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EXPERIENCES OF IMMIGRANT WOMEN ACCESSING HEALTH CARE IN PUNTA ARENAS, CHILE

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ABSTRACT

Objective: to understand the experience of immigrant women on access to health care in the city of Punta Arenas, Chile.
Method: a qualitative, exploratory, and descriptive approach study, in which 13 immigrant women took part. Data collection was carried out between March and July 2019, through four different focus groups. A thematic analysis was carried out.
Results: from the analysis of the participants' narratives, the following categories emerged, detailed and analyzed in the light of other studies related to the theme: Use of the health services; Satisfaction in using the health services, and Obstacles to the use of the health services.
Conclusion: in general, the immigrant population is required to know about their rights and duties as users of the health system.

DESCRIPTORS: Women. Comprehensive health care. Women's health services. Emigrants and Immigrants. Migrant receiving society. Nursing.

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EXPERIENCIAS DE LAS MUJERES INMIGRANTES EN EL ACCESO A LA SALUD EN PUNTA ARENAS, CHILE

RESUMEN

Objetivo: comprender la experiencia de las mujeres inmigrantes sobre el acceso a la salud en la ciudad de Punta Arenas, Chile.
Método: estudio de enfoque cualitativo, exploratorio, descriptivo, en el cual participaron 13 mujeres inmigrantes. La recolección de datos se realizó entre marzo y julio de 2019, a través de cuatro grupos focales distintos. Se ejecutó un análisis de tipo temático.
Resultados: a partir del análisis de las narraciones de las participantes, emergieron las siguientes categorías detalladas y analizadas a la luz de otros estudios relacionados a la temática: Utilización de los servicios de salud; Satisfacción en el uso de los servicios de salud y Barreras para el uso de los servicios de salud.
Conclusión: en general, se requiere de educación a la población inmigrante sobre sus derechos y deberes como usuario del sistema de salud.

DESCRIPTORES: Mujeres. Atención integral de salud. Servicios de salud para mujeres. Emigrantes e inmigrantes. Sociedad receptora de migrantes. Enfermería.

EXPERIÊNCIAS DAS MULHERES IMIGRANTES NO ACESSO À SAÚDE EM PUNTA ARENAS, CHILE

RESUMO

Objetivo: compreender a experiência das mulheres imigrantes sobre o acesso à saúde na cidade de Punta Arenas, no Chile.
Método: estudo qualitativo, exploratório, de abordagem descritiva, no qual participaram 13 mulheres imigrantes. A coleta de dados ocorreu entre março e julho de 2019, por meio de quatro grupos focais diferentes. Foi realizada uma análise temática.
Resultados: a partir da análise das narrativas dos participantes, emergiram as categorias analisadas à luz de outros estudos relacionados ao tema: Uso dos serviços de saúde; Satisfação no uso dos serviços de saúde e Barreiras ao uso dos serviços de saúde.
Conclusão: Em geral, é necessário promover a educação da população imigrante sobre seus direitos e deveres como usuários do sistema de saúde.

DESCRITORES: Mulheres. Atenção integral de saúde. Serviços de saúde para mulheres. Emigrantes e imigrantes. Sociedade receptora de migrantes. Enfermagem.

INTRODUCTION

The right to health for all people is recognized by the World Health Organization, which promotes equal conditions in this access, and highlights it in vulnerable groups, among which are immigrants, who, regardless of their immigration status, must be able to access to and take advantage of the highest grade of health care.

The study defined the concept of access as multidimensional, relating the constant interaction of the health systems with the individuals, where the factors of availability, acceptance, and access are in a continuous interaction that affects the health of society[1].

Chile has a mixed access health care system, where services are available to the population free of charge and also privately.[2] Access to health, through care and examinations, is carried out by diverse health networks, both public and private. In these spaces there is great variety of professionals of the most diverse specialties organized systematically throughout the national territory.

The broad coverage of health care provides the population with mostly universal access, emphasizing that these services can be public or private. This service network is considered to cover the entire national territory.[3]

Among the social determinants is migration since, when there is a significant change in territory and culture, there is also diversity and divergences of the new residence. These differences can be directly reflected in the living conditions of this population, as well as in their health, and it is necessary to reverse this situation through public policies. This diversification in terms of migration also reflects changes, not only individual, but also in the family and in the community in which it is inserted.[4] Scientific evidences have identified significant vulnerability levels around the migratory movements of the recent years,[2] an extremely relevant aspect for the governments and institutions that receive immigrants in their daily life. However, the social returns identified in this population are more strongly related to the health systems, which intensifies the importance of health care and generates significant impacts on the quality of life of these people.[5]

The increasing participation of women in the migratory movements is manifested in the fact that, today, they move with greater independence and no longer in relation to their family position or under the authority of men, but rather they represent half of the immigrant population's labor force.

