisternas, I. (2010). Fitoterapia, sus orígenes, características y situación en Chile. Revista Médica de Chile, 138(10), 1288-1293. https://doi.org/10.4067/S0034- 98872010001100014

Baber R.J., Panay, N., & Fenton, A. (2016). Recommendations on women's midlife health and menopause hormone therapy. Climacteric, 19(2):109-150.

Banks, E. (2002). From dogs' testicles to mares' urine: the origins and contemporary use of hormonal therapy for the menopause. Feminist Review, 72(1), 2-25.

Barozet, E., & Fierro, J. (2011). The middle class in Chile: the characteristics and evolution 1990-2011. Kas International Reports 12, 25-41. Retrieved from: https://www.kas.de/c/document_library/get_file?uuid=82938776-26e9-96de-740e- 75493a3b8cd3&groupId=252038

Bastias, G., Pantoja, T., Leisewitz, T., & Zarate, V. (2008). Health care reform in Chile. CMAJ, 179 (12) 1289-1292. https://doi.org/10.1503/cmaj.071843

Belli, G. (2014). El intenso calor de la luna. Barcelona: Seix Barral.

Beyene, Y. (1986). Cultural significance and physiological manifestations of menopause: a biocultural analysis. Culture, Medicine and Psychiatry, 10(1), 47-71.

Bianchi, M., Arteaga, E., & Villaseca, P. (2002). Baja incidencia de patología endometrial en mujeres postmenopausicas con sagrado anormal que reciben terapia de reemplazo hormonal. Revista Chilena de Obstetricia y Ginecología, 62(2), 136-138.

Bianchi, M. (2009). Menopausia y terapia de reemplazo hormonal: una visión desde la práctica clínica. Revista Médica de la Clínica Las Condes, 20(1), 8-14. Retrieved from: http://www.clc.cl/Dev_CLC/media/Imagenes/PDF%20revista%20m%C3%A9dica/2009/ 1%20enero/01MENOPAUSIA-1.pdf

Blanco, M. (2012). ¿Autobiografia o autoetnografia? Desacatos, 38(1), 169-178.

Blofield, M. (2001). The politics of moral sin: a study of abortion and divorce in Catholic Chile since 1990. Santiago: FLACSO-Chile Ediciones.

Blümel, J.E., Bravo, F., Recabarren, M., & Sarrá, S. (2003). Función sexual en mujeres usuarias de terapia de reemplazo hormonal. Revista Médica de Chile, 131(11), 1251-1255.

Blümel, J., Aravena, H., Brantes, S., Cruzat, L., Lavin, P., Montaño, R., Navarrete, I., & Osorio, E. (2010). Posición oficial de la Sociedad Chilena de Climaterio para el manejo clínico de la mujer climatérica. Revista Médica de Chile, 138(5), 645-651. https://doi.org/10.4067/S0034-98872010000500017

Blüme, J., & Arteaga, E. (2017). Los riesgos de no usar terapia hormonal de la menopausia: deterioro de la calidad de vida. Revista Médica de Chile, 145(6), 760-764. https://doi.org/10.4067/s0034-98872017000600760

Blüme l, J.E., Arteaga, E., Parra, J., Monsalve, C., Reyes, V., Vallejo, M.S., & Chea, R. (2018). Decision-making for the treatment of climacteric symptoms using the menopause rating scale. Maturitas, 111(1), 15-19. https://doi.org/10.1016/j.maturitas.2018.02.010

Bourdieu, P. (1984). Distinction: a social critique of the judgement of taste. Cambridge, MA: Harvard University Press.

Brown, R. H. (1993). Cultural representation and ideological domination. Social Forces, 71(3), 657-676. Retrieved from: http://www.jstor.org/stable/2579889

Brunner, R., Gass, M., Aragaki, A., Hays, J., Granek, I., Woods, N., Mason, E., Brzyski, R., Ockene, J., Assaf, A., LaCroix, A., Matthews, K., & Wallace, R. (2005). Effects of conjugated equine estrogen on health-related quality of life in postmenopausal women with hysterectomy. Results from the Women's Health Initiative Randomized clinical trial. Archives of Internal Medicine, 165(17), 1976-1986. Retrieved from: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/486713

Calasanti, T. (2007). Bodacious berry, potency wood and the aging monster: gender and age relations in anti-aging ads. Social Force 86(1), 335-355. Retrieved from: http://www.jstor.org/stable/4495039

Calvo, E., Bertranou, F., & Bertranou, E. (2010). Are old-age pension system reforms moving away from individual retirement accounts in Latin America? Journal of Social Policy, 39(2), 223-234. https://doi.org/10.1017/S0047279409990663

Camara de Diputados. (2017). Comisión de salud analizó deficiencias en implementación de terapia de reemplazo hormonal para las mujeres postmenopausicas. Published on September 12, 2017. Retrieved from: https://www. camara.cl/prensa/noticias_detalle.aspx?prmid=132646

Campos, C., & Saldaña, L. (2018). Relaciones de género y arreglos en parejas de profesionales: ejecución v/s responsabilización. Revista Estudos Feministas, 26(2), e42931.

B

Candea, M. (2007). Arbitrary locations: in defense of the bounded field site. Journal of the Royal Anthropological Institute, 13(1), 167-184. https://doi.org/10.1111/j.1467- 9655.2007.00419.x

Carrasco, A.M. (1998). Constitución de género y ciclo vital entre los Aymaras contemporáneos de Chile. Chungará, 30(1), 87-103. https://doi.org/10.4067/S0717-73561998000100007

Castro, J. (2015). Estados Unidos y la guerra por el desarrollo: el control de la natalidad en Chile 1960-1970. Revista Complutense de Historia de América, 41(1), 95-120. https://doi.org/10.5209/rev_RCHA.2015.v41.49898

Chedraui, P. (2008). Impaired quality of life among middle aged women: A multicentre Latin American study. Maturitas, 61(4), 323-329. https://doi.org/10.1016/j.maturitas.2008.09.026

Chlebowski, R. T., Hendrix, S., Langer, R., Stefanick, M., Gass, M., Lane, D., Rodabough, R., Gilligan, M., Cyr, M., Thomson, C., Khandekar, J., Petrovitch, H. & MacTiernan, A. (2003). Influence of estrogen plus progestin on breast cancer and mammography in healthy postmenopausal women: the Women's Health Initiative randomized trial. Journal of the American Medical Association, 289(24),3243-3253. Retrieved from: https://jamanetwork.com/journals/jama/fullarticle/196804

Clark, Margaret. (1967). The anthropology of aging: a new area for studies of culture and personality. Gerontologist, 7(1), 55-64.

Clarke, A., Shim, J., Mamo, L., Fosket, J.R., & Fishman, J. (2003). Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. American Sociological Review, 68(2), 161-194.

Clarke, A., Shim, J., Mamo, L., Fosket, J.R., & Fishman, J. (2010). Biomedicalization. A theoretical and substantive introduction. In A. Clarke, L. Mamo, J.R. Fosket, J. Fishman & J. Shim (Eds). Biomedicalization: technoscience, health and illness in the U.S. [e- reader version] (pp. XVI-LVII). Durham and London: Duke University Press. Retrieved from: https://play.google.com/books/reader?id=LiOheK_2uZ8C

Clarke, A. (2010) Epilogue. Thoughts on biomedicalization and its transnational travels. In A. Clarke, L. Mamo, J.R. Fosket, J. Fishman & J. Shim (Eds). Biomedicalization: technoscience, health and illness in the U.S. [e-reader version] (pp. 334-359). Durham and London: Duke University Press. Retrieved from: https://play.google.com/books/reader?id=LiOheK_2uZ8C

B

Clifford, J. (1986). Introduction: partial truths. In J. Clifford and G. Marcus (Eds). Writing cultures: The poetics and politics of ethnography (pp. 5-26). Berkeley: University of California Press.

Clifford, J. (1997). Routes: travel and translation in the late twentieth century. Cambridge, MA: Harvard University Press.

Coelho, C., Lessa, T., de Carvalho, R.M., Coelho, L., Scari, R., Fernandes, N., & Junior, J. (2011). Qualidade de vida em mulheres praticantes de Hatha Ioga. Motriz Rio Claro, 17(1), 33-38. https://doi.org/10.5016/1980-6574.2011v17n1p33

Cohen, L. (1994). Old age: cultural and critical perspective. Annual Review of Anthropology, 23(1), 137-158.

