

# We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

6,900

Open access books available

186,000

International authors and editors

200M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index  
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?  
Contact [book.department@intechopen.com](mailto:book.department@intechopen.com)

Numbers displayed above are based on latest data collected.  
For more information visit [www.intechopen.com](http://www.intechopen.com)



# Poverty, Reproductive Health and Public Health Policies in Chile

*Estela Arcos Griffiths*

## Abstract

In Chile the social inequality is the result of the accumulation and concentration of income, wealth and property coming from the prevailing neoliberal model in the Chilean economy. Under this model, persistent gaps in basic living standards, precarious assets, disparities in health, and inequalities in well-being, employment, treatment and safety of people have been configured. Using the case study methodology, evidence of the phenomenon is presented, making an analysis of the expression of poverty and other social determinants in the results of the reproductive health of socially vulnerable women. Scientific literature on the situation of exclusion and invisibility of subgroups of women who have experienced domestic violence, unplanned pregnancy, early motherhood, migration and ethnic status is analyzed. In turn, the results of effective transfers of health and social benefits to women in social adversity are mentioned in the management of health policy and the social protection system. Finally, a reflection is presented on the need for innovation in the processes of human capital formation in health and social science, and as a response, strategies are proposed to address it to from the complexity of the phenomenon of vulnerability and inequality in reproductive health analyzed.

**Keywords:** poverty, reproductive health, public health, vulnerability, reproductive rights

## 1. Introduction

Equity is not synonymous with equality, because equality means to give value to the inequalities, from the idea of justice, therefore, this premise demands a social epidemiological approach to value inequities and inequalities as health problems determinants [1]. Health equity implies, ideally, that everyone should have the opportunity to attain their full health potential and no one should be excluded to reach such potential [1]. This equity is then defined as equality of access to the health care comparing the same needs; equality in the use of resources for the same needs; equality of quality of care and equality of health results [2, 3]. Disparities and inequalities in health are an objective expression of the socioeconomic disadvantage accumulated by the individuals throughout their lifetime, which should be prevented with timely intervention strategies, where the intensity and duration of which would vary according to the degree of vulnerability [4]. The scientific literature has given a fund of evidence about the influence that the social determinants have on the individual and familiar health, as the substratum of diverse illnesses that manifest regardless the universal access that people may have to health systems [5, 6]. The social inequality is the result of the accumulation and concentration of

incomes, wealth and property coming from the prevailing neoliberal model in the Chilean economy [7–10]. Under this model have raised public, economic, political and social policies [9], which have set a new generation of inequalities expressed in persistent gaps in the basic living standards, the precariousness of assets, negatively affected emotional ties and solidarity, health disparities and inequalities regarding well-being, jobs, treatment and security of people in their communities [8, 11–15].

Currently, Chile is recognized as the Latin American country with the highest human development index (HDI), according data of 2020 (0.851), the lowest poverty rate and one of the highest levels of per capita income in the region [11, 15]. The country is in the world's 62nd place in the Gender Development Index (GDI) and 39nd place in Gender Index scores about 2019 across 129 countries, at the same time, has one of the highest inequality rates in Latin America, being the country with the most inequality of the Organization for Economic Cooperation and Development [16, 17]. When we consider the inequality as a result of the inequality of incomes, education and health, the country fall 11 places in the world's ranking, falling to the 54th place (Chile's HDI falls from 0.851 to 0.709) [15]. Considering this context, the Chilean society shows and keeps deep inequalities, inequities and differences that generate a sense of growing frustration, mistrust and social unrest in the population [14, 18–19].

## **2. Methodology**

To address the situation of poverty, inequality, reproductive health, a case study is carried out to understand the how and why of the causes and consequences of the phenomena that occurred in Chile, unit of analysis, regarding the subject under study. The case study corresponds to an empirical investigation based on a set of heterogeneous evidences in its origin and that converge in the explanation of a set of contemporary phenomena that arise in real life regarding poverty, inequality, reproductive health and public policies. Objective methods of searching for evidence are used through repositories of university databases and Chilean and international public organizations. The foregoing is complemented with information from studies carried out by the author with a team of researchers who approached the research on the subject in question in particular groups and territories and that account for the knowledge generated in the field work.

Finally, three strategies are presented for the development of competencies and skills in transdisciplinary and integrated management practices in primary health care for midwifery students and academics and student from other health and social science careers-professions.

## **3. Poverty, inequality and disparity in reproductive health: evidences about the Chilean case**

The concept of health inequalities has been defined as “the differences that in health are not only unnecessary and avoidable, but also are considered unfair” [20–23] and, inequity is considered as any reducible difference or inequality, related to heterogeneous life conditions tied up with incomes differences, even when the poorest have equality of access to health services [21, 24, 25]. The perspective of social, cultural and political determinants of health has allowed to understand the mechanism underlying as substratum in the “causes of the causes” and in the routes or production processes of the inequities [22, 26]. That is how it is detected the interaction between health and the social circumstances within the

area where people live, where poverty has been described as the most potentially toxic risk factor for the population health, effect which shows from early ages, reproduce during adult life and transfer to following generations [10, 23, 24, 27]. Scientific evidences have demonstrated that there is a relation between the income gap between rich and poor and the mortality rate and physical and mental health problems [10, 28], which affects the possibilities and opportunities for people development. There is an unequal distribution of the mortality rate in Chile, because the child mortality in children born to mothers with no education have significantly lower survival rates than those born to mothers with secondary or higher education [29]. Is one of the reasons that justifies that medicine alone cannot solve people's health problems, since 56% of the variations of health conditions are explained by social and ecological factors [23, 30].

The condition of women is a political, economic, and social issue and the inequalities registered must be explained by social, economic, and cultural phenomenon [31]. The inequality consists of a systematic exclusion from power, resources, and opportunities [17, 31]. The attempt to identify the factors that explain women social and economic vulnerability should start examining first the impact of developing models, and some of their components, on the gender social inequalities [31].

In the 1960s, the standard of living of the richest and the poorest people was compared and it turned out that the poor lived thirty times worse than the rich. At the end of the 1990s, the poor already lived eighty-two times worse than the rich. The differences between the rich and the poor are constantly increasing. They appear already on a family level, but they are also reflected on the fate of children and, especially, women. The efforts to visualize the inequalities between men and women are more recent [17]. The study of differentiated impacts that economic policies on men and women have had, and currently have, has demonstrated that regardless of women's social group, they have created a continue discrimination of women compared to their male colleagues [17]. The income distribution is based on an imposed cultural contract, which highly values motherhood and naturalizes the unpaid domestic work of women.

Global incomes separated by sex show that, although the gap is growing [19], the earning capacity remains minor for women, while their contribution to the reproduction continues in the dark statistics [32]. There is a welfare and mercantilist concept of the economic models that create a strong "feminization of poverty" and exclusion of the incorrectly called "ethnic minorities". Women represent an increasing percentage of those people considered to be poor. In a world that is heading towards the globalization, women's poverty creates enclaves of people in need in the midst of wealth and originates growing pressure on the developed world, whether generating expensive humanitarian crisis or trigger—for the first time in history—a surge of women migrating without their husbands and children to look for a job in richest countries, which has a significant impact in the family and society. The available evidence suggests that the proportion of poor is higher among the family groups with a female head of the household, especially when the woman has small children. In Latin America, single female-headed families are largest in the category of low incomes (homeless) [33].