Recently, there has been a significant increase in the participation of women in migration processes, following an active role in the development of governments, allowing for the identification of migration effects in certain regions. Another significant fact is the visualization of these women from a gender perspective, investigating possible internalizations from their original context to the new immersion location. This demonstrates the duty to investigate if their migration is involved with possible social stereotypes, trafficking networks, prostitution, sexual exploitation, and/or work. These factors also shed light on the importance of ensuring gender equality for women and avoiding any difficulties in reducing the labor market by harming their quality of life after changing nationality and differences in everyday cultures.[6] In Chile, immigrant women represent 67.6% of the employment rate, 20 percentage points higher than that of Chilean women, with 46.8%.[7]

A migratory report from Chile establishes, through the granting of permanent residence permits and temporary visas between 2005 and 2016, that 323,325 people obtained a definitive permit to live in Chile, increasing from 17,085 in 2010 to 53,188 in 2016, having an important growth when granting this permit to immigrants from Colombia, Venezuela and Haiti, the immigrants mainly residing in the Metropolitan regions, Antofagasta, and Tarapacá. Magallanes welcomes 0.6% (1,806 people) of immigrants with definitive permission. Regarding the national gender, 53.3% are female and the predominant age is between 30 and 44 years old.[8]

In Punta Arenas, there is a clear feminization of migration with 54.5% of a total of 3,039 immigrants coming mainly from Colombia (39%), Venezuela (17%), Argentina (11%), and Paraguay (8%).[9] The main activities carried out by the immigrants without gender difference are employees (dependents), housewives, and students.[10]

This study aims to understand the experience of immigrant women on access to health in the city of Punta Arenas, Chile.

METHOD

The research was carried out with a qualitative approach, which allows describing the experiences of immigrant women in access to health. With descriptive nature, it allowed investigating and deepening on a phenomenon slightly studied in the region due to the considerable migration in the area.

To be included in this study, the participants had to be international immigrant women (18 years old), having used public or private health services directly or indirectly in Punta Arenas, and being native Spanish speakers. Immigrants with dual nationality are excluded from this research when one of the nationalities is Chilean, as well as those immigrants who hold a nationality card at the time of the study.

Considering that the percentage of immigrants in the region is 3%, to obtain the sample contacts were made with strategic sectors to identify and contact foreign women from different countries. The sample consisted of 13 women of Venezuelan, Colombian, and Paraguayan nationality. The theoretical saturation determined the final size of the sample.

The city of Punta Arenas is located in the southernmost end of Chile; it is the most populous city in the Chilean Patagonia with 131,592 inhabitants, and corresponds to the capital of the Magallanes region.[11] It is a city that, among its population, has a heritage of Croatian, Spanish, and English immigrants as international immigrants, and *Chilotes* as national immigrants. According to the latest Urban Quality of Life Index survey, Punta Arenas ranks as the city with the best quality of life among intermediate cities –between 50,000 and 250,000 inhabitants– and, nationally, ranks fourth in terms of working conditions.[12]

As regards the health system, it has two hospitals in the public network and a private clinic, five Family Health Centers (*Centros de Salud Familiar*, CESFAM) and three Community Family Health Centers (*Centros Comunitarios de Salud Familiar*, CECOSF) belonging to the primary care network and dependents on the municipality. This network also has a Primary Emergency Care Service (*Servicio de Atención Primaria de Urgencia*, SAPU) and a Community Mental Health Center, as well as two High Resolution Medical Centers from the private sector.

Data collection was carried out between March and July 2019, where the sample of this study was identified at four different times, through institutions and organizations that had contact with migrating women, namely:

The first moment of contact was made with the president of the Venezuelan group in Patagonia in Punta Arenas, who summoned its affiliates and managed to agree on the session at the facilities of the University of Magallanes.

The second moment came through a Chilean referral, which provided the telephone number of the owner of a microenterprise, a Colombian immigrant in the city, and who has workers of her same nationality. A first meeting was held with the owner of the business and then the discussion group was held in the company's facilities.

The third moment was generated from a cleaning company that mostly works with immigrant women, the local people manager was contacted via email, and then a meeting was held with her and a second representative of that company, to finally be able to carry out the discussion group in the work place facilities where the participants were summoned.

The fourth and last moment could be settled through social networks, where a Paraguayan immigrant who markets products made a contact by telephone and finally agreed on a day for the discussion group where she and her two partners, all three of Paraguayan nationality, were present.