Congreso de Chile. (2015). Modifica el Código Sanitario, en lo referido al ámbito del ejercicio profesional de la matronería. Boletín N°10191-11. Retrieved from: https://www.camara.cl/paspx?prmTIPO=DOCUMENTOCOMUNICACIONCUENTA&prmID=6873

Contreras, D. (2003). Poverty and inequality in a rapid growth economy: Chile 1990–1996, Journal of Development Studies, 39(3), 181–200.

Contreras-García, Y. & González, A. (2015). Funcionamiento familiar en mujeres climatéricas sintomáticas usuarias del nivel primario de atención en Chile. Revista Cubana de Obstetricia y Ginecología, 41(4), 376-387. Retrieved from: http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0138-600X2015000400007&lng=es&tlng=es.

Contreras, D., Alamos, M. J., Chang, M., & Bedregal, P. (2015). Opiniones sobre terapias complementarias por parte de los estudiantes de medicina de la Pontificia Universidad Católica de Chile. Año 2014. Revista Médica de Chile, 143(8), 1020-1027. https://doi.org/10.4067/S0034-98872015000800009

Cornely, P., Belmar, R., Falk, L., Filerman, G., Rodriguez-Trias, H., Sidel, V., Silver, G., & Wegman, M. (1977). History of the health care system in Chile. AJPH, 67(1), 31-36. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1653583/

Cox, B. (1996). Should a doctor prescribe hormone replacement therapy which has been manufactured from mare's urine? Journal of Medical Ethics, 22(4), 199-203.

Crang, M., & Cook, I. (1995). Doing ethnographies. Norwich: Geobooks.

Creswell, J. (2007). Qualitative inquiry and research design: choosing among five approaches (2nd ed.). Thousand Oaks, CA: Sage Publications.

Cuello, M., Oyarzun, E., & Wild, R. (2004). Perfil actual y requisitos para un programa de especialización en obstetricia y ginecología en el nuevo milenio en Chile. Revista Chilena de Obstetricia y Ginecología, 69(2), 136-148.

Danckers, L. (2009). Salud ósea y menopausia. Revista Médica de la Clínica Las Condes, 20(1), 67-73.

Dannreuther, C., & Gideon, J. (2008). Entitled to health? Social protection in Chile's plan AUGE. Development and Change, 39(5), 845–864.

Das, V. (1996). Language and body: transactions in the construction of pain. Daedalus, 125(1), 67-91. Retrieved from: http://www.jstor.org/stable/20027354

Das, V. (2007). Life and words: violence and the descent into the ordinary. Berkeley: University of California Press.

Davis, K. (1995). Reshaping the female body: the dilemma of cosmetic surgery. London: Routledge.

Del Cairo, C., & Jaramillo-Marín, J. (2008). Clifford Geertz y el ensamble de un proyecto antropológico crítico. Tabula Rasa, 8(1), 15-41. Retrieved from: https://www.redalyc.org/pdf/396/39600802.pdf

Del Prado M., Fuenzalida, A., Jara, D., Figueroa R., Flores, D., & Blümel, J. (2008). Evaluación de la calidad de vida en mujeres de 40 a 59 años mediante la escala MRS (Menopause Rating Scale). Revista Médica de Chile, 136(12), 1511- 1517.https://doi.org/10.4067/S0034-98872008001200002

B

Diaz, M., & Mora, R. (2011). Diagnostico de la implementación de políticas públicas para la tercera edad en Chile. Concepción: Universidad de Concepción.

Diniz, S. (2012). Materno-infantilism, feminism and maternal health policy in Brazil. Reproductive Health Matters, 20(39),125-132. https://doi.org/10.1016/S0968-8080(12)39616-X

Dois Castellón, A., Urrutia Soto, M., Araya Gutiérrez, A., & Carrasco Aldunate, P. (2017). Experiencia de usuarias de un centro de atención primaria chileno con menopausia y representaciones sociales. Revista Cubana de Obstetricia y Ginecología, 43(3), 41-50. Retrieved from: http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0138-600X2017000300005&lng=es&tlng=pt.

Dos Santos, T. (1973). Concepto de clases sociales. Buenos Aires: Editorial Galerna.

Donoso, C., Bustos, C., Huerta, P., Pacheco, J., & Castillo, C. (2013). Seguimiento de las transformaciones de los sistemas de salud de Chile, después de la reforma del AUGE- GES: un análisis del discurso de los actores claves del sistema público de salud en la Región del Bío-Bío en Torno a la integración público-privada. Acta Científica del XXIX Congreso de la Asociación Latinoamericana de Sociología. Santiago, 2013. Retrieved from: http://actacientifica.servicioit.cl/biblioteca/gt/GT19/GT19_DonosoOrellana_BustosIbarra.pdf

Donoso, E., & Carvajal, S. (2012). El cambio del perfil epidemiológico de la mortalidad materna en Chile dificultará el cumplimiento del 5º objetivo del Milenio. Revista Medica de Chile, 140(10), 1253-1262.

Douglas, M. (1966). Purity and danger: an analysis of the concepts of pollution and taboo. London: Routledge & Kegan Paul.

Duran, G., & Kremerman, M. (2015). Los verdaderos sueldos de Chile: panorama actual del valor del trabajo usando la encuesta NESI. Santiago: Fundación Sol. Retrieved from: http://www.fundacionsol.cl/wp-content/uploads/2015/06/Verdaderos-Salarios-2015.pdf

Duran, G., & Kremerman, M. (2018). Los verdaderos sueldos de Chile: panorama actual del valor de la fuerza de trabajo usando la ESI 2017. Santiago: Fundación Sol. Retrieved from: http://www.fundacionsol.cl/wp-content/uploads/2018/08/Los-Verdaderos-Salarios- NESI-2017-1.pdf

Edmonds, A. (2010). Pretty modern: beauty, sex and plastic surgery in Brazil. Durham and London: Duke University Press.

Edmonds, A., & Sanabria, E. (2014). Medical borderlands: engineering the body with plastic surgery and hormonal therapies in Brazil. Anthropology and Medicine, 21(2), 202-216. https://doi.org/10.1080/13648470.2014.918933

Ellis, C., & Bochner, A. (2000). Autoethnography, personal narrative, reflexivity: researcher as subject. The handbook of qualitative research. Retrieved from: http://works.bepress.com/carolyn_ellis/49/

Emerson, R., Fretz, R., & Shaw, L. (2007). Participant observation and fieldnotes. In P. Atkinson et al. (Eds.), Handbook of ethnography (pp. 352-368). London: SAGE Publications.

Errandonea, I. (2009). Mujer, nutrición y envejecimiento. Revista Médica de la Clínica Las Condes, 20(1), 92-98.

Escande, A., Servant, N.,Rabenoelina, F., Auzou, G., Kloosterboer, H., Cavaillès, V., Balaguer, P., & Maudelonde, T.(2009). Regulation of activities of steroid hormone receptors by tibolone and its primary metabolites. Journal of Steroid Biochemistry & Molecular Biology, 116(1-2), 8-14. https://doi.org/10.1016/j.jsbmb.2009.03.008

Escobar, P., & LeBert, C. (2003). The new labor market: the effects of the neoliberal experiment in Chile. Latin American Perspectives, 30 (5), 70-78. Retrieved from: https://www.jstor.org/stable/3184959

Escribano, J., Rodea, G., Martín, A., Cristobal, I., González, P., Salinas, J., & Sánchez-Borrego,R. (2016). Tratamiento del síndrome genitourinario de la menopausia mediante láser fraccionado CO2: una opción terapéutica emergente. Revista Chilena de Obstetricia y Ginecología, 81(2), 138-151. https://doi.org/10.4067/S0717-75262016000200011

Especialista afirma que tras la menopausia si se puede gozar de una vida sexual plena (2011, October 17). Retrieved from: http://www.biobiochile.cl/2011/10/17/especialista-afirma- que-tras-la-menopausia-si-se-puede-gozar-de-una-vida-sexual-plena.shtml

Espinoza, V., Barozet, E., & Mendez, M. (2013). Estratificación y movilidad social bajo un modelo neoliberal: el caso de Chile. Revista Lavboratorio, 25(1), 169-191. Retrieved from: https://publicaciones.sociales.uba.ar/index.php/lavboratorio/article/view/125

Esteban, M.L. (2004). Antropología encarnada: antropología desde una misma. Papeles del CEIC, 12(1), 1-21. Retrieved from: http://www.ehu.es/CEIC/papeles/12.pdf

Ettinger, B., Grady, D., Tosteson, A., Pressman, A., & Macer, J. (2003). Effect of the Women's Health Initiative on women's decisions to discontinue postmenopausal hormone therapy. Obstetrics & Gynecology, 102(6), 1225-1232. https://doi.org/10.1016/j.obstetgynecol.2003.08.007

Fajardo, J. (2009). Yoga, cuerpo e imagen: espiritualidad y bienestar, de la terapia a la publicidad. Universitas Humanística, 68 (2), 33-47.