Regarding reproductive health, women's greater social vulnerability and economic precariousness during pregnancy is associated to higher stress levels and anxiety and, as a consequence, higher incidence of prematurity, low birth weight, early weaning, poor child care quality, higher rates of disadvantage, child developmental delay, poor child care quality, attention deficit and hyperactivity, language problems, poor social competences and lifelong behavior problems, which is the first link in the transmission and reproduction of inequalities of health, welfare



and human capital [34–36]. In addition, it has been pointed out that coronary heart disease, type 2 diabetes, vascular accidents, hypertension, and higher rates of adult mortality are related to the history of fetal malnutrition and low birth weight [35]. Moreover, the reproductive, neonatal, mental, and family health deteriorate when women have precarious employments and pregnancies without social security, informal and insecure houses, low schooling, psychosocial risk, absence of partner at home and high dependency rate [35].

In Chile, through surveys performed in vulnerable women's groups, it was possible to obtain an in-depth knowledge of the experience of motherhood in extreme vulnerability conditions [37]. The women's stories showed a motherhood perceived as a negative event, unexpected, assumed with resignation and anguish which, for some authors, generate internal disorganization, break of bonds and depression [37]. Feelings such as discomfort, despair and loneliness emerged, both for being an unforeseen pregnancy and for being unexpected and that is consistent with the precariousness of the social support to teach women on how to take care in a context of social vulnerability [37, 38]. Women describe a life condition where the social construction of hopelessness, invisibility and social exclusion have been naturalized, a condition which affects the practice of motherhood, childcare and sexual and reproductive rights [37, 39]. The situation of invisibility is not an isolated fact, because it occurs in a condition of poverty with a gender perspective. Women perceive a distance between them and health personnel, which they feel as lack of understanding of their condition of vulnerability and poverty, due to the asymmetrical power relations and stigmatization of guilty for their pregnancy [39]. The more difficult it is for a woman to carry out motherhood and children care, the further she is from a project that justify the exercise of her reproductive rights [40, 41].

In the context of reproductive health and poverty, some relevant facts for women are domestic violence (DV), unplanned pregnancy, immigrant status, Mapuche ethnicity and teenage motherhood.

### **3.1 Violence against women**

Is a global public health problem [42] and its prevalence is higher in developing countries [43]. Pregnancy is an especially vulnerable period in terms of violence, affecting women's reproductive capacity [44], since pregnant women have an increased risk than no pregnant women [45]. Prevalence studies about DV have reported figures varying from 0,9% to 41,6,0%, being more severe or moderate post birth [42, 46]. One out of every five pregnant teenage women and one out of every six pregnant adult women have reported violent experiences during pregnancy. Violence during pregnancy becomes four times probable if the pregnancy was unexpected or unplanned [47].

The impact of domestic violence on the results of reproductive and neonatal health may be explained by the existence of indirect mechanisms that induce risks like psychological and social stress, which would be like underlying factors of adverse obstetric and neonatal results. It has been reported that biomedical risks, for women with experience of domestic violence, are related to pregnancy hypertensive states (PHS), intra-hepatic cholestasis of pregnancy (ICP), and in case of current violence with urinary tract infection, intrauterine growth restriction, preterm delivery and ICP [48]. Other associated risks are poor weight gain, vaginal, cervical or kidney infections, abdominal trauma, bleeding, exacerbation of chronic diseases, complications during labor, delay in the prenatal care, depression, suicide attempt and, even death [42, 43, 46]. At the same time, violence determines disturbances in the interaction between mother and son, which increases the possibility of negligence, abuse and neglect during the first year of life. The Biomedical risks

for neonatal health related to domestic violence are low rate of gestational age, and higher variability of anthropometric indicators such as weight and length at birth. It was observed 2.8 higher risk of small for gestational age newborns in relation to those of women without recognizing experiences of violence [48].

### **3.2 Unplanned pregnancy**

Regarding unplanned pregnancy, it is observed that in high-income countries half of the pregnancies are unplanned, which increases sanitary costs for women care, originates personal and family crisis for women and commits timely health care [49, 50]. In the period 2015–2019, there were 121.0 million of unwanted pregnancies per year, which represent a rate of 64 unwanted pregnancies for every 1000 women between 15 to 49 years old. Out of the total, a 61.0% of the unwanted pregnancies resulted in abortion, that is to say, a global rate of 39 abortions per 1000 women. The rates of unwanted pregnancies are higher in countries where abortion is illegal [51]. It is pointed out that 63 million of these unwanted pregnancies are, at least, consequence that 22 million women around the world have an unsatisfied need of family planning [49, 52]. In the United States 50% of pregnancies are unplanned, a 50% result in abortion and increases women's depression and 47.0% of the live births come from an unplanned pregnancy [50, 53].

In Chile, in the five-year period of 2010, the unplanned pregnancy represented a 51,0% out the total of the pregnant entered to the public health system, prenatal care, higher in the extreme age groups, reaching an 85.6% in pregnant under 15 years old and a 66% in older than 45 years old [54]. In the United States, there are disparities in the rates of unwanted pregnancies between poor and non-poor women, being the rate 5 times higher in the first group [25]. In addition, Also, pregnancy disparities have been observed regarding unplanned pregnancies in the poor women subgroups of 18 to 24 years old or who cohabit with a partner, since they have twice or three times the national rate [55, 56]. It is possible that the unplanned pregnancy is related to social naturalization of motherhood, in addition to the access difficulties and the lack of information about the fertility regulation means [56, 57].

Timely access to health centers in order to search early for pregnancies is very important for women who did not plan a pregnancy, since they find out 2 weeks later than women with wanted pregnancies. Fetal organs are formed at the 8th week, so a 2-week delay further than the normal 6 weeks' recognition period could prevent a form taking fast responses regarding reproductive health, especially in women with unwanted pregnancies. The possible effect of unhealthy behaviors, such as smoking and drinking, could be continuously unnoticed during the embryonic period, when most of the malformations occur [57]. It has been reported that women from minority ethnic groups have noticed very late, compared to white non-Hispanic women, since they have less information about family planning and less access to health care [57, 58]. The evidence show that unplanned pregnancy is related to disparities in women health and perinatal health in relation to the late prenatal care: low birth weight, child abuse and negligence, child behavior problems, exposure risk to illicit drugs or tobacco, not preventing alterations due to not taking folic acid timely, high prevalence of depression, depression during pregnancy and postpartum [52, 59, 60].

### **3.3 Immigrant pregnant women**

Illegal immigrant pregnant women constitute a socially vulnerable group, since they have legal limitations to access to prenatal and obstetric care to protect their health and their children's health [52, 61]. Scientific evidence demonstrate that

immigrant women's reproductive health is exposed to a high rate of unplanned pregnancies, pregnancy rejection and late prenatal care. It is possible that the access difficulties and the lack of information about the fertility regulation means predispose women to unplanned pregnancy in this group [56, 57]. The possible effect of unhealthy behaviors, such as smoking and drinking, could be unnoticed during the embryonic period, when most of the malformations occur [58]. Inadequate prenatal health care to migrant women has as consequence 4 times more risk to give birth children with low birth weight and seven times more risk of prematurity [61].

### **3.4 Maternity in adolescent women**

Regarding early motherhood, it has been informed that when reproductive timing has been examined in teenager women who start their sexual life early, the results show that teenagers with subsequent children with short/long gestational intervals belong to social groups differentiated by structural and cultural determinations. In poor women, early motherhood is considered as a non- normative crisis that determines reproductive inequity and, in some cases, excess of unwanted fertility [62, 63]. Within this framework, the concern about what happens with teenage pregnancy is not only based on studies on pregnancy rate trends and biomedical morbidity, but also on the consequences of sexual and reproductive behavior pattern and its path on education, work, and family life after delivery [63, 64]. In developing countries, longitudinal follow-up studies of teenage mothers have observed that the mother-son binomial is a strong candidate to lead-up to poverty from one generation to the next one, especially when the father is absent, because in addition to producing economic deprivation it has a negative effect on the child's socialization process [63, 65]. The disadvantage situation of the adolescent mother tends to be repeat harder on her daughter, who shows school problems and become pregnant earlier than her mother the reproductive and sexual behavior perpetuated [66].