To identify such organizations, primary contact was settled with the Regional Ministerial Health Secretariat (*Secretaría Regional Ministerial de Salud*, SEREMI) and the immigrants' boss, who identified and provided the contacts of the main groups of immigrants living in Punta Arenas.

After direct contact with immigrants living in Chile, it was possible to identify the 13 women who met the eligibility criteria for inclusion in this study, which allowed the formation of four different focus groups and characterizes the data collection as a whole. Of the four focus groups, three were women from Venezuela, Colombia, and Paraguay (3 participants each), and the fourth group was comprised only of Venezuelans and Colombians (4 participants).

A guide instrument was used for developing the session, which lasted a mean of 45 minutes, time during which the participants were free to express what they lived and felt in their health care experiences. The session ended when the participants had no new ideas to contribute.

After the session ended, they were transcribed in detail to carry out a thematic analysis of the same and structuring of the data. As a methodological reference the proposal by Bardin[13] was used, with the aim of giving an in-depth reading of what the immigrants wanted to express, collecting the most important ideas and thoughts; for later developing this material in categories and subcategories, rescuing the central message of each experience.

To facilitate the analysis and coding of the data, computer programs were used, such as Excel and Word. This allowed for an analysis of the experience lived by the immigrant women in relation to access to health.

The ethical considerations were addressed based on the seven universal requirements of the research that was submitted to evaluation by the scientific ethical committee of the University of Magallanes, Chile, verifying that the study meets the ethical criteria that allow for protecting women's privacy, respect, and dignity.[13] All the participants read and signed the informed consent after explaining the objective of the study and its methodology. Their authorization was requested to be recorded and for subsequently disclosing the results. Each participant was assigned a fictitious name to protect their privacy.

RESULTS

From the analysis of the participants' narratives, the following detailed categories emerged and were analyzed in the light of other studies related to the theme: Use of the health services; Satisfaction in using the health services, and Obstacles to the use of the health services.

Characterization of the participants

The ages of the participants ranged from 25 to 57 years old (Mean = 39.7; Standard deviation [SD] = 9.1). Approximately 54% had high school education, 23% had completed university education, 38% were married, and 46% reported being single. 92% live with their family, a direct relative or only with their partner. Only 1 of the participants reported doing unpaid activities. Their time of residence in Punta Arenas ranged from 2 to 144 months (Mean = 57 and SD = 44.7).

Use of the health services

The participants recognize the use of the public service as a reference center for their ailments and report that, when their pathologies are complicated, they go to the emergency service; they also acknowledge having enrolled in the National Health Fund as a key to obtaining access to health care

services, mainly the CESFAM. *When we really need it, we go to the hospital urgency room* (Julia). […] *when we arrived we went to the hospital, they told us. You come here, but you have to go to the office, they already told us at the office that we had to be registered in a card* (Lidia). *I went to get the card first and because without the card they do not treat you at the office* [...] *they have to have your card* (Cristina).

The immigrants in the study also reported self-medication, preferring the use of over-the-counter medications for minor ailments and being aware that there are many drugs that they have tried to acquire and are sold under a medical prescription, with those that have the longest residence time knowing places where they can buy some of those drugs. […] *I self-medicate, if it hurts here or there* [she points to her limbs] [...] *I take something (*Andrea). *I have gone to the pharmacy and they have not sold it to me I do not have a prescription* (Mía). *I buy something at the pharmacy but go to wait if I have a little cold, no, I'm not going to the urgency room* (Cristina). […] *no, going to waste time waiting to be treated, I self-medicate* (Lidia).

The use of technicality was reported in this research and, more than hindering use, it hinders communication between the user and the health professional, the waiting times experienced by them and also those reported by third parties generate some uncertainty when they need this care and, above all, the shortage of hours for medical specialists generates fear, since they consider that if access is difficult for the natives, it is even more difficult for foreigners. […] *I do a cervical exam every year and in my country in 3 to 8 days it is ready and you must go fetch it and take to your doctor* […] *I am surprised that they told me that if it went wrong they would call me* […] *is that how it works here?* [...] *or is it because I'm a foreigner?* (María). […] *they told me in the office, have you taken the "PAP"?* [...] *I thought, what are they talking about? I remained silent and the matron repeated it. I did not understand what she was talking about* (Romina). […] *in my first ultrasound in Chile on my pregnancy the doctor told me: "uncover your tummy so that we can see your baby", I remained still because I didn't understand what they were saying to me* (Rocío). […] *in my country people wait for surgery, for example, but never like here, they don't call you* (Julia). […] *in my country it is more accessible to find a specialist, there is more variety, more access* (Lidia). […] *if someone gets sick with a cancer-like disease, it will be very difficult to treat* […] *I have always thought that if someone gets a serious disease, the person will have to go* [...] *get out of here* [...] *but what if you do not have? It has to be limited to what it is possible to offer* (Norma). […] *The other thing is that here you ask for an appointment with a specialist, and they don't give it to you for a week or fifteen days no Even three months, four months, if I have an ulcer in four months from now, I will be bleeding to death!* (Catalina).