Falzon, M.A. (2009). Introduction. Multi-sited ethnography: theory, practice and locality in contemporary research. In M.A. Falzon (Ed.) Multi-sited ethnography: theory, practice and locality in contemporary research (pp. 1-24). Oxford: Ashgate Publishing.

FDA. (2018). Menopause and hormones: common questions. Retrieved from: https://www.fda.gov/ForConsumers/ByAudience/ForWomen/ucm118624.htm

Feuerstein, G. (2001). The yoga tradition: its history, literature, philosophy and practice. Prescott: Hohm Press.

Foucault, M. [1976] (1998). The history of sexuality, Vol. 1: the will to knowledge. London: Penguin.

Foucault, M. (1988). Technologies of the Self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), Technologies of the self: a seminar with Michel Foucault (pp. 16-49). Amherst, MA: University of Massachusetts Press.

B

Freedom House. (2014). The Freedom House global ranking: freedom of the press. Retrieved from: https://freedomhouse.org/report/freedom-press/2014/chile

Fuentes, A. (2014). Las distintas formas de envejecer en Chile: desigualdades socioeconómicas en las transiciones de funcionalidad en una cohorte de adultos mayores del Gran Santiago. (Doctoral Thesis, Universidad de Chile, Santiago, Chile). Retrieved from: http://bibliodigital.saludpublica.uchile.cl:8080/dspace/bitstream/handle/123456789/537/Tesis_Alejandra%20Fuentes.pdf?sequence=1&isAllowed=y

Fundación Sol. (2015). Pensiones. Retrieved from: http://www.fundacionsol.cl/tema-grafico/pensiones/

Galletta, A. (2013). Mastering the semi-structured interview and beyond: from research design to analysis and publication. New York and London: New York University Press.

Geertz, C. (1973). The interpretation of cultures. New York: Basic Books.

Geertz, C. (1983). Local knowledge: further essays in interpretive anthropology. New York: Basic Books.

Geertz, C. (1988). Works and lives: the anthropologist as author. Stanford, CA: Stanford University Press.

Gerente que anunció pensiones del 100% del sueldo responde a críticas. (2016, July 15). Retrieved from: http://www.cooperativa.cl/noticias/economia/sistema-previsional/afp/gerente-que-anuncio-pensiones-del-100-del-sueldo-responde-a- criticas/2016-07-15/153146.html

Giddens, A. (1993). The transformation of intimacy:sexuality, love, and eroticism in modern societies. Cambridge: Polity Press.

Godelier, M. (1977). Perspectives in Marxist anthropology. Cambridge: Cambridge University Press.

González, I. (2016). Del apoyo mutuo a la acción colectiva: lupus al GES (Master's degree thesis in Public Health). Universidad de Chile, Santiago, Chile.

Gomez-Rubio, C., Zavala-Villalón G., Ganga-León C., Rojas Paillalef, W., Álvarez Astorga, R., & Salas Allende, S. (2016). Jubilación en Chile: vivencias y percepciones de mujeres jubiladas por el sistema privado de pensiones. Psicoperspectivas, Individuo y Sociedad, 15(3), 112-122. Retrieved from: https://scielo.conicyt.cl/pdf/psicop/v15n3/art11.pdf

Grant, C., Fasce, E., & Fasce, F. (2009). Hipertensión arterial y menopausia: epidemiología, mecanismos fisiopatológicos y tratamiento. Revista Médica de la Clínica Las Condes, 20(1), 31-37.

B

Griffin, R. A. (2012). I AM an angry black woman: black feminist autoethnography, voice, and resistance. Women's Studies in Communication, 35(2), 138-157. https://doi.org/10.1080/07491409.2012.724524Guber, R. (2001). La etnografía: método, campo y reflexividad. Bogotá: Grupo Editorial Norma.

Guillemin, M. (2000). Working practices of the menopause clinic. Science, Technology, & Human Values, 25(4), 449-471.

Guillou, M., Carabantes, J., & Bustos, V. (2009). Disponibilidad de médicos y especialistas en Chile. Revista Medica de Chile, 139(1), 559-570. Retrieved from: https://scielo.conicyt.cl/pdf/rmc/v139n5/art01.pdf

Hage, G. (2005). A not so multi-sited ethnography of a not so imagined community. Anthropological Theory, 5(4), 463-475. https://doi.org/10.1177/1463499605059232

Hall, S. (1980). Encoding/decoding. In: Centre for Contemporary Cultural Studies (Ed.) Culture, media, language: working papers in cultural studies 1972-79 (pp. 128-138). London: Hutchinson.

Hall, S. (1997). The work of representation. In Stuart Hall (Ed). Representation: cultural representation and signifying practices. London: SAGE Publications.

Heinemann, K., Ruebig, A., Potthoff, P., Schneider, H.P., Strelow, F., Heinemann, L.A., & Do,M.T. (2004). The Menopause rating scale (MRS) scale: a methodological review. Health and Quality of Life Outcomes, 2(1), 2-45. https://doi.org/10.1186/1477-7525-2-45

Helman, C. (2001). Culture, health and illness. London: Arnold.

Hernandez, S. (2013, March 22). Gloria [blog post]. El Dínamo. Retrieved on February 22, 2014 from: http://www.eldinamo.cl/blog/gloria/

Holstein, M. (2018). On being an old woman in contemporary society. Generations 41(4), 6-11. Retrieved from: http://www.asaging.org/blog/being-old-woman-c ontemporary-society

Holt, N. (2003). Representation, legitimation, and autoethnography: an autoethnographic writing story. International Journal of Qualitative Methods 2(1) 1-22.

Hooks, B. (1984). Feminist theory. from margin to the center. Cambridge, MA: South End Press. Howe, D. (2011). Impairment: sporting bodies: sensuous, lived and impaired. In F. Mascia-Lees (Ed.) A companion to the anthropology of the body and embodiment (pp. 276-291). Chichester: Willey-Blackwell.

Hunt, S. (2000). The subjective health of older women: measuring outcomes in relation to prevention. Quality of Life Research, 9 (1), 709-719.

B

Husserl, E. (1948). Experience and judgment. Evanston, IL: Northwestern University Press.
Illanes, M. (2010). En el nombre del pueblo, del estado y de la ciencia: historia social de la salud pública en Chile 1880-1973 (hacia una historia social del siglo XX). Santiago: Ministerio de Salud.

Instituto Nacional de Estadísticas. (2014). Estadísticas vitales. Anuario 2014. Retrieved from: http://www.ine.cl/docs/default-source/publicaciones/2016/anuario-de-estad%C3%ADsticas-vitales-2014.pdf?sfvrsn=18

Instituto Nacional de Estadísticas. (2017). Compendio estadístico. Retrieved from: https://www.ine.cl/docs/default-source/publicaciones/2017/compendio-estadistico-2017.pdf?sfvrsn=6

International Menopause Society. (n.d.). Aims of the IMS. Retrieved from: http://www.imsociety.org/aims_of_ims.php

Jacobson, D. (1991). Reading ethnography. Albany: State University of New York Press.

Jackson, M. (1989). Paths towards a clearing: radical empiricism and ethnographic inquiry. Bloomington: Indiana University Press.

Jadresic, E. (2009). Climaterio: depresión y alteraciones del ánimo. Revista Médica de la Clínica Las Condes, 20(1), 61-65.

Jara, E. (2018). Gestar y parir con derechos: el caso de la atención en salud materna de las mujeres pehuenche en la red asistencial Alto Bio Bio- Santa Bárbara-Los Ángeles. (Master Thesis Politics and Governance), Universidad de Concepción, Concepción.

Jiron, P. (2007). Unravelling invisible inequalities in the city through urban daily mobility: the case of Santiago de Chile. Swiss Journal of Sociology 33(1), 45-68.

Kaczmarek, M., & Szwed, A. (1997). A review of anthropological approaches to aging. Anthropological Review, 1(60), 35-46.

Kaufman, S. (1981). Components of identity in old age: a case study. Ethos, 9(1), 51-87.

Keith, J. (1980). "The best is yet to be": toward an anthropology of age. Annual Review of Anthropology, 9(1), 339-364.

Kleinman, A. (1980). Patients and healers in the context of culture: an exploration on the borderland between anthropology, medicine and psychiatry. Berkeley: University of California Press.