### **3.5 Motherhood in ethnic groups**

Finally, some reflections on poverty and reproductive health of women from Mapuche ethnicity. In Chile, poverty and marginalization are eminently rural and affect, mostly, to the regions with a highest proportion of rural and indigenous population [67]. In a study carried out in a rural area of southern Chile, a social reality of accumulated disadvantages and a situation of vulnerability was observed in Mapuche's women whose determinants of the inequity and discrimination were gender (woman), ethnicity (indigenous), class (poverty) and territory (rural) [68]. Many of the health risks of indigenous women were directly related to their reproductive health, since they had a high fertility rate, early motherhood, short birth interval and poor access to family planning services [68]. Another study analyzed the relative risk (RR) concepts of perinatal mortality and the findings revealed a direct relation between maternal poverty of Mapuche's women and perinatal mortality [69].

## **4. Public health policy management**

There is concrete evidence that gender stereotypes are maintained and naturalized in health policies and programs [70]. Women's health programs have paid more attention to aspects related to reproductive health rather than to reproductive rights [71]. Everyday life elements present in people's life style has been rescued and put in a leading role by promotion and prevention programs, however, they are partially included in the institutional practice.



Regarding the health care providers and the female users of the public health network, the trend is to regulate the habits, modify beliefs and cancel the explanations reports by women. That is, it is excluded people's social dimension and cultural meanings [71]. Consultant women tend to inform their cases relating their symptoms to diverse aspects of their daily lives, as well as with their own opinions and beliefs about what is happening to them. For their part, health professionals emphasize objectivity and the separation between the subject who knows and the objects that are known, they tend to direct the conversation in strictly clinical terms, without allowing women to express themselves as they wish. Professionals decide what issues are appropriate and what not to manage the context of the interview. This hierarchical relationship is exacerbated in case of lower-class women and represents the fundamental asymmetry that explains many of the disagreements between providers and female users. This form of social interaction categorizes the human reproduction as a biological event, which establishes the basis to exclude the contextualization [72].

It is in these poverty contexts, where the challenge is generated for midwifery professionals to open a space to make effective the sexual and reproductive rights and, as a consequence, to modify the inequalities relationships in the reproduction and sexual day-to-day labour. This space gives an opportunity for midwives and social science professionals to give an integrated contribution to acknowledge the existing bonds between the women's health condition and the socially structured environments where they live. The changes required in the models and processes of "how to do, with what and whom with" are due to the scenarios of deep and complex social transformations generated by the growing social inequality [73, 74]. Due to the above mentioned, it is imperative to give better and greater attention to the poorest, most vulnerable, and unprotected groups, not only to strengthen prevention and promote skills that allow them their sexual and reproductive rights, but also to facilitate resilience, personal and family psycho-social development and respect for their social rights [37]. On the other hand, from the lessons learned in the Primary Health Care, the evaluation of the effectiveness of the transfer benefits of the social programs is key in the development of capabilities in the integrated management of the Primary Health Care level and from the intersector, because they are in a privilege position to take the challenge and commitment to guarantee the access to benefits to vulnerable people [75].

The general and local social, economic and political situation deserves to make balances and permanent checking on the sexual and reproductive health management to primary health level as a way to keep a dialog among the different institutions in charge to execute preventive convergent policies. In this balance, social and human capital women's in vulnerable societies require leaders that create bonds, trust, and social networks to construct synergy processes where the appreciation and mutual respect coexist [76]. Due this, it is urgent a permanent strengthening of female and male midwives as managers and executors of humanized reproductive health policy and social protection, increase the etno-cultural knowledge, apply gender perspective in health practice, strengthen management in integrated network and participate in the local analysis of integrated information systems [76].

## **5. How to reduce the consequences of social inequality on the results of reproductive health in socially vulnerable women's?**

It has already been noted that income inequalities contribute to health inequality, regardless of universal access to health systems. In addition, it has been noted that Chile has one of the greater concentrations of wealth and one of the higher levels of inequality the world [77]. Social, economic, cultural and politic determinants had allowed to understand the mechanism underlying the production processes of these



health inequalities. Therefore, estimating that reducing the adverse consequences of reproductive health could be remedied through the distribution of wealth is a true possibility, but for a very long term and practically utopian in the developing countries.

The mitigation of the poor results in reproductive health in poor communities, must focus on the changes required by the segmented and fragmented health practice, both in health programs as well as in social programs. The best practices for an integrated management are reached through the articulation of activities and fluid relations between disciplines, professions, departments, institutions, and organizations [78]. Thus, it is overcome the ambivalence of the responsibilities and the institutional segmentation in the execution of the reproductive health policy, among other [79].

Reality shows that the construction of disciplinary knowledge has been performed through activities governed by models and/or paradigms that organize the thinking and mutilated vision of reality. In Chile, midwives working in primary health care recognize poor skills to address complex social problems that affect women's healthy [80, 81]. The health practice has been developed excessively segmented and without communication, which is a culture of fragmented work that just benefits to those who apply specific perspectives and do not solve collective issues of greater social complexity. The fragmentation is the heart of ineffectiveness because it determines a poor link between health systems and social systems [79]. To achieve an approximation to what people, require an accurate diagnosis is needed, which must necessarily represent the psychosocial reality of the groups with which we will work and, have as much knowledge as possible of the forms of solution from people's own perspectives, of what they recognize as problems and what they want as a solution.

For this reason, the opportunity to take on the task is an ethical and social responsibility imperative. Today it is required to assume a transdisciplinary approach as a form of cooperation among the different disciplines, since health problems are extraordinarily complex, and their study can just be performed through the convergence and combination of different perspectives [82]. The interaction between the disciplines results on an intercommunication and mutual enrichment with a transformation of research methodologies, fundamental concepts and terminologies modification. There is a balance of power in the established relations, where the teamwork negotiation facilitates all sorts of clarifications and debates about methodological, conceptual, and ideological issues [83]. Transdisciplinary promotes the development of skills related to complex thinking, divergent thinking, adaptability, sensitivity to other people, risk acceptance, acceptance of diversity and new roles in integrated management networks.

In this scenario, the challenge for the professional empowerment for midwifery is related to changes in the pre- and postgraduate training of midwives. It begins in a transformative process with innovations and relevance in the design of educational practices linked to behaviors and social changes, for the generation of competencies and capacities of human capital with a gender and transdisciplinary perspective [84, 85]. The gender perspective allows work teams to eliminate stereotypes as a substrate of gender inequality, stigma and prejudice and the transdisciplinary perspective facilitates the understanding of the entire network of interactions and contradictions that occur between the different phenomena, where the complexity and uncertainty of the results of an action prevail [84, 85]. The observation and analysis of the social reality of health through transdiscipline breaks with the barriers of static and intolerant professional profiles, to rethink knowledge from a cognitive continuum in which one dialogs and constructs collectively, to overcome disparities and inequality in reproductive health among socially vulnerable women [86].