Satisfaction in the use of the health services

It is known that immigration proposes an adjustment that the health system and its personnel must make: it is the challenge of every country with a high immigration rate. Thus, this research shows that immigrant women classify the care received as good, referring that they have professional teams, technological teams, medications, etc. What they highlight is the personal care they receive, which seems below the average to them, reporting experiences of discrimination, depersonalized treatment, noticing certain differences compared to the natives, and generating distrust in the care provided.

The participants pointed out that the staff is in part a capstone for obtaining medical care, even in some cases it was classified as discriminatory treatment. […] *it depends on the people who treat you... because sometimes they wake up bad and treat you badly* […] *and others wake up well and treat you well* (Cristina). And *I don't know why some of them take care of you, it doesn't have to do with how you like the girl who marks the appointment* […] *because if she does not like an immigrant, she doesn't give you the appointment, it has happened to me* [...] *I arrived when the girl was all ill-tempered, she asked me for my papers and as papers I gave her my passport* [...] *no there is no*

appointment[…] *and another one passed and she gave them the appointment* [...] *that is discrimination, it has happened to me several times* (Andrea).

The situations experienced by the participants refer to treatment and dissatisfaction with the health system, reporting care that is not very sensitive and distant, which provides distrust in the service. The medical figure stands out as the most criticized health professional, due to the remoteness of their care and the lack of basic medical procedures that the participants manifest that these professionals do not perform and that tend to generate mistrust and insecurity in the diagnosis and treatment with calm. […] *it is very different because in most of my appointments the doctor does not look at me, does not know the color of your eyes, arrives, writes what you have and writes down the drug 'what is it for, what is it that hurts so I'll give you this' they do not even examine you* (Julia). […] *as María says she is absolutely right ... they have equipment, medication, dental, you can do almost all the types of exams on me, that's why I'm not complaining but the doctor's part... they don't inspire trust.* (Romina). […] *I doubt they do more with the infrastructure, with good support staff, if the doctors are not good, this terrifies me* […] *in the naval hospital the cubicle opened, someone came out 'what do you have, done' on a computer screen* […] *that man didn't even explain to me that he was ordering me and when I realized it, he turned his back to me* (Rocío).

Discrimination was also verified in this study in that on some occasions the participants experienced these situations. Some of them are highlighted here. […] *as an immigrant you feel like in the limbo* [...] *because you do not know if the person who is taking care of you is doing it right or wrong, then you always ask yourself, will it work out for me* […] *could it be that they are telling me the truth* […] *will it be that they tell this to me because I am a foreigner. Many times you leave with the doubt, if the diagnosis is correct, if the medication they gave you is correct, if the procedure they gave you is correct, because you don't know if they treated you as they should or not* [...] *and you are afraid to react and discuss something because you think they will tell you what are you doing here* […] *if you don't like it leave* (María). […] *fear that it is possible to be treated differently because someone is a foreigner* […] *in Venezuela, for example, if the nurse tells me I cannot treat you now* [...] *I go and tell her how is it that you cannot treat me and blablabla…* [...] *but not here. Here, if the nurse tells me that, I soon think: if I reproach her and say something to her, the first thing she will say to me is: what you are going to tell me if you are a foreigner, go to your country and someone is going to come out of the public and I am rebuked too, then you remain silent* (María).

It can be seen that immigrant women show numerous difficulties in accessing the health services and are exposed to social determinants specific to the city where they live, which are increased by greater inequality, xenophobia, and discrimination. It is here that social and community factors become an element of the determinants that negatively affect immigrant women's access to health.

Obstacles to accessing and using the health services

This research and the accounts of the participants revealed that immigrant women in their entirety are unaware of the laws in force and effect in the country regarding health care, only one group mentioned having heard about the immigration laws. […] *The truth is I don't know, I've heard something about an emergency law* (María). […] *there must be, I have no information, but there must be* […] *because when I got pregnant, they told me that if I got sick or felt bad I should go to the hospital* […] *there must be a law that protects the pregnant woman* (Romina).