Knibbe, K., & Versteeg, P. (2008). Assessing phenomenology in anthropology. Critique of Anthropology, 28(1), 47-62.

B

Kremerman, M. (2017). AFP y buenas pensiones, una ecuación imposible. Retrieved from: http://www.fundacionsol.cl/2017/08/afp-buenas-pensiones-una-ecuacion-imposible/

Kunstman, S., & Gainza, D. (2009a). Enfermedad cardiovascular en la mujer y su relación con la menopausia. Revista Médica de la Clínica Las Condes, 20(1), 39-45.

Kunstman, S., & Gainza, D. (2009b). Dislipidemia en la mujer: diagnóstico, clasificación y manejo. Revista Médica de la Clínica Las Condes, 20(1), 47-52.

Lagarde, M. (1990). Los cautiverios de las mujeres: madresposas, monjas, putas, presas y locas. Ciudad de Mexico: UNAM.

Lamas, M. (2008). El aborto en la agenda del desarrollo en América Latina. Perfiles Latinoamericanos, 16(31), 65-93. Retrieved from: http://www.scielo.org.mx/scielo.php?script=sci_arttext&pid=S0188-76532008000100004&lng=es&tlng=es.

Lapegna, P. (2009). Ethnographers of the world… united? Current debates on the ethnographic study of "globalization." Journal of World Systems Research, 15(1), 3-24. Retrieved from: http://jwsr.pitt.edu/ojs/index.php/jwsr/article/viewFile/336/348

Larraín, J., Larraín, P., Lelio, S., Maza, G., (Producers) & Lelio, S. (Director) (2013). Gloria (motion picture). Chile: Alamode films.

Larrañaga, O. (2010). El estado bienestar en Chile: 1910-2010. Santiago: Programa de las Naciones Unidas para el Desarrollo.

Latour, B. (1987). Science in action: how to follow scientists and engineers through society. Cambridge, MA: Harvard University Press.

Latour, B. (2004). Why has critique run out of steam? From matters of fact to matters of c oncern. Critical Inquiry, 30(2), 225-248.Laurell, A. (2016). Políticas de salud en pugna: aseguramiento frente a sistemas universales públicos. Revista Latino-Americana de Enfermagem, 24(1), 1-7. https://doi.org/10.1590/1518-8345.1074.2668

Lea, J. (2009). Liberation or limitation? Understanding Iyengar Yoga as a practice of the self. Body Society, 15(3), 71-92.

Leal, C. (2016, September 22). Radio Bíobío se consolida como la emisora más escuchada en Chile y líder informativa en Santiago [press release]. Retrieved from: https://www.biobiochile.cl/noticias/nacional/chile/2016/09/22/radio-bio-bio-se-consolida- como-la-emisora-mas-escuchada-de-chile-y-lider-informativa-en-santiago.shtml

B

Leplège, A., & Dennerstein, L. (2000). Editorial: menopause and quality of life. Quality of Life Research, 9(6), 689-692. Retrieved from http://www.jstor.org/stable/4036940

Leslie, C. (1980). Medical pluralism in global perspective. Society, Science and Medicine, 14B(4), 191-195.

Lewis, O. (1959) Five families: Mexican case study in the culture of poverty. New York: Basic Books.

Lillo, E., Oyarzo, S., Carroza, J., & Román, A. (2016). Midwifery in Chile, a successful experience to improve women's sexual and reproductive health: facilitators & challenges. Journal of Asian Midwives, 3(1), 63-69. Retrieved from: https://ecommons.aku.edu/jam/vol3/iss1/7/

Lizama, A. (2015). Las paradojas del Yoga: el caso de Chile. (Doctoral thesis in Sociology) Universidad de Barcelona, Catalunya.

Lock, M. (1986). Ambiguities of aging: Japanese experience and perceptions of menopause. Culture, Medicine and Psychiatry, 10(1), 23-46.

Lock, M. (1993a) Encounters with aging: mythologies of menopause in Japan and North America. Berkeley: University of California Press.

Lock, M. (1993b). Cultivating the body: anthropology and epistemologies of bodily practice and knowledge. Annual Review of Anthropology, 22(1), 133-155.

Lock, M., & Kaufert, P. (2001). Menopause, local biologies, and cultures of aging. American Journal of Human Biology 13(4), 494–504.

Lock, M., & Nguyen, V.K. (2010). An anthropology of biomedicine. Oxford: Blackwell Publishing.

Lopez-Alegría, F., & Soares, D. R. (2011). Síntomas climatéricos y calidad de vida de usuarias de consultorios de atención primaria de salud, Santiago. Revista Médica de Chile, 139(5), 618-624. https://doi.org/10.4067/S0034-98872011000500009

Lopez Gonzalez, V., & Diaz Paez, A. (1998). Efectos del Hatha yoga sobre la salud. Parte II. Revista Cubana de Medicina General Integral, 14(5), 499-503.

Los hombres son la causa de la menopausia según estudio. (2013, June 14). Terra. Retrieved from: http://noticias.terra.es/ciencia/los-hombres-son-la-causa-de-la-menopausia-segun- un-estudio,787a76762f34f310VgnVCM5000009ccceb0aRCRD.html

Maduritud la nueva etapa en la vida de la mujer. (2012, May 22). Terra. Retrieved from: http://vidayestilo.terra.cl/mujer/maduritud-la-nueva-etapa-de-la-mujer-post- 40,c9989a78090d2310VgnVCM20000099f154d0RCRD.html

Marcus, G. (1995). Ethnography in/of the world system: the emergence of multi-sited ethnography. Annual Review of Anthropology, 24(1), 95-117.

Marcus, G. (2005). Multi-sited ethnography: five or six things I know about it now. Retrieved from: http://eprints.ncrm.ac.uk/64/1/georgemarcus.pdf

Marcus, G. (2013). Experimental forms for the expression of norms in the ethnography of the contemporary. HAU: Journal of Ethnographic Theory, 3(2), 197–217.

Martin, E. (1986). The Woman in the body. A cultural analysis of reproduction. Boston, MA: Beacon Press.

Menéndez, E. (2005). Intencionalidad, experiencia y función: la articulación de los saberes médicos. Revista de Antropología Social, 14(1), 33-69.

Meyer, V. (2001). The medicalization of menopause: critique and consequences. International Journal of Health Services, 31(4), 769-792. https://doi.org/10.2190/M77D-YV2Y- D5NU-FXNW

Ministerio de Desarrollo Social. (2012). Informe de política social. Retrieved from: http://www.ministeriodesarrollosocial.gob.cl/ipos-2012/media/ipos_2012_pp_94-125.pdf

Ministerio de Desarrollo Social. (2015). Presentación de resultados encuesta CASEN 2015. Retrieved from http://observatorio.ministeriodesarrollosocial.gob.cl/casen- multidimensional/casen/docs/CASEN_2015_Ampliando_la_mirada_sobre_la_pobreza_d esigualdad.pdf

Ministerio de Desarrollo Social. (2016). Casen 2015L salud, síntesis de resultados. Retrieved from: http://observatorio.ministeriodesarrollosocial.gob.cl/casen-multidimensional/casen/docs/CASEN_2015_Resultados_salud.pdf

Ministerio de Desarrollo Social. (2017). Valor de la Canasta Básica de Alimentos y Líneas de Pobreza Informe Mensual Febrero de 2017. Retrieved from: http://observatorio.ministeriodesarrollosocial.gob.cl/layout/doc/ipc/Valor%20CBA%20y%20LP%C2%B4s%2017.02.pdf

Ministerio de Salud. (2006). Política de salud y pueblos indígenas. Santiago: MINSAL. Retrieved from: http://www.sstalcahuano.cl/file/pespi/politica.pdf

Ministerio de Salud. (2014). Orientaciones técnicas para la atención integral de la mujer en edad de climaterio en el nivel primario de la red de salud (APS). Santiago: MINSAL. Retrieved from: http://www.MINSAL.cl/sites/default/files/files/OTCLIMATERIOinteriorValenteindd040 22014.pdf

Ministerio de Salud. (2016). Historia del MINSAL partes 1 y 2. Retrieved from: http://web.MINSAL.cl/historia-del-MINSAL-1a-parte/

Missoni, E., & Solimano, G. (2010). Towards universal health coverage: the Chilean experience. In: World Health Report 2010. Background Paper, 4.

Mitchell, J. P. (2012). Introduction. In Marit Melhuus, Jon P. Mitchell & Helena Wulff (Eds.), Ethnographic practice in the present (pp.1-16). New York: Berghahn Books.