In short, both for public policy managers and in the health and social sciences academia, the biomedical and medicalized model must be complemented by the psychosocial model by the complexity of interactions between biological,

psychological, and socio-cultural components that health problems have. The optimization of qualitative results at the primary level of health care requires examining and reflecting on how problems are constituted, contextualizing the individual and collective social reality, defining its territoriality, and then building, together with the care subjects, a collective strategy that enhances the assets and strategies of action of women, families, households, and community group. For the systemic resolution of complex problems, the formation of competencies and skills of a relevant and effective health practice using a sequenced combination in three strategic axes is essential: a) selection of critical cases that induce critical, reflective, and creative thinking with integrative work methodologies. Creativity is the ability to think, produce and act innovatively in the various fields of social action; b) Case study with advice and monitoring of inclusive and simultaneous work with students of careers in Health, Law, Informatics, Sociology and Anthropology, among others, to incorporate methodological procedures that allow them to recognize the assets and liabilities of women-families-households and communities and to define territorial areas with vulnerability and social exclusion and, c) Training academics in problem-based learning methodologies, problem solving, evidence-based medicine and communication and expression implemented in an educational practice focused on learning. This strategy generates synergy in the social and cultural construction of knowledge, improves understanding from the perspective of the other and achieves learning situated in the social reality where the experiences of life and health of women are realized. Also, the ability to tolerate diversity, appreciate the points of view of others (intellectual empathy), collaborate in a productive way in a group, and communicate their thinking will be strengthened in future professionals. In this way, the resolution capacity of transdisciplinary teams is improved, which is the way to overcome the segmentation and fragmentation of public management in reproductive health, and, as a result, to ensure the delivery of timely and relevant support to the vulnerable population.

## **6. Management proposals for the development of competencies and skills in integrated health practice**

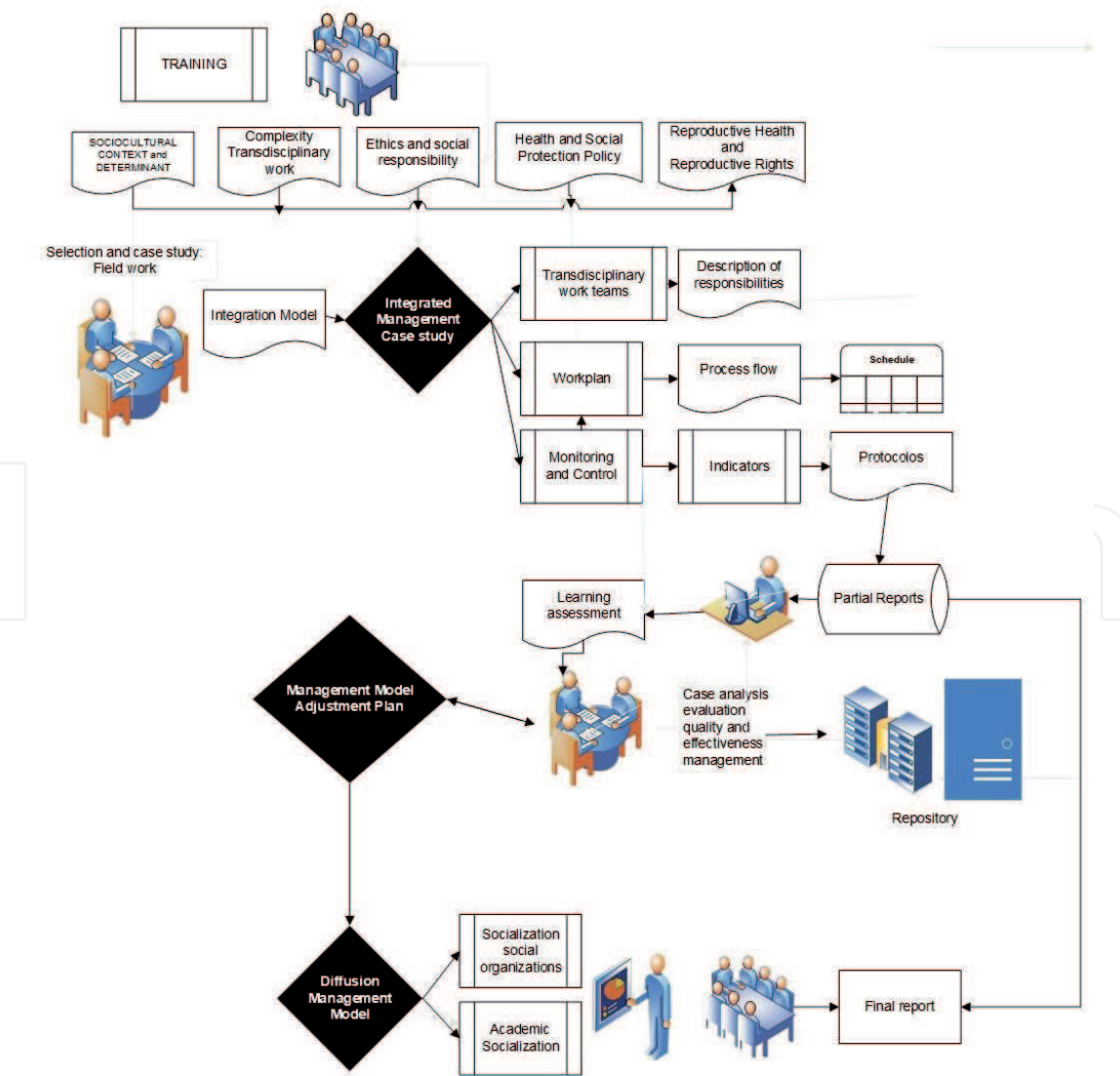
### **6.1 Building alliances from transdisciplinarity for the integrated care of reproductive health**

A management model is designed for the process of transferring benefits from programs linked to the Social Protection Network in a public family health center located in a territorial area with highly socially vulnerable neighborhoods. The design of the management model takes as reference the following assumptions i) service providers and students in practice, from health and social sciences careers, have a partial view of the social reality and lack of knowledge of the social determinants affecting the health and reproductive health of women with a history of early motherhood, unplanned pregnancy, domestic violence, immigrant women, women of the Mapuche ethnic group; ii) complexity and diversity of social dynamics; iii) low level of knowledge of public social protection policy; iv) fragmentation of work at the primary level of health care and, with the intersector; v) fragmentation of institutional databases; vi) basic capabilities for the processing and analysis of databases of the Red Protege in health centers and local government departments; and vii) value dilemmas, the social commitment and accumulated experience of the work teams. For this reason, the management model is created with the work teams involved, because the endogenous development of the change processes, accompanied by experts, facilitates the adoption of innovations, and minimizes resistance to change. The design and implementation will be carried out in a process that is structured in four axes:

- i. To “literature” teams on the socio-cultural context and social determinants, based on evidence from the target population.
- ii. Training in the content and foundations of public policy on social protection, ethics, and social commitment.
- iii. Development of integrated working practices, use of participatory methodologies, formulation of learning strategies, design of manuals, guides and protocols according to the contents of the associated programmes of the Social Protection Network.
- iv. Design of the monitoring and systematization process of benefit transfer records.

Participation in the intervention will be voluntary and the decision will be made by the woman once she knows the objectives, its procedures, is able to assess its costs and benefits, her questions are answered and explain the content of the Informed Consent Act for signature.

The design, implementation and application are represented in a process flow diagram (Figure 1).



**Figure 1.**  
*Management of integrated processes in reproductive health in primary health care.*

## **6.2 Model for promoting of sexual and reproductive rights in rural women**

Women living in rural areas socialize their lives in an environment where there is no stimulus. This kind of socialization has perpetuated a condition of procrastination, subordination, inequality, and exclusion that make the practice of the exercise of sexual and reproductive rights unfeasible, as set out in the Cairo Plan of Action and the Beijing World Women's Conference. On the other hand, the institutional social resources responsible for the promotion of these rights, for various reasons, have not been effective in managing to position women as subjects of right in the definition of their sexual and reproductive life. The proposed Active Communication Strategy Model for Rural Women (MECAR) is a complementary instruction/information alternative that seeks to promote the empowerment of rural women around the exercise of sexual and reproductive rights.