Likewise, the participants recognized that it is very difficult to navigate the local system, that information is lacking in reception areas, and that the system is disorganized, which means that care is delayed until bureaucratic procedures are obtained. […] *you arrive and do not know many things about the system, do not know where to get care, we also have no one to guide us, many people you ask, they do not guide us, they do not tell us, you know you have to go to that place* […] *at the*

beginning I asked people from here and they just gave me few answers [...] *in our case we are guided by the government and there is none to guide us* (Lidia). […] *my niece had an ear infection and an earwax plug and the doctor gave her a referral to be examined on Monday because that day was Saturday, when she went, she thought they were going to do an ear wash that same day, but they didn't give her an appointment for the 28th* […] *I don't know why if there were many people that day, I don't know how the procedure is* (Carla). *I prefer to pay a fare and be treated at the Naval Hospital* (Rocío). […] *it is possible to buy a voucher and be cared for at the milico's* [military] *place* (Catalina). *Certainly, it is clear you can be cared for* (Rocío).

Another point that stands out as an obstacle to accessing health services is the economic cost of care, since immigrant women recognize it as a great difficulty to overcome. […] *there are medications that the hospital does not give me and I am not going to buy it because it is quite expensive* (Catalina). […] *for us as immigrants at the beginning it is difficult for me, that I went and needed something and I waited, I was saying that I am lacking this medication and I went to the pharmacy and it is very expensive so what do we do we can take a little away from here* [...] *a little from there* [...] *the economic factor is very important for the immigrants* (Romina). *In some medicines I see that they are sold super expensive and the specialist ones the same, that one is expensive indeed* (Celeste). […] *we have a government system that is like FONASA, but the difference is that we do not pay, if you go with the flu, they give you the medications, they give you everything, you do not have to go shopping, you do not pay for hospitalization, surgeries or specialists, nothing. Here, it is expensive* (Julia).

DISCUSSION

The narratives of the immigrant women who took part in this study demonstrate in their speeches the ways to access health care, and the difficulties they mentioned show how this social determinant is weakened. In the context of health, from the perspective of migration, the difficulties to integrate into new lifestyles and environments intensify; there are also great vulnerabilities and risks to the health of these people and their families.[4] Within this difficulty is the access to health and the use of emergency public services as the largest provider of services for immigrants upon arrival at their destination. What the study found is that immigrants mostly use the public health services, preferring to use emergency services upon arriving at the new country.[14] Likewise, obtaining a card that enables them to use the health services is key in access to health care,[14–15] as reported by the participants in this study.

Self-medication is also a tool used by immigrants when symptoms are not important.[14] Migrants in an irregular situation often avoid formal care mechanisms for fear of being deported, resorting to self-medication,[5] which is also reported by the participants; although self-medication is a practice that is also carried out by the natives of the country, it is important to highlight that this self-medication is associated with a series of difficulties in accessing the formal services.

The main difficulties encountered for the use of the health system are widely described and often cross the obstacles to access but, among those that can be found, is language, use of technicalities, waiting times, ignorance of the current legislation, and the required administrative procedures.[14–16] Other difficulties are the complexity for navigating the health system, and the difficulty of accessing specialists and the care for different diseases or severe diagnoses.[17–18] What was especially reported by the participants is the difference in idioms within the language frame, the waiting times, and the lack of specialists among the first ones.

In a survey carried out in the city of Barcelona, it was possible to relate the satisfaction of the users regarding the health systems. From the perspective of care with immigrants, it was identified that 89% of the participants reported respectful care and 59.4% noted that immigrants were discriminated against in these same health environments. In the same survey, data were found such as 68.4% of

the participants reporting that cultural differences affect the quality of care received.[19] It is a study that approaches the reality of the participants, those who recognize the current technology, but did report perceptions of differences in treatment and access due to their immigrant status. A study conducted with immigrants in Chile found that migrant communities are not satisfied with health care, on average, 75% (35% were women) from 89 migrant countries answered negatively to this assessment, demonstrating their discontent with the medical care received.[20]

Regarding satisfaction with care, it was found in the research with some studies that the administrative staff has an impact on the perception of how care is provided on the process of access to the health system in the care centers,[15–21] which is supported by the results of this research where the administrative personnel is considered as an obstacle to access to health care.