Mol, A. (2002). The body multiple: ontology in medical practice. London: Duke University Press.

Mol, A. (2008). The logic of care: health and the problem of patient choice. New York: Routledge.

Molinet, S. (2012). ¿Existen políticas de promoción para el ejercicio de derechos de las personas mayores de pueblos originarios a 10 años del plan mundial sobre envejecimiento? Retrieved from: https://www.gerontologia.org/portal/information/showInformation.php?idinfo=2465

Montecino, S. (1990). Símbolo mariano y la constitución de la identidad femenina en Chile. Revista de Estudios Públicos, 39(1), 283-290.

Montero, A., Vergara, J., Ríos, M., & Villarroel, R. (2017). La objeción de conciencia en el debate sobre la despenalización del aborto por tres causales en Chile. Revista Chilena de Obstetricia y Ginecología, 82(4): 350-360. https://doi.org/10.4067/s0717- 75262017000400350

Montoya-Aguilar, C. (2010). La atención primaria de salud en Chile y el papel de los medicos: nuevos objetivos en el año 2010. Cuadernos Médico Sociales, 50(3): 167-177.

Morales, F. (2011). ¿A quién representa el feminismo? Análisis de relatos de mujeres feministas en Santiago y Concepción en torno a la menopausia (Undergraduate thesis in Anthropology). Universidad de Concepción, Chile.

Mosby's Medical Dictionary. (2013). (9th ed.). St. Louis, MO: Mosby Elsevier. Murphy, R. (1987). The body silent. New York: Henry Holt and Company.

Mykytyn, C.E. (2006). Anti-aging medicine: predictions, moral obligations, and biomedical intervention. Anthropological Quarterly, 79(1), 5-31.

Navarrete, I. (2015). Envejecimiento y menopausia: experiencias corporales e identidad de Género en mujeres mayores de la Región Metropolitana (Undergraduate thesis in Social Anthropology). University of Chile, Santiago.

B

Nogales Gaete, J. (2004). Medicina alternativa y complementaria. Revista Chilena de Neuro- psiquiatría, 42(4), 243-250. https://doi.org/10.4067/S0717-92272004000400001

OECD. (2015, May 21). Todos juntos ¿por qué reducir la desigualdad nos beneficia? En Chile. Retrieved from: https://www.oecd.org/chile/OECD2015-In-It-Together-Highlights- Chile.pdf

Ortner, S., & Whitehead, H. (1981). Accounting for sexual meanings. In S. Ortner and H. Whitehead (Eds) Sexual meanings: the cultural construction of gender and sexuality (pp. 1-28). Cambridge: Cambridge University Press.

Ortner, S. (2006). Anthropology and social theory: culture, power and the active subject (Kindle edition). Durham and London: Duke University Press.

Osorio, F. (1998). La explicación en antropología. Cinta Moebio 4(1), 201-240 Retrieved from: www.moebio.uchile.cl/04/osorio01.htm

Osorio, P., & Sadler, M. (2005). La construcción socio-cultural de la vejez desde una mirada de género. In O. Gonzalez and R. Reneré (Eds). Climaterio en la atención primaria (pp. 7- 20). Santiago: Editorial Bywaters.

Osorio, P. (2007). Construcción social de la vejez y expectativas ante la jubilación en mujeres chilenas. Universum, 22(2), 194-212.

Osorio, P. (2010). Envejecimiento, género y políticas en Chile. In: Envejecimiento, género y políticas públicas: coloquio regional de expertos (1st ed., 59-69). Montevideo: Lucida Ediciones.

Osorio, P. (2013). Health and widowhood: meanings and experience of elderly women in Chile. Health, 5(8), 1272-1276. https://doi.org/10.4236/health.2013.58173

Oudshoorn, N. (1990). On the making of sex hormones: research materials and the production of knowledge. Social Studies of Science, 20(1), 5-33.

Oudshoorn, N. (1993). United we stand: the pharmaceutical industry, laboratory, and clinic in the development of sex hormones into scientific drugs, 1920-1940. Science, Technology, & Human Values, 18(1), 5-24.

Özdemir, O., & Çöl, M. (2004). The age at menopause and associated factors at the health center area in Ankara, Turkey. Maturitas, 49(3), 211–219.

Pan-American Health Organization. (2014). Health in the Americas. Country report: Chile. Retrieved from: https://www.paho.org/salud-en-las-americas-2017/?page_id=105

B

Parada, M. (2004). Evolución del sistema de protección social de la salud en Chile: un análisis sociológico (Doctoral thesis in Sociology). Universidad Autonoma de Madrid, Madrid.

Paredes, D., Iturra, V., & Lufin, M. (2016). A spatial decomposition of income inequality in Chile, Regional Studies, 50(5), 771-789.

Pearsall, M. (1997). The other within us: feminist explorations of women and aging. Boulder, CO Westview Press.

Perkinson, S., & Solimeo, S. (2013). Aging in cultural context and as narrative process: conceptual foundations of the anthropology of aging as reflected in the works of Margaret Clark and Sharon Kaufman. The Gerontologist, 54(1), 101-107.

Pink, S. (2007). Doing visual ethnography (2nd edition). London: Sage Publications. Pink, S. (2009). Doing sensory ethnography. London: Sage Publications.

Pink, S. (2013). Engaging the senses in ethnographic practice. The Senses and Society, 8(3), 261- 267. https://doi.org/10.2752/174589313X13712175020431

Pizarro, E., Villarroel, M., Fertilio, O., Gadán, A., Gonzalez, M., Ibarra, A., Parra, M., Riveros, R., Sandoval, C., Silva, P., & Valverde, V. (2008). Percepciones, actitudes y conductas de médicos gineco-obstetras respecto al uso actual de terapia de reemplazo hormonal. Revista Chilena de Obstetricia y Ginecología, 73(1), 11-20.

Rabinow, P. (1977). Reflections on fieldwork in Morocco. Berkeley: University of California Press.

Raby, T., Sierra Valderrama, P., Tsunekawa, H., Craig, J., Carvajal, J., & Cuello, M. (2014). Capacidad diagnóstica de la ecografía para detectar cáncer de endometrio en mujeres posmenopaúsicas sintomáticas y asintomáticas: experiencia de la Universidad Católica de Chile. Revista Chilena de Obstetricia y Ginecología, 79(3), 166-172. https://doi.org/10.4067/S0717-75262014000300004

Ramírez, M. (2006). Manufacturing heterosexuality: hormone replacement therapy and menopause in urban Oaxaca. Culture, Health & Sexuality, 8(6), 545–558.

Rasmussen, S. (1987). Interpreting androgynous woman: female aging and personhood among the Kel Ewey Tuareg. Ethnology 26(1), 17-30

Ratner, C. (2000). Agency and culture. Journal for the Theory of Social Behavior, 30(4), 413- 434.

Ringa, V. (2000). Menopause and treatments. Quality of Life Research, 9(1), 695-707.

Riska, E. (2010) Gender and medicalization and biomedicalization theories. In A Clarke, L. Mamo, J.R. Fosket, J. Fishman & J. Shim (Eds). Biomedicalization:

B

technoscience, health and illness in the U.S. [e-reader version] (pp. 101-126). Durham and London: Duke University Press. Retrieved from: https://play.google.com///books/reader?id=LiOheK_2uZ8C

Robles, C. (2013). Los desafíos de la protección social en un país de renta alta: el caso Chileno. Revista Uruguaya de Ciencia Política, 22(spe), 94-112. Retrieved from: http://www.scielo.edu.uy/scielo.php?script=sci_arttext&pid=S1688-499X2013000200006&lng=es&tlng=es.

Rocha, G., Sierralta, W., & Valladares, L. (2016). Efecto del 27-hidroxicolesterol en la acción antiplaquetaria de estradiol en mujeres postmenopáusicas. Revista Médica de Chile, 144(11), 1377-1381.https://doi.org/10.4067/S0034-98872016001100002

Rojas, S., Lopera, J., Cardona, J., Vargas, P., & Hormaza, M. (2014). Síndrome metabólico en la menopausia, conceptos clave. Revista Chilena de Obstetricia y Ginecología, 79(2), 121-128. https://doi.org/10.4067/S0717-75262014000200010

Roman, O., Pineda, S., & Señoret, M. (2007). Perfil y número de médicos generales que requiere el país. Revista Médica de Chile, 135(1), 1209-1215. https://doi.org/10.4067/S0034-98872007000900018

Rubin, G. (1975). The traffic in women: notes on the "political economy" of sex. In R. Reiter (Ed.), Toward an anthropology of women (pp. 157-210). New York: Monthly Review Press.