The challenge of opening a space for the effective exercise of sexual and reproductive rights and, as a consequence, to modify relations of inequality in the work of reproduction and sexuality opens up a possibility, for health and social sciences professionals and students, to contribute to the recognition of the links between women's health status and the socially structured environments in which women live.

MECAR model objectives:

- To recognize socio-cultural traits; level of knowledge, beliefs, and practices of sexual and reproductive rights; characterize power relations in the couple and family; define the type of functioning and conflicts of the family, parenting models and social support networks for rural women.
- To know the types and forms of use of the media of the population subject to the intervention.
- To design a communication model for the promotion and exercise of sexual and reproductive rights based on the manifest and latent needs of women in a selected rural community.
- To know the institutional context of norms, perceptions, and information level of health service providers regarding human rights, sexual rights, reproductive rights, sexual and reproductive health concepts and women's health program content before and after the intervention.
- To know the types and forms of use of women's health services related to sexual and reproductive health, in official and alternative health centers, before and after the intervention.
- To know and compare the conditions of access, availability, and degree of use of services by rural women before and after the intervention
- Dimension the impact of the intervention on the awareness and practice of human rights, sexual rights, and reproductive rights; family functioning; power relations in the family.

Expected result of MECAR: To obtain an approach to the degree of change and contribution that MECAR produces to the process of strengthening women's self-management and self-determination to begin the path that will allow them to assume their condition as subjects of rights responsible for their life project.



Methodology: the intervention, MECAR, uses the sequenced combination of a communication strategy and interactive sessions as complementary alternatives to education on sexual and reproductive rights. The idea is to apply the model generated from the customs and traditions of the rural women's population, respecting the idiosyncrasies of their socio-cultural context, also incorporating official and traditional health resources.

MECAR has two essential components: instruction/information actions aimed at promoting reproductive rights and sexual rights for rural women, and instruction/information actions for the health team and formal and informal health leaders. A transdisciplinary team will implement instruction/information activities through a communication strategy and group workshops and analysis meetings with women, health care providers and other local leaders (active strategy).

The model operates through the following thematic axes: Gender Concept and Relations; Communication and Identity; Safe Shared Sexuality and Motherhood; Constitutional, Legal and Human Rights; Reproductive Rights and Reproductive Health; Family Planning; Prevalent and Emerging Diseases of Women; Sexually Transmitted Diseases; Adolescence and Sexuality; Women's Program Health Services; Prevention and Consequences of Physical Abuse; Family and Parenting, Role of Mother and Father, Community Participation and Leadership, and Creation; Legal protection against actions of violation of rights.

The contents will be developed in 16 radio modules and reinforced with group workshops, using active, participatory, experiential, and reflective methodology, which has as its central axis the commitment of the person, their experiences and learning of life. This methodology provides the only opportunity for participants to discover their own knowledge and the ability to learn new and diverse content related to the situation they face. The activities will be implemented with teaching-learning modules that allow women to replicate them in their family and community context. Each module will have predefined objectives, themes and methodology in which practical and theoretical activities will be combined. An important component of each module is the evaluation process because it allows for feedback to the program. The symbology and codes used in the module design are adapted to the population receiving the intervention.

In parallel, training activities are carried out for professionals and students in gender relations, reproductive health and sexuality; human rights, sexual and reproductive rights; quality of provider-user interaction for health service providers, doctors, midwives, dentists, nurses, paramedical assistants, administrative and service personnel, with monitoring and evaluation of baseline behaviors before and after the application of the training, in order to contrast the responses they are able to give to behavior change in the population of participating women.

In the field, a simultaneous examination of family and community factors and resources that may facilitate or interfere with women's health-related behaviors is conducted. This will prepare the health team and students for the potential increase in demand for health services. In harmony with this model, the people who carry out the activities will establish a dialogical communication with the women to create a link in the community.

### **6.3 High complexity case study: problem-based learning construction**

It offers a space for reflection and practice of a contextualized, integrated, and flexible learning model based on problematic situations where the student defines strategies for the autonomous and collective construction of knowledge.

In this proposal, the sequential combination of three axes is used:

- a. Analysis of critical cases that induce critical thinking, reflective-conscious learning and debate using integrative work methodologies
- b. Fieldwork, consultancy and monitoring for the development of work competencies in the being, knowledge, know-how, and know-how to be in undergraduate students, community agents and officials of the intra and intersectoral.
- c. Training in constructivist methodologies of collective learning with a gender perspective, application of qualitative methodologies and social vulnerability approach, problem solving, evidence-based health care, communication-expression, and leadership.

For the first axis: An educational strategy is proposed that combines educational methodological resources related to cognitive, operational, and social relationship and interaction. Activities are proposed to strengthen skills in the use of conventional system records, interviews with program supervisors, professionals, and officials. Activities are planned with groups of women, affected by similar health problems, to learn the opinions and meanings they give to their problems and ways of solving them. Participant observation, field work, individual interviews with women. Joint presentation of the analysis of critical situations in a round table with the participation of experts Training and monitoring activities for the use of resource networks such as: data banks and networks, documentary networks, project banks, scientific cooperation networks, governmental and non-governmental community resources. The integrated participation of students from schools of the Faculty of Medicine, Law, Informatics and Anthropology, community agents, specialists and officials are considered.

For the second axis, transdisciplinary systems of field work, consultancy and monitoring are implemented, both individually and collectively, according to the profile of the problems to be addressed. A cadastre of access systems is configured, as well as a map of methodological, information and social resources that will be located on a university server site.

The third axis consists of a training program expressed in seven workshops: Incorporation of the gender perspective at work, Social Vulnerability Approach, Application of qualitative methodologies for the contextualization of the social reality, Problem-based learning, Evidence-based health care, Communication-Expression, and Leadership. For the execution of these workshops there are specialists convened by invitation. Also considered is the idea of convening teams from other centers, from the intersector, to enhance the multiplier effect of the workshops. For the execution of the workshops, we count on the facilities of the primary health centers of the public network.

## 7. Conclusion

Finally, to mitigate the consequences of the growing social inequalities in reproductive health and reproductive rights, an integrated management of professionals from all social sectors is urgently needed, with networking and active community participation. It is necessary to broaden the view of reproductive health actions, understood as a network of meanings and interactions, in which women's behaviors are configured in a diversity of sociocultural, psychoaffective and political contexts. The best practices for an integrated management are reached through the articulation of activities and fluid relations between disciplines, professions, departments, institutions, and organizations In Chile, it is the alternative to correct the inequities

of the prevailing neoliberal economic model and achieve progress in the reproductive experiences of vulnerable women and families. It is a matter of justice and social responsibility. The proposed interventions contribute to the social construction of learning skills for the practice of integrated and participatory work in primary health care, where the complexity of the phenomena must be approached holistically.

### **Conflict of interest**

The author declares no conflict of interest.

### **Author details**

Estela Arcos Griffiths

External Researcher of the CSOC 10 18-19 Project Sponsored by the Universidad Playa Ancha, Chile

\*Address all correspondence to: [estelaarcos2014@gmail.com](mailto:estelaarcos2014@gmail.com)

### **IntechOpen**

© 2021 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/3.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. 