A study with an ethnographic methodology carried out in Chile that analyzes the interactions of the staff with immigrant users identified that administrative clerks are often unaware of the specification of the migratory phenomenon and can act from their own perspective promoting cases of prejudice and xenophobia. These actions can be perceived when these staff members do not respond specifically to the requests of the immigrant patient, deny any assistance, and do not accept their registration for various reasons.[22] Regarding treatment and satisfaction, it is clear that there is no content available on this topic in the literature, that is, foreign women; in this sense, there are many studies that directly address the satisfaction of women with health care, such as a Brazilian study, which identified a satisfaction rate of 84.3% of the pregnant women with prenatal visits.[22] However, there are only a few studies that address this issue, but referring to hostile and discriminatory encounters by health professionals when accessing the health services, as well as lack of understanding and/or acceptance of cultural differences in providing care to immigrant patients.[23]

It is also highlighted that the lack of effective communication and of culturally competent care corresponds to the most critical obstacle in medical care encounters. The interactions of immigrant women with health providers. Several informants discussed some immigrants' lack of trust in the health care providers as a result of previously poor experiences. Immigrant women attributed lack of confidence to fear of discrimination, rejection, and language barriers.[17] In addition, several participants mentioned a gap in the expectations since, in a vulnerable state, they expected more caring and empathetic care than the health care providers were willing to provide.[18] Women claimed to feel ignored by the physicians simply because they are immigrants.[16] From the reports of the participants, the aforementioned coincides, but the lack of trust towards the medical professionals and the fear of expressing their opinions, desires or of demanding the care they consider appropriate and adequate are more evident; they consider as latent the possibility for suffering discrimination by the health personnel.

Regarding knowledge of the operation and laws that govern the protection of health rights for the immigrants, the study is clear: regarding the operation, it is difficult at first and, despite a long residence time, deficiencies in knowledge can still be observed and, regarding the protection laws, ignorance is absolute. The same happens in a research where ignoring how the health system works frequently generates unequal access (in view of the same need) for the immigrant population, which can even lead to their exclusion from the health services.[24]

As a social determinant of health and in its element of structural and political factors, migration describes the lack of legislation guaranteeing access to health and the existence of policies that create obstacles and affect health. The element that is related to working and living conditions must also be considered, such as lesser access to a dignified wage. These elements make migrant women make lesser use of the health services and that they find access more difficult. A study where it was observed that undocumented immigrants prefer not to attend public hospitals to care for their health problems, that preference is based on fear due to their irregular condition and, on the other hand, there

is ignorance and lack of information regarding the right to health and its unrestricted and universal nature that exists in every city where the research is carried out. There is an increasing use of the public health services in immigrants who resolve their immigration status.[25]

Ignorance of their rights and the functioning of the health system were recognized as important obstacles to access.[26] Among the main difficulties to access the health system reported by the immigrants is lack of knowledge of the current legislation and of the required administrative procedures.[14] In a 2016 study, it is described that immigrant women felt that they were not competent enough to promote personal and family health, as they had limited access and understanding of health information, lacked the necessary skills to communicate with providers health care, and had insufficient knowledge and confidence to make health-related decisions.[17]

There are reasons to avoid or interrupt the search for health, since care is mainly related to the fear of the immigrants to be rejected, to the lack of knowledge about the rights, to the organization of the health system, and to difficulties in complying with the legal conditions and access procedures. Likewise, the participants expressed that lack of knowledge on the laws that regulate access to medical care and the fact of being undocumented acted as an additional solid reason for not approaching the health care centers, as well as fear of being rejected.[15–16]

One of the studies indicates an easy and expedited access to health; it has the particularity of having been carried out in a state of the United States, where access to health is inherent to the migratory situation, since it ensures access to all its residents.[23]

All this evidence is consistent with what was found in the participants' accounts, where all the interviewees were unaware of the current and previous legislation on the protection of their health rights, so it can be assumed that many times they did not access health care due to fear or ignorance of the consequences of being recognized as undocumented.

Among the limitations that can be reported is the difficulty of meeting with three or more immigrants, since most of them work and, after that, they must take care of their relatives, so the interview technique would be easier to carry out in order to get more reports. In addition to complementing the experiences of immigrant women with that of immigrant men and carrying out quantitative studies.

It is important to reflect on the times we are currently living, where quality of life is constantly threatened by various factors, in which immigration is becoming more frequent in the search for this desired "quality of life", where lack of tolerance threatens the physical and psychological integrity of the new members of our country. It is necessary to educate in the new multiculturalism that society is in, to include humanized treatment more than ever, to talk about immigration, to learn about new cultures and what is their association with the health practices. To expand the vision of all the health professionals towards what is necessary for culturally sensitive care, this makes the study an unprecedented investigation in the region where it is developed and could mark the beginning of future research studies that will allow myths to be demolished and reduce the inequities that immigrants face in this southern zone.