Ruiz, M., Campodónico, I., Contreras, P., Herrera, R., Arteaga, E., & Soto, E. (2002). WHI: riesgos de cáncer mamario y problemas cardiovasculares con terapia de reemplazo hormonal (THR) combinada continua. Revista Chilena de Obstetricia y Ginecología, 67(4), 263-274. https://doi.org/10.4067/S0717-75262002000400001

Säävälä, M. (1997). Child as hope: contextualizing fertility transition in rural South India. (Doctoral thesis in Anthropology). University of Amsterdam, Amsterdam.

Salazar, A., Paravic, T., & Barriga, O. (2011). Percepción de las mujeres y sus parejas sobre la calidad de vida en el climaterio. Revista Chilena de Obstetricia y Ginecología, 76(2), 64-70.

Salazar, C. (2017). Social contract on elderly caregiving in contemporary Chile: perspectives of a group of social scientists. Anthropology & Aging, 38(1), 60-79. https://doi.org/10.5195/aa.2017.134

Saldaña, L. (2018). Relaciones de género y arreglos domésticos: masculinidades cambiantes en Concepción, Chile. Polis, Revista Latinoamericana, 50(1), 183-204.

Salfate, Y., Lopez, P. (Producers) & Gonzalez, P. (Director) (2013). Socias: el éxito tiene su precio (dramatic television series). Chile: Televisión Nacional de Chile.

Salinas, H. (2017). Envejecimiento poblacional y unidades de climaterio. Revista Chilena de Obstetricia y Ginecología, 82(3), 293-297.https://doi.org/10.4067/s0717-75262017000300293

Sanabria, E. (2016). Plastic bodies: sex hormones and menstrual suppression in Brazil. Durham and London: Duke University Press.

Sanabria, E. (2014). "The same thing in a different box": similarity and difference in pharmaceutical sex hormone consumption and marketing. Medical Anthropology Quarterly, 28(4), 537-555. https://doi.org/10.1111/maq.12123

Sanabria, E. (2011). From sub- to super-citizenship: sex hormones and the body politic in Brazil. Ethnos, 75(4) 377-401. https://doi.org/10.1080/00141844.2010.544393

Sánchez-Ramírez, G., & Alvarez-Gordillo, G. (2008). ¿Hormonas sí, hormonas no? La terapia hormonal de reemplazo en la pre y posmenopausia. Revista Mujer Salud, RSMLAC, 2-3(1), 101-117.

Sánchez, M. (2016). Análisis estadístico del sistema de Isapres con enfoque de género. City: Superintendencia de Salud, Gobierno de Chile. Retrieved from: http://www.supersalud.gob.cl/documentacion/666/articles-14689_recurso_1.pdf

Sandberg, L. (2013). Affirmative old age: the aging body and feminist theories of difference. International Journal of Ageing and Later Life, 8(1), 11-40. Retrieved from: http://www.ep.liu.se/ej/ijal/2013/v8/i1/12-197/ijal12-197.pdf

Sebastian Lelio: En Gloria está presente una sociedad chilena en proceso reivindicativo. (2013, April). Revista NOS. Retrieved from: http://www.revistanos.cl/2013/04/sebastian-lelio-en-gloria-esta-presente-una-sociedad-chilena-en-proceso-reivindicativo/

Servicio Nacional del Adulto Mayor (n.d.) Retrieved from: http://www.SENAMA.gob.cl/servicio-nacional-del-adulto-mayor

Scheper-Hughes, N., & Lock, M. (1987). The mindful body: a prolegomenon to future work in medical anthropology. Medical Anthropology Quarterly, 1(1), 6-41.

Scheper-Hughes, N. (1994). Embodied knowledge: thinking with the body in critical medical anthropology. In R. Borofsky (Ed), Assessing cultural anthropology (pp. 229-242). New York: McGraw-Hill.

Scott, J. (1991). The evidence of experience. Critical Inquiry, 17(4), 773-797.

Schweitzer, M. (1991). Anthropology of aging: a partially annotated bibliography. London: ABC-CLIO.

Silverman, D. (2013). Doing qualitative research. Kindle edition. California: SAGE Publications.

Singer, M. (1995). Beyond the ivory tower: critical praxis in medical anthropology. Medical Anthropology Quarterly, 9(1), 80-106. Slobin, D. (1987). Thinking for speaking. Proceedings of the thirteenth annual meeting of the Berkeley Linguistics Society 1987 (pp. 435-445). Retrieved from: ttps://journals.linguisticsociety.org/proceedings/index.php/BLS/article/viewFile/1826/15 98

Slobin, D. (1996). From thought and language to thinking for speaking. In J.J. Gumperz & S.C. Levinson (Eds.), Rethinking linguistic relativity (pp. 70-96). Cambridge: Cambridge University Press.

Slobin, D. (2003). Language and thought online: cognitive consequences of linguistic relativity. In D. Gentner & S. Goldin-Meadow (Eds.), Language in mind: advances in the study of language and thought (pp. 157-192). Cambridge, MA: MIT Press.

Smith, B. R. (2004). Adjusting the quotidian: Ashtanga yoga as everyday practice. In M. Gibson, D. Rodan, F. Newman, R. Blaber, W. Parkins, G. Craig and C. Gordon (Eds), Cultural Studies Association of Australia (CSAA) Conference 2004 Online Proceedings, retrieved from: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.459.4583&rep=rep1&type=pdf

Smith, B. R. (2007). Body, mind and spirit? Towards an analysis of the practice of yoga. Body Society, 13(1), 225-246.

Snow, D., Morrill, C., & Anderson, L. (2003). Elaborating analytic ethnography: linking fieldwork and theory. Ethnography, 4(2), 181-200. Retrieved from: https://www.jstor.org/stable/24047808

Sociedad Chilena de Climaterio (n.d.). Misión y visión. Retrieved from: http://www.sociedadclimaterio.cl/sobre-sochiclim/mision-vision/ Sociedad Chilena de Endocrinología Ginecológica. (n.d.). http://www.socheg.cl/

Sordo, P. (2014). No quiero envejecer: las claves para vivir plenamente y disfrutar del paso de los años. Madrid: Planeta.

Soto, A. (2009). Medicinas complementarias en el sistema público de salud: experiencia de la Unidad de Salud del Trabajador del Servicio de Salud Metropolitano Sur. (Undergraduate thesis in Social Anthropology). Universidad de Chile, Santiago.

Strauss, S. (2005). Positioning yoga: balance acts across cultures. Oxford: Berg Publishers.

Stillerman, J. (2004). Gender, class and generational contexts for consumption in contemporary Chile. Journal of Consumer Culture, 4(1), 51-78. https://doi.org/10.1177/1469540504040904

Tajer, D. (2012). Género y salud: las políticas en acción. Buenos Aires: Lugar Editorial.

Tetelboin, C. (2003). La transformacion neoliberal del sistema de salud, Chile 1973-1990. Reformas de primera generación. Mexico: Universidad Autonoma Metropolitana.

Throop, J. (2005). Hypocognition, a sense of uncanny and the anthropology of ambiguity:reflections on Robert I. Levy's contribution to theories of experience in anthropology. Ethos, 33(4), 499-511.

Trincado, P. (2009). Tiroides y climaterio. Revista Médica de la Clínica Las Condes, 20(1), 55- 60.

Turner, V. (1969). The ritual process: structure and anti-structure. Chicago, IL: Aldine Publishing.

Unger, J., De Paepe, P., Cantuarias, G.S. & Herrera, O.A. (2008). Chile's neoliberal health reform: an assessment and critique. PLoS Med 5(4): e79. https://doi.org/10.1371/journal.pmed.0050079.

United Nations. (2016, June 21). International Day of Yoga. Retrieved from http://www.un.org/en/events/yogaday/background.shtml

Valentino, G., Tagle, R., & Acevedo, M. (2014). Dieta DASH y menopausia: más allá de los beneficios en hipertensión arterial. Revista Chilena de Cardiología, 33(3), 215- 222.https://doi.org/10.4067/S0718-85602014000300008

Van der Geest, S. (2002). Respect and reciprocity: care of elderly people in rural Ghana. J ournal of Cross-Cultural Gerontology, 17(1), 3-31.

Van der Geest, S. (2010). Graceful and successful aging: observations from Ghana and the Netherlands. In B. Röder, W. de Jong, & W. Kurt (Eds), Alter (n) anders denken: kulturelle und biologische perspektiven (pp. 227-238). Wien, Köln, Weimar: Böhlau Verlag GMBH & Cie.