## References

- [1] Braveman P, Gruskin S. Defining equity in health. *J Epidemiol Community Health*. 2003;57:254-258. DOI: 10.1136/jech.57.4.254
- [2] Braveman P. Social conditions, health equity, and human rights. *Health an Humand Rights*. 2010;12(2):31-48. <https://www.jstor.org/stable/healhumarigh.12.2.31>
- [3] Ndiaye K, Krieger J, Warren J, Hecht M, Okuyemi K. Health Disparities and Discrimination: Three Perspectives. *J Health Dispar Res Pract*. 2008;2(3): 51-71. DOI: 10.1901/jaba.2008.2-51
- [4] Small R, Taft A, Brown S. The power of social connection and support in improving health: lessons from social support interventions with childbearing women. *BMC public health*. 2011;11: S54. DOI. org/10.1186/1471-2458-11-S5-S4
- [5] Alazraqui M, Mota E, Spinelli H. El abordaje epidemiológico de las desigualdades en salud a nivel local. *Cad. Saúde Pública*. 2007;23(2):321-330. <http://dx.doi.org/10.1590/S0102-311X2007000200008>
- [6] Puyol Á. Ethics, equity and social determinants of health. *Gac Sanit*. 2012; 26(2):178-181. [http://scielo.isciii.es/scielo.php?script=sci\\_arttext&pid=S0213-91112012000200016&lng=es](http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S0213-91112012000200016&lng=es).
- [7] Diaz A. Economía política de la desigualdad social, el reto del siglo XXI: reducir la desigualdad social. In: *Economía política de la desigualdad social Santo Domingo*, editors, Rep. Dominicana. 2018. 326 p. <https://www.researchgate.net/publication/344119510>
- [8] Araujo K. La calle y las desigualdades interaccionales. Serie Documentos de Trabajo PNUD–Desigualdad 2016;6:1-59. [https://www.cl.undp.org/content/chile/es/home/library/poverty/documentos\\_de\\_trabajo/](https://www.cl.undp.org/content/chile/es/home/library/poverty/documentos_de_trabajo/)
- [9] Baru RV, Mohan M. Globalisation and neoliberalism as structural drivers of health inequities. *Health research policy and systems*. 2018;16(Suppl1):91. DOI:10.1186/s12961-018-0365-2.
- [10] Engelgau MM, Zhang P, Jan S, Mahal A. Economic Dimensions of Health Inequities: The Role of Implementation Research. *Ethnicity & disease*. 2019;29(Suppl 1):103-112. DOI:10.18865/ed.29.S1.103
- [11] Conceição P. Más allá del ingreso, más allá de los promedios, más allá del presente. *Desigualdades del Desarrollo Humano en el siglo XXI. Informe sobre desarrollo humano. Programas de las Naciones Unidas para el Desarrollo Humano (PNUD) 2019*. [http://hdr.undp.org/sites/default/files/hdr\\_2019\\_overview\\_-\\_spanish.pdf](http://hdr.undp.org/sites/default/files/hdr_2019_overview_-_spanish.pdf)
- [12] Venkatapuram S, Bell R, Marmot M. The right to sutures: social epidemiology, human rights, and social justice. *Health and Human Rights [Internet]*. 2010; 12(2):3-16. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3694312/>
- [13] Dulin M, Tapp H, Smith H, de Hernandez B, Coffman M, Furuseth O, et al. A trans-disciplinary approach to the evaluation of social determinants of health in a Hispanic population. *BMC Public Health*. 2012;12:769. <https://doi.org/10.1186/1471-2458-12-769>
- [14] Frei R. La economía moral de la desigualdad en Chile: Un modelo para armar. Serie Documentos de trabajo. PNUD–Area Pobreza y Desigualdad. 2016/08,39p. [https://www.cl.undp.org/content/chile/es/home/library/poverty/documentos\\_de\\_trabajo/](https://www.cl.undp.org/content/chile/es/home/library/poverty/documentos_de_trabajo/)



la-economia-moral-de-la-desigualdad-en-chile.html

- [15] UNDP. The next frontier. Human development and the Anthropocene. Human Development Report. e United Nations Development Programme UNDP 2020, 412p. <http://hdr.undp.org/sites/default/files/hdr2020.pdf>
- [16] OECD. In It Together: Why Less Inequality Benefits All. 2015. <https://doi.org/10.1787/9789264235120-en>
- [17] Kmietowicz Z. Gender equality: countries are failing to deliver changes by 2030. *BMJ* 2019;365:l4049. DOI: <https://doi.org/10.1136/bmj.l4049>
- [18] Basu R.L. Poverty Removal Measures of Amartya Sen and the Smithian Dilemma. *Revista Científica Arbitrada de la Fundación MenteClara*. 2020; 5 (115). DOI: [doi.org/10.32351/rca.v5.115](https://doi.org/10.32351/rca.v5.115)
- [19] OECD. Gender Equality in the Pacific Alliance. Promoting Women's Economic Empowerment. OCDE Publishing, Paris. 2016. <https://doi.org/10.1787/9789264262959-en>
- [20] Nielsen F. Inequality and inequity. *Social Science Research*. 2017;62:29-35. <https://doi.org/10.1016/j.ssresearch.2016.12.009>
- [21] Sreenivasan G. Ethics and Epidemiology: Residual Health inequalities. *Public Health Ethics* 2009;2(3):244-249. <https://doi.org/10.1093/phe/php030>
- [22] Gutiérrez JP, Leyva Flores R, & Aracena Genao B. Social inequality in sexual and reproductive health in Ecuador: an analysis of gaps by levels of provincial poverty 2009-2015. *International Journal for Equity in Health*. 2019;18(49). <https://doi.org/10.1186/s12939-019-0951-0>
- [23] Braveman P, Gottlieb G. The Social Determinants of Health: It's Time to

- Consider the Causes of the Causes. *Public Health Reports*. 2014;129(1) S1. <https://doi.org/10.1177/00333549141291S206>
- [24] Mota, C. S., Atkin, K., Trad, L. A., & Dias A. Social disparities producing health inequities and shaping sickle cell disorder in Brazil. *Health Sociology Review*. 2017; 26(3), 280-292. <https://doi.org/10.1080/14461242.2017.1361855>
- [25] Oberman, M. Motherhood, Abortion, and the Medicalization of Poverty. *The Journal of Law, Medicine & Ethics : A Journal of the American Society of Law, Medicine & Ethics*. 2018; 46(3):665-671. <https://doi.org/10.1177/1073110518804221>
- [26] Kickbusch I. The political determinants of health—10 years on. *BMJ* 2015; 350 :h81. DOI: <https://doi.org/10.1136/bmj.h81>
- [27] Keene D, & Padilla M. Spatial stigma and health inequality. *Critical Public Health*. 2014; 24(4): 392-404. <https://doi.org/10.1080/09581596.2013.873532>
- [28] Oliver A, Healey A, & Le Grand J. Addressing health inequalities. *Lancet*. 2002; 360 (9332): 565-567. DOI: [https://doi.org/10.1016/S0140-6736\(02\)09713-1](https://doi.org/10.1016/S0140-6736(02)09713-1)
- [29] Aguilera X, Delgado I, Icaza G, Apablaza M, Villanueva L, Castillo-Laborde C. Under five and infant mortality in Chile (1990-2016): Trends, disparities, and causes of death. *Plos One*. 2020;15(9):pp. e0239974. DOI: [10.1371/journal.pone.0239974](https://doi.org/10.1371/journal.pone.0239974)
- [30] Hensher M, Zywert K. Can healthcare adapt to a world of tightening ecological constraints? Challenges on the road to a post-growth future. *BMJ*. 2020; 371: m4168. DOI: <https://doi.org/10.1136/bmj.m4168>
- [31] Cuberes D, Teignier M. Gender inequality and economic growth.

Background Paper for World Development Report 2012: Gender Equality and Development. The World Bank, Washington, DC. <https://openknowledge.worldbank.org/bitstream/handle/10986/9117/WDR2012-0019.pdf?sequence=1>

[32] Galvez T. Aspectos económicos de la equidad de género. Naciones Unidas, Comisión Económica para América Latina y El Caribe (CEPAL). Serie Mujer y Desarrollo. 2001 N° 35. Santiago de Chile. CEPAL Unidad Mujer y Desarrollo. [https://repositorio.cepal.org/bitstream/handle/11362/5882/1/S01060530\\_es.pdf](https://repositorio.cepal.org/bitstream/handle/11362/5882/1/S01060530_es.pdf) <http://www.eclac.cl/publicaciones/UnidadMujer/1/LCL1561/lcl1561e.pdf>

[33] Buvinic M, O'Donnell M. Gender Matters in Economic Empowerment Interventions: A Research Review. The World Bank Research Observer. 2019; 34 (2): 309-346. <https://doi.org/10.1093/wbro/lky004>.