When elaborating this study, the difficulty to contact the foreign women was perceived as a limitation, considering that there are no specific places or means of communication to identify them. Therefore, the deduced sample size from this study is also considered as a limitation.

CONCLUSION

In general, the experiences of immigrant women in the city of Punta Arenas have been mostly negative with many difficulties in health care access, mainly associated with ignorance, costs, and obstacles. Thus, ignorance and lack of information provided by the governmental entities that have the first contact with them is one of the main difficulties to access the health services when required

and to be able to better navigate this health system. In terms of costs, the experiences lived by the immigrant women are not far from those of the natives, due to the high health costs in Chile.

The most significant experiences reported by the participants refer to negative moments lived, where they felt fear and mistrust. There were reports of discrimination in the treatment received and of depersonalized care, experiences that can be translated into late consultation that lead to health complications. Despite this, reports were found of some participants who liked the Available fromfrastructure and technology.

Finally, these results allow us to consider that education is required for the immigrant population about their rights and duties as users of the health system. Education, promotion of inclusion and tolerance to the common population in the region. As well as furthering both quantitative and qualitative research, to fully understand the immigration phenomenon in this southern region, encompassing all the dimensions that this theme allows.

REFERENCES

1. Mcintyre D, Thiede MSB. Access as a policy-relevant concept in low and middle income countries. Health Econ Policy Law [Internet]. 2009 [cited 2019 Aug 9];4(2):179-93. Available from: https://doi.org/10.1017/S1744133109004836.
2. Gattini C, Leiva JA. Salud en Chile 2010: Panorama de la situación de salud y del sistema de salud en Chile. Santiago (CL): Organización Panamericana de la Salud [Internet]. 2011 [cited 2019 Sept 1]. Available from: http://new.paho.org/chi/images/PDFs/salud%20chile%202010.pdf
3. Observatorio Chileno de Salud Pública. Provisión de servicios asistenciales de salud. Santiago (CL): Escuela de Salud Pública; 2018.
4. Van Der Laat C. La migración como determinante social de la salud. In: Cabieses B, Bernales M, Mcintyre AM. La migración internacional como determinante social de la salud en Chile: evidencia y propuestas para políticas públicas. Santiago (CL): Universidad del Desarrollo; 2017. p. 29-38.
5. Cabieses B, Galvez P, Ajraz N. Migración internacional y salud: el aporte de las teorías sociales migratorias a las decisiones en salud pública. Rev Perú med exp salud publica [Internet]. 2018 [cited 2019 June 9]; 35(2):285-91. Available from: https://doi.org/10.17843/rpmesp.2018.352.3102.
6. Valencia YP. Perspectiva de género en los fenómenos migratorios: estudio desde Europa y América Latina. Rev Ces Derecho [Internet]. 2016 [cited 2019 Sept t 1];7(2):145-62. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S2145-77192016000200011&lng=en&nrm=iso
7. Chile. Población migrante en Chile [Internet]. Santiago: Departamento de extranjería y migración; 2017 [cited 2019 June 8]. Available from: https://www.extranjeria.gob.cl/estadisticas-migratorias
8. Chile. Encuesta de caracterización Socioeconómica Nacional: Inmigrantes principales resultados [Internet]. Santiago: Ministerio de Desarrollo Social; 2016 [cited 2019 June 8]. Available from: http://observatorio.ministeriodesarrollosocial.gob.cl/casen-multidimensional/casen/docs/CASEN_2015_INMIGRANTES_21122016_EXTENDIDA_publicada.pd
9. Chile. Población migrante en Chile [Internet]. Santiago: Departamento de extranjería y migración; 2018 [cited 2019 Jun 8]. Available from: https://www.extranjeria.gob.cl/estadisticas-migratorias/.
10. Ministerio de Desarrollo Social y Familia (Chile). Encuesta de caracterización Socioeconómica Nacional [Internet]. Santiago (CL): Ministerio de Desarrollo Social y Familia; 2018 [cited 2019 June 8]. Available from: http://observatorio.ministeriodesarrollosocial.gob.cl/casen/casen_obj.php

11. Instituto Nacional de Estadísticas (Chile). Estimaciones y proyecciones de la población de Chile 1992-2050 [Internet]. Santiago: Instituto Nacional de Estadísticas; 2018 [cited 2019 June 9]. Available from: https://www.censo2017.cl/descargas/proyecciones/metodologia-estimaciones-y-proyecciones-de-poblacion-chile-1992-2050.pdf