Van der Geest, S., von Faber, M., & Sadler, E. (2010). Shifting meanings of successful aging: anthropological reflections. In J. Bouwer (Ed), Successful aging, spirituality and meaning: multidisciplinary perspectives (pp. 137-149). Leuven: Peeters Publishers.

Vargas, V., & Poblete, S. (2008). Health prioritization: the case of Chile. Health Affairs, 27(3), 782-792. https://doi.org/10.1377/hlthaff.27.3.782.

Vidal, F. (2013). Representación de la familia Chilena en las teleseries: resultados preliminares. Actas del XXIX Congreso Latinoamericano de Sociología. Retrieved from: http://actacientifica.servicioit.cl/biblioteca/gt/GT3/GT3_FranciscoVidalVelis.pdf

Viveiros de Castro, E. (2013). The relative native. Journal of Ethnographic Theory, 3(3), 473-502.

Vives, A., Gray, N., Gonzalez, F., & Molina, A. (2018). Gender and aging at work in Chile: employment, working conditions, work–life balance and health of men and women in an aging workforce. Annals of Work Exposures and Health, wxy021. https://doi.org/10.1093/annweh/wxy021

Weeks, J. (2003). Sexuality. London: Routledge.

Wilson, R. (1966). Feminine forever. London: W.H. Allen.

Wolf, E. (1982). Europe and the people without history. California: California University Press.

Women's Health Initiative. (2010, September 21). Retrieved from: https://www.nhlbi.nih.gov/science/womens-health-initiative-whi

World Bank. (2009). Estudio de brechas de oferta y demanda de médicos especialistas en Chile: informe final. Retrieved from: http://documentos.bancomundial.org/curated/es/824501468010509985/pdf/706500WP0SPANI0l000Cuerpo0Principal.pdf

World Bank. (2014). Poverty and equity: country dashboard Chile. Retrieved from: http://povertydata.worldbank.org/poverty/country/CHL

World Economic Forum. (2016). Global gender gap report index. Retrieved from: http://reports.weforum.org/global-gender-gap-report-2016/economies/#economy=CHL

World Health Organization. (2015a). The global strategy and action plan on aging and health. Retrieved from: http://www.who.int/aging/global-strategy/en/

World Health Organization. (2015b). Chile: datos estadísticos. Retrieved from: http://www.who.int/countries/chl/es/

World Health Organization. (2018). GA30.0 menopause. In International classification of diseases (ICD-11) for mortality and morbidity statistics. Retrieved from: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1965418440

Writing Group for the Women's Health Initiative Investigators. (2002). Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. JAMA, 288(3):321–333. https://doi.org/10.1001/jama.288.3.321

Yopo Díaz, M. (2016). Enacting motherhood: time and social change in Chile. Journal of Gender Studies, 27(4), 411-427. https://doi.org/10.1080/09589236.2016.1223619

Zarate, M. S. (2001). Enfermedades de mujeres. Ginecología, médicos y presunciones de género. Chile, fines del siglo XIX. Pensamiento Crítico, 1(1), 2-30.

Zarate, M.S. (2007). Dar a luz en Chile, siglo XIX: de la ciencia de hembra a la ciencia obstétrica. Santiago: DIBAM Ediciones.

Zuñiga, A. (2007). Sistemas sanitarios y reforma AUGE en Chile. Acta Bioethica, 13(2), 237-245. https://doi.org/10.4067/S1726-569X2007000200012

B

MAPS OF RESEARCH SETTING

Map 1. Chile

Note: The cities of Santiago and Concepción are encircled. Source: https://commons.wikimedia.org/wiki/File:Map_of_South_America.png

A

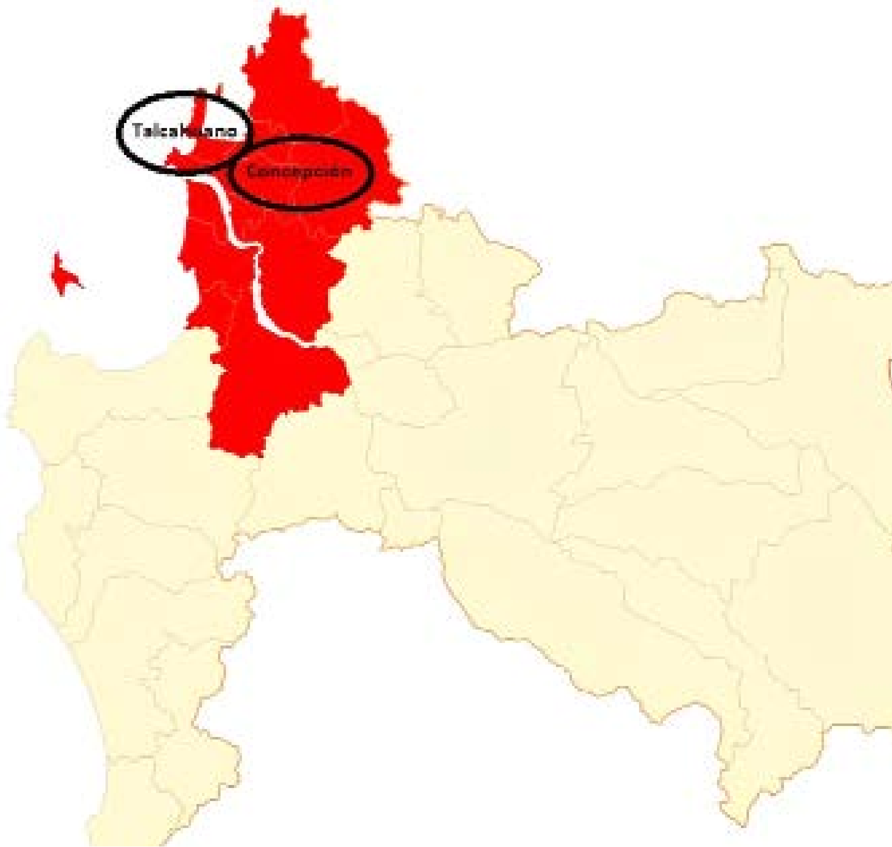
A

Map 2. Santiago

Note: The research settings of Pudahuel, Providencia, Nuñoa, and Las Condes are encircled. Source:https://upload.wikimedia.org/wikipedia/commons/c/cf/Comunas_de_Santiago_%28nomb

res%29.svg

Author: Valdebenito, O. Creative Commons License.



Map 3. Great Concepción

Note: Province of Concepción includes several cities. Talcahuano and Concepción are encircled. Source: https://upload.wikimedia.org/wikipedia/commons/8/8f/Provincia_de_Concepci%C3%B3n.svg. Author: Door B1mbo – Own work, CC BY-SA 2.5,

SUMMARY

This research explores the meanings of women's aging within contemporary Chilean society. Its purpose is threefold: first, to understand how female aging is constructed in Chile in different social groups; secondly, to understand how women from different social backgrounds give meaning to their experience of menopause and aging; and, finally, to analyze how those meanings are related to the ideas put forward by different actors such as the Western medical system, alternative treatments, the media, and public policy. I used a multi-sited ethnographic approach, conducting interviews with medical specialists, women in the process of menopause, ethnographic observations, and content analysis of both scientific papers and media representations of women's aging.

First, I describe the health care system in Chile in terms of its historical development and its current structure. I describe and discuss how aging women are affected by the neglects and gaps that discriminate against them in both the public and private health care systems. I also discuss the way public policy is addressing the issue of female aging in Chile. I contend that there are no comprehensive public policies for the needs of aging women, and that the only visible effort is linked to recently approved technical guidelines for treating menopausal women. This presents a very medicalized view of women's needs and is focused the distribution of hormonal replacement therapies. Unfortunately, there is no political subject to represent middle-aged women's needs in the public debate.

Secondly, I analyze the biomedical discursive practices on menopause and female aging, by examining academic papers published between 2002 and 2017 in Chilean medical journals and by exploring the perceptions of the interviewed Chilean gynecologists and endocrinologists.

They also present a highly medicalized view of women's aging, where all troubles are explained in relation to the decline of hormonal production. The dominant narrative (healthscape) is a medicalized view of menopause, as hormonal replacement therapies are believed to be the ultimate solution for a wide range of issues that women may face as they age. To a lesser extent, they acknowledged the use of hormonal replacement therapy as an enhancement technology available to upper-middle-class women. Medical specialists resented the high level of resistance that Chilean women express when it comes to taking hormonal replacement therapies, which may explain particular features of the Chilean medicalization healthscape.