[34] Dibaba, Y., Fantahun, M. & Hindin, M.J. The association of unwanted pregnancy and social support with depressive symptoms in pregnancy: evidence from rural Southwestern Ethiopia. BMC Pregnancy Childbirth 13, 135 (2013). <https://doi.org/10.1186/1471-2393-13-135>

[35] Bernazzani O, Bifulco A. Motherhood as a vulnerability factor in major depression: the role of negative pregnancy experiences. Social Science & Medicine. 2003; 56 (6): 1249-1260. [https://doi.org/10.1016/S0277-9536\(02\)00123-5](https://doi.org/10.1016/S0277-9536(02)00123-5)

[36] Aiser A, Currie J. The intergenerational transmission of inequality: Maternal disadvantage and health at birth. Science 2014; 344: 856-861. DOI: 10.1126/science.1251872

[37] Muñoz LA, Sánchez X, Arcos E, Vollrath A & Bonatti C. The motherhood experience in the context

of social vulnerability: a comprehensive approach to social phenomenology1. Rev Latino-Am. Enfermagem. 2013; 21(4), 913-919. <https://dx.doi.org/10.1590/S0104-11692013000400012>

[38] Arcos E, Muñoz LA, Sánchez X, Vollrath A, Latorre C, Bonatti C et al. Vulnerabilidad social en mujeres embarazadas de una comuna de la Región Metropolitana. Rev méd. Chile 2011, 139(6), 739-747. <https://dx.doi.org/10.4067/S0034-98872011000600007>

[39] Arcos, Estela, Canales, Mónica, Muñoz, Luz Angélica, Toffoletto, María Cecilia, Sánchez, Ximena, & Vollrath, Antonia. (2016). Invisibility of social vulnerability and social rights to a comprehensive health care in Chile. Texto & Contexto - Enfermagem, 2016;25(4), e6150015. <https://dx.doi.org/10.1590/0104-07072016006150015>

[40] Blake VK, McGowan ML. Filling a Federal Void: Promises and Perils of State Law in Addressing Women's Health Disparities. Journal of Law, Medicine & Ethics. 2020;48(3):485-90. DOI:10.1177/1073110520958873.

[41] Mattar L, Dinis C. Hieraquias reprodutivas: Maternidade e desigualdades no exercício de direitos humanos pelas mulheres. Interface (Botucatu). 2012;16(40): 107-20. <https://doi.org/10.1590/S1414-32832012005000001>.

[42] Daoud N, Urquia ML, O'Campo P, Heaman M, Janssen PA, Smylie J et al. Prevalence of Abuse and Violence Before, During, and After Pregnancy in a National Sample of Canadian Women. AJPH. 2012;102(10):1893-1901. <https://doi.org/10.2105/AJPH.2012.300843>

[43] Zheng B, Zhu X, Hu Z, Zhou W, Yu Y, Yin S et al. The prevalence of domestic violence and its association with family factors: a cross-sectional study among pregnant women in

- urban communities of Hengyang City, China. *BMC Public Health*. 2020;20(1):1-9. <https://doi.org/10.1186/s12889-020-08683-9>.
- [44] Sarkar N. The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *Journal of Obstetrics and Gynaecology*. 2008;28(3):266-271. DOI: 10.1080/01443610802042415
- [45] Mauri E, Nespoli A, Persico G, & Zobbi VF. Domestic violence during pregnancy: Midwives' experiences. *Midwifery*. 2015; 31(5):498-504. <https://doi.org/10.1016/j.midw.2015.02.002>
- [46] Bahadır-Yılma E & Küçük E. Unplanned and Risk Pregnancy, Domestic Violence and the Psychosocial Health Status of Pregnant Women in North-East Turkey. *IJCS*. 2015;8(3):585-593. <http://www.internationaljournalofcaringsciences.org/>
- [47] Finnbogadóttir H, Dykes A, Wann-Hansson C. Prevalence of domestic violence during pregnancy and related risk factors: a cross-sectional study in southern Sweden. *BMC Women's Health*. 2014;14,63. <https://doi.org/10.1186/1472-6874-14-63>
- [48] Arcos E, Uarac M, Molina I, Repossi A, Ulloa M. Impact of domestic violence on reproductive and neonatal health. *Rev. méd. Chile*. 2001;129(12):1413-1424. <https://dx.doi.org/10.4067/S0034-98872001001200007>
- [49] McKeating A, Crosby D, Collins M, O'Higgins A, McMahon L, Turner M. A longitudinal study of unplanned pregnancy in a maternity hospital setting. *International Journal of Gynecology and Obstetrics*. 2015;128:106-109. <https://doi.org/10.1016/j.ijgo.2014.08.012>
- [50] Horvath S, Schreiber C & Schreiber C A. Unintended Pregnancy, Induced Abortion, and Mental Health. *Current Psychiatry Reports*. 2017;19(11):1-6. <https://doi.org/10.1007/s11920-017-0832-4>
- [51] Bearak J, Popinchalk A, GanatraB, Moller A-B, Tunçalp Ö, Beavin C et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019. *Lancet Glob Health*. 2020;8:e1152-61. [https://doi.org/10.1016/S2214-109X\(20\)30315-6](https://doi.org/10.1016/S2214-109X(20)30315-6)
- [52] Casillas A, Bodenmann P, Epiney M, Ge'taz L, Irion O, Gaspoz JM et al. The Border of Reproductive Control: Undocumented immigration as a risk factor for unintended pregnancy in Switzerland. *J Immigrant Minority Health*. 2015;17:527-534. DOI 10.1007/s10903-013-9939-9.
- [53] Lifflander A, Gaydos LMD, Hogue CJR. Circumstances of pregnancy: low Income women in Georgia describe the difference between planned and unplanned pregnancies. *Maternal & Child Health Journal*. 2007;11(1):81-89. doi:10.1007/s10995-006-0138-3
- [54] Ministerio de Salud de Chile. Departamento de Estadística e Información de Salud. 2015: [http://extranet.deis.cl/?page\\_id=5939](http://extranet.deis.cl/?page_id=5939)
- [55] Finer L, Zolna M. Unintended pregnancy in the United States: incidence and disparities, 2006. *Contraception*. 2011;(84):478-485. <https://doi.org/10.1016/j.contraception.2011.07.013>
- [56] Coelho E, Andrade M, Vitoriano L, Souza J, Silva D, Gusmão M et al. Association between unplanned pregnancy and the socioeconomic context of women in the area of family health. *Acta paul. enferm*. 2012; 25(3): 415-422. <http://dx.doi.org/10.1590/S0103-21002012000300015>