Thirdly, I explore media representations of menopause and female aging by analyzing various productions in the period from 2008 until 2017. I conclude that the mass media represent a negative view of female aging, suggesting that its troubles can be solved by the use of technologies and biomedical treatments or that they can be prevented through "the right way of living." This discourse puts a great deal of pressure on women who are encouraged to change what are considered negative behavior patterns. This discourse is very much in alignment with the biomedical discourse since it conveys that "aging as a disease" can be prevented and turned into "healthy successful aging" with the help of medical care and other self-care technologies.

Fourthly, I attempt to unfold the meanings that both menopause and aging have for women in their midlife by analyzing narratives of their experiences. I explore the meanings they give to their body and the process of aging. To account for social differences, I interviewed upper-middle-class women and working-class women in urban areas. I found out that both groups tended to reproduce in their bodily experiences the traditional norms attributed to women. In both groups, women worried about aging and feeling a physical decline, but they had different strategies to deal with those feelings. While upper-middle-class women resorted to biomedical echnology to fight aging, working-class women tended to accept aging as something inevitable and found ways to be grateful for what they have.

Finally, I explore the experiences and body perceptions of women (mainly from the upper-middle-class) who turned to yoga in their search for wellbeing. I argue that yoga provides positive meanings for aging women and it can be defined as a practice of resistance against hegemonic discourses about female aging. I contend that yoga practice can be related to the idea of "affirmative old-age" as it leads to experiencing the process of aging as empowering and challenges the assumptions of the so-called successful aging.

In conclusion I suggest that Chilean society is not prepared to face the ongoing aging of its population. Particularly in the case of women, the measures are limited and biased as they focus mainly on the biomedical paradigm. There are no political subjects able to represent aging women's needs and there is a lack of alternative and affirmative views in the understanding of women's aging.

SAMENVATTING

Dit onderzoek verkent de betekenis van het ouder worden van vrouwen in de hedendaagse Chileense maatschappij. Het onderzoek heeft drie doelenstellingen: ten eerste probeer ik inzicht te verschaffen in de manier waarop vrouwelijke veroudering in verschillende sociale groepen in Chili wordt geconstrueerd. Ten tweede onderzoek ik hoe vrouwen, met verschillende sociale achtergronden, betekenis geven aan hun ervaring met de menopauze en het ouder worden. Ten slotte analyseer ik hoe deze betekenissen gerelateerd zijn aan de opvattingen van verschillende actoren, zoals het westerse medische systeem, alternatieve behandelaars, de media en het regeringsbeleid. Voor het toepassen van een multi-sited etnografische benadering, heb ik gebruik gemaakt van interviews met medische specialisten, met vrouwen in de menopauze en in het proces van ouder worden, van etnografische observaties en van een analyse van zowel wetenschappelijke papers en publicaties in de media over vrouwen in het ouderwordingsproces.

Eerst beschrijf ik het gezondheidszorgsysteem in Chili in zowel de facetten van diens historische ontwikkeling als van zijn huidige structuur. Ik beschrijf en bespreek hoe ouder wordende vrouwen negatief worden beïnvloed door het gebrek aan erkenning en de lacunes die hen discrimineren in zowel het publieke als private gezondheidszorgsysteem in Chili. Ik bespreek ook de manier waarop het overheidsbeleid de kwestie van de veroudering van vrouwen in Chili tegemoet treedt. Ik beweer dat er geen alomvattend regeringsbeleid bestaat ten aanzien van de behoeften van oudere vrouwen; de enige zichtbare beleidsinspanning is gekoppeld aan de onlangs goedgekeurde technische richtlijnen voor de behandeling van vrouwen in de menopauze. Deze geven een zeer gemedicaliseerd beeld van de behoeften van vrouwen, namelijk in de vorm van distributie van hormonale substitutietherapieën. Helaas zijn vrouwen in de menopauze geen politiek thema in Chili en al doende zijn er ook geen politieke actoren die de behoeften van vrouwen op middelbare leeftijd in het publieke debat vertegenwoordigen.

Ten tweede analyseer ik de biomedische discursieve praktijken over menopauze en veroudering van vrouwen, door academische artikelen te bestuderen die tussen 2002 en 2017 zijn gepubliceerd in Chileense medische tijdschriften en door de percepties van de geïnterviewde Chileense gynaecologen en endocrinologen te onderzoeken. Ze zorgen voor een zeer gemedicaliseerd beeld van het ouderwordingsproces van vrouwen, waarbij alle problemen worden uitgelegd in relatie tot het verminderen van de hormonale productie. Het dominante verhaal (healthscape) komt overeen met medicalisering, omdat wordt verondersteld dat hormonale substitutietherapieën de ultieme oplossing te zijn voor een breed scala aan problemen waarmee vrouwen te maken kunnen krijgen als ze ouder worden. In mindere wordt het gebruik erkend van hormonale substitutietherapie als een verbeteringstechnologie die beschikbaar is voor vrouwen uit de hogere klasse. Chileense medische specialisten betreuren de hoge mate van weerstand die Chileense vrouwen uiten, als het gaat om het ondergaan van hormonale substitutietherapieën en dit zou bepaalde kenmerken van het healthscape van de Chileense medicalisering kunnen verklaren.

Ten derde onderzoek ik de media representation van het onderwerp menopauze en ouderwordingsproces van vrouwen, door een analyse van mediabeelden die in de periode van 2008 tot 2017 zijn geproduceerd. Ik concludeer dat de massamedia een negatief beeld geven van het proces van ouder worden bij vrouwen, door te suggereren dat problemen gecompenseerd kunnen worden door het gebruik van technologieën en biomedische behandelingen. Ook wordt gesuggereerd dat dit proces voorkomen zou kunnen worden door "de juiste manier van leven". Dit discours stelt hoge eisen aan vrouwen, die worden aangemaand om te veranderen wat als negatieve gedragspatronen wordt beschouwd. Dit discours sluit nauw aan bij het biomedische discours, omdat het idee overbrengt dat 'veroudering als ziekte' kan worden voorkomen en omgezet kan worden in een 'gezond en succesvol ouder worden' met behulp van medische zorg en andere zelfzorgtechnologieën.

Ten vierde probeer ik de betekenis die zowel de menopauze als de vergrijzing hebben voor vrouwen op middelbare leeftijd te ontrafelen door verhalen van hun ervaringen te analyseren. Ik onderzoek het beeld dat zij hebben van hun lichaam en het proces van veroudering. Omdat ik sociale verschillen wil verklaren, heb ik vrouwen uit de hogere middenklasse en vrouwen uit de lagere klassen geïnterviewd, beide in stedelijke gebieden. Ik kwam erachter dat beide groepen de neiging hebben om in hun lichamelijke ervaringen de traditionele normen te reproduceren die aan vrouwen worden toegeschreven. In beide groepen maken vrouwen zich zorgen over ouder worden en voelen ze een lichamelijk verval, maar ze hebben verschillende strategieën om met die gevoelens om te gaan. Terwijl vrouwen uit de hogere middenklasse hun toevlucht nemen tot biomedische technologie om het ouder worden te bestrijden, neigen vrouwen uit de lagere klassen ernaar om het ouder worden te accepteren als iets onvermijdelijks en vinden ze de manier om zich te vereenzelvigen met hun lot.

Ten slotte onderzoek ik de ervaringen en lichaamspercepties van vrouwen (voornamelijk uit de hogere middenklasse) die yoga gebruiken bij hun zoektocht naar welzijn. Ik beargumenteer dat yoga positieve betekenissen biedt voor oudere vrouwen en het kan worden gedefinieerd als een praktijk van weerstand tegen hegemoniale discoursen over veroudering van vrouwen. Ik beweer dat yogabeoefening gerelateerd kan zijn aan het idee van "bevestigende ouderdom" heeft geleid tot het ervaren van het proces van veroudering als empowerment en daagt de aannames van de zogenaamde "succesvolle veroudering" uit.

Zodoende concludeer ik dat de Chileense samenleving niet is voorbereid op het huidige vergrijzingsproces van haar bevolking. Met name in het geval van vrouwen zijn de maatregelen beperkt en eenzijdig omdat ze zich vooral richten op het biomedische paradigma. In Chili zijn geen politieke actoren die de behoeften van vrouwen in hun ouderwordingsproces kunnen vertegenwoordigen en er is bovendien een gebrek aan alternatieve en positieve opvattingen over het ouderwordingsproces van vrouwen.