- [57] Quelopana A, Alcalde C. Exploring Knowledge, Belief and Experiences in Sexual and Reproductive Health in Immigrant Hispanic Women. *J Immigrant Minority Health*. 2014; 16:1001-1006. DOI 10.1007/s10903-013-9807-7
- [58] Ayoola A. Late Recognition of Unintended Pregnancies. *Public Health Nurs*. 2015;32(5):462-470. DOI: 0.1111/phn.12182
- [59] Yanikkerem E, Ay S, Piro N. Planned and unplanned pregnancy: Effects on health practice and depression during pregnancy. *J Obstet Gynaecol Res*. 2013;39(1):180-187. DOI: 10.1111/j.1447-0756.2012.01958.
- [60] Kita S, Minatani M, Hikita N, Matsuzaki M, Shiraishi M, Haruna M. A Systematic Review of the Physical, Mental, Social, and Economic Problems of Immigrant Women in the Perinatal Period in Japan. *J Immigrant Minority Health*. 2015; 17:1863-1881. DOI 10.1007/s10903-015-0192-2
- [61] Munro K, Jarvis C, Munoz M, D'Souza V, Graves L. Undocumented Pregnant Women: What Does the Literature Tell Us? *J Immigrant Minority Health*. 2013; 15:281-291 DOI: 10.1007/s10903-012-9587-5
- [62] Uriguen García A, González J, Espinoza J, Hidalgo T, García F, Gallegos M et al. Embarazo en la adolescencia: ¿La nueva "epidemia" de los países en desarrollo? *Archivos Venezolanos de Farmacología y Terapéutica*. 2019;38(3):232-245.
- [63] Faisal-Cury A, Tabb K, Niciunovas G, Cunningham C, Menezes R & Huang, H. Lower education among low-income Brazilian adolescent females is associated with planned pregnancies. *International Journal of Women's Health*. 2017;9:43-48. DOI:10.2147/IJWH.S118911.
- [64] Lewis C, Faulkner M, Scarborough, M, & Berkeley B. Preventing subsequent births for low-income adolescent mothers: an exploratory investigation of mediating factors in intensive case management. *AJPH*. 2012;102(10):1862-1865. DOI:10.2105/AJPH.2012.300914
- [65] Sentell T, Câmara SMA, Ylli A, Velez M, Domingues MR, Bassani DG, et al. Data gaps in adolescent fertility surveillance in middle-income countries in Latin America and South Eastern Europe: Barriers to evidence-based health promotion. *South Eastern European Journal of Public Health (SEEJPH)*. 2019. DOI: 10.4119/seejph-1885.
- [66] González E, Molina T. Características de la maternidad adolescente de madres a hijas. *Rev. chil. obstet. ginecol*. 2007;72(6):374-382. DOI 10.4067/S0717-75262007000600004
- [67] Agostini C, Brown P, & Roman A. Estimando Indigencia y Pobreza Indígena Regional con Datos Censales y Encuestas de Hogares. *Cuad. econ*. 2010;47(135)125-150. <https://dx.doi.org/10.4067/S0717-68212010000100005>
- [68] Arcos E, Molina I, Quezada C. Equidad en salud reproductiva en mujeres Mapuches. *Sexualidad, Salud y Sociedad - Revista Latinoamericana*. 2010;5:97-118. <https://www.redalyc.org/articulo.oa?id=293323015006>
- [69] Rojas F. Pobreza y mortalidad perinatal en la población mapuche de la Araucanía. *Rev. chil. pediatr*. 2011;82(2):93-104. DOI:10.4067/S0370-41062011000200003
- [70] Cambronero-Saiz B. Gender policies and advertising and marketing practices that affect women's health. *Global Health Action*. 2013;6(1):1-6. DOI:10.3402/gha.v6i0.20372



- [71] Castro F, Edivey B, Peñaranda Correa F. Understanding the meanings of motherhood: the case of a prenatal care program in a health center in Popayán, Colombia. *Salud Colectiva*. 2011;7(3):333-45. [http://www.scielo.org.ar/scielo.php?script=sci\\_arttext&pid=S1851-82652011000400004&lng=es](http://www.scielo.org.ar/scielo.php?script=sci_arttext&pid=S1851-82652011000400004&lng=es).
- [72] Ospina Vanegas DP, Cristancho Gómez SM, Lafaurie Villamil MM, Rubio León DC. Humanización de los servicios reproductivos desde las experiencias de las mujeres: aportes para la reflexión. *Revista Cuidarte*. 2020;11(2):1-13. DOI:10.15649/cuidarte.100
- [73] García-Ramírez J, Vélez-Álvarez C. Latin-American public policy regarding social determinants of health. *Rev salud pública*. 2013; 15 (5): 731-742. <http://www.redalyc.org/articulo.oa?id=42230941007>
- [74] Stange K. The problem of fragmentation and the need for integrative solutions. *Annals of Family Medicine*. 2009; 7 (2): 100-103. DOI:10.1370/afm.971
- [75] OMS. Subsanan las desigualdades en una generación: Alcanzar la equidad sanitaria actuando sobre los determinantes sociales de la salud. Resumen analítico del informe final. Organización Mundial de la Salud. 2008. <https://apps.who.int/iris/handle/10665/69830>
- [76] Arcos E, Muñoz LA, Sánchez X, Vollrath A, Gazmuri P, Baeza M. Effectiveness of the Comprehensive Childhood Protection System for vulnerable mothers and children. *Rev Latino-Am Enfermagem*. 2013;21(5):1071-1079. <https://dx.doi.org/10.1590/S0104-11692013000500009>
- [77] Gallardo K, Varas L, Gallardo M. Inequality of opportunity in health: evidence from Chile. *Rev. saúde pública*. 2017;51:110. <https://doi.org/10.11606/S1518-8787.2017051007034>
- [78] Telo SV, WittRR. Sexual and Reproductive Health: Team Competences in Primary Health Care Services. *Ciencia & Saude Coletiva*. 2018;23(11):3481-3490. DOI:10.1590/1413-812320182311.20962016.
- [79] Okafor M, Ede V, Kinuthia R, Satcher D. Explication of a Behavioral Health-Primary Care Integration Learning Collaborative and Its Quality Improvement Implications. *Community Mental Health J*. 2018;54(8):1109-15. DOI:10.1007/s10597-017-0230-8.
- [80] Binfa L, Pantoja L, Cavada G, Labarca T, Jorquera E. Assessment Of Professional Empowerment Among Midwifery Graduates In Chile. *Journal of Practical & Professional Nursing*. 2020. DOI:10.24966/PPN-5681/100020
- [81] Binfa L, Labarca T, Jorquera E, Cavada G. Perception of Professional Empowerment among Midwifery Graduates: School of Midwifery, University of Chile. *J Midwifery Women's Health*. 2017;62(5):631-632. <https://doi.org/10.1111/jmwh.12690>
- [82] Terry AL, Brown JB, Van Hoorn R, Stewart M. Evolution and 15-year effect of a pan-Canadian training program: Transdisciplinary Understanding and Training on Research-Primary Health Care. *Can Fam Physician* 2018;64(6):475-6. <http://www.cfp.ca/content/64/6/475/tab-article-info>
- [83] Druetz T. Integrated primary health care in low- and middle-income countries: a double challenge. *BMC medical ethics*. 2018;19(Suppl 1):48. DOI:10.1186/s12910-018-0288-z.
- [84] Arcos E, Poblete J, Molina I, Miranda C, Zúñiga Y, Fecci E et al.

Gender perspective in health  
care teaching: A pending task.  
Rev. méd. chil. 2007;135(6):708-  
717. [http://dx.doi.org/10.4067/  
S0034-98872007000600004](http://dx.doi.org/10.4067/S0034-98872007000600004)

[85] Gehlert S, Murray A, Sohmer D,  
McClintock M, Conzen S, Olopade O.  
The Importance of Transdisciplinary  
Collaborations for Understanding  
and Resolving Health Disparities.  
Social Work in Public  
Health. 2010;25(3/4):408-22.  
DOI:10.1080/19371910903241124.

[86] Stewart M, Wuite S, Ramsden V,  
Burge F, Beaulieu M-D, Fortin M  
et al. Transdisciplinary understandings  
and training on research: successfully  
building research capacity in primary  
health care. Can Fam Physician.  
2014;60(6):581-2. PMCID: PMC4055331