12. Instituto de Estudios Urbanos y Territoriales (Chile). Índice de Calidad de Vida Urbana Comunas y Ciudades de Chile [Internet]. Santiago: Camara Chilena de la Construcción; 2018 [cited 2019 Sept 1]. 54 p. Available from: http://estudiosurbanos.uc.cl/images/noticias-actividades/2018/Mayo-2018/20180508_ICVU_2018_-_Version_Definitiva.pdf

13. Bardin L. Análise de conteúdo. São Paulo, SP(BR): Edições 70; 2011.

14. Bas-Sarmiento P, Gutiérrez MF, Marín MJA, Ramírez MG. Percepciones y experiencias de acceso a los servicios de salud y su utilización en la población inmigrante. Gaceta Sanitaria [Internet]. 2015 [cited 2019 Aug 10];29(4):244-51. Available from: https://doi.org/10.1016/j.gaceta.2015.03.008

15. Pérez-Urdiales I, Goicolea I, Sebastián MS, Irazusta A, Linander I. Sub-Saharan African immigrant women's experiences of (lack of) access to appropriate healthcare in the public health system in the Basque Country, Spain. Int J Equity Health [Internet]. 2019 [cited 2019 Sept 1];18(1):2-11. Available from: https://doi.org/10.1186/s12939-019-0958-6.

16. Topa J, Nogueira C, Neves S. Experiences of Brazilian women in maternal health services. Revista Gênero & Direito [Internet]. 2016 [cited 2019 June 9];5(2):25-51. Available from: https://doi.org/10.18351/2179-7137/ged.v5n2p25-51

17. Tsai TI, Lee SYD. Health literacy as the missing link in the provision of immigrant health care: A qualitative study of Southeast Asian immigrant women in Taiwan. Int J Enfermeira Stud [Internet]. 2016 [cited 2019 June 20]; 54(1):65-74. Available from: https://doi.org/10.1016/j.ijnurstu.2015.03.021

18. Czapka EA, Sagbakken M. "Where to find those doctors?" A qualitative study on barriers and facilitators in access to and utilization of health care services by Polish migrants in Norway. BMC Health Serv Res [Internet]. 2016 [cited 2019 Aug 20];16(1):2-14. Available from: https://doi.org/10.1186/s12913-016-1715-9

19. Velasco C, Vinasco AM, Trilla A. Percepciones de un grupo de inmigrantes sobre el Sistema Nacional de Salud y sus servicios. Aten Primaria [Internet]. 2016 [cited 2019 Sept 1];48(3):149-58. Available from: https://doi.org/10.1016/j.aprim.2015.01.015

20. Vivar XLM. Evaluación de la satisfacción con el sistema de atención de salud de hombres y mujeres migrantes provenientes de Perú, Ecuador, Colombia, Bolivia y Brasil que habitan en la región metropolitana [tesis]. Santiago (CL): Escuela de Salud Pública: Universidad Mayor; 2011.

21. Greder K, Reina AS. Procuring Health: Experiences of Mexican Immigrant Women in Rural Midwestern Communities. Qual Health Res [Internet]. 2019 [cited 2019 Sept 1];29(9):1334-44. Available from: https://doi.org/10.1177/1049732318816676.

22. Gomes CBA, Dias RS, Silva WGB, Pacheco MAB, Sousa FGM, Loyola CMD. Prenatal nursing consultation: narratives of pregnant women and nurses. Texto Contexto Enferm [Internet]. 2019 [cited 2020 Mar 10];28:(e20170544):e20170544. Available from: https://doi.org/10.1590/1980-265x-tce-2017-0544

23. Lindsay AC, Oliveira MG, Wallington SF, Greaney ML, Machado MM, Pagliuca LMF, et al. Access and utilization of healthcare services in Massachusetts, United States: a qualitative study of the perspectives and experiences of Brazilian-born immigrant women. BMC Health Serv Res [Internet]. 2016 [cited 2019 Jul 14];16(1):2-8. Available from: https://doi.org/10.1186 / s12913-016-1723-9

24. Vásquez ML, Vargas I, Aller MB. Reflexiones sobre el impacto de la crisis en la salud y la atención sanitaria de la población inmigrante. Informe SESPAS 2014. Gac Sanit [Internet]. 2014 [cited 2019 Jun 30]; 28(Suppl 1):142-6. Available from: https://doi.org/10.1016/j.gaceta.2014.02.012

25. Goldberg A, Silveira C. Desigualdad social, condiciones de acceso a la salud pública y procesos de atención en inmigrantes bolivianos de Buenos Aires y São Paulo: una indagación comparativa. Saude Soc [Internet]. 2013 [cited 2019 Sept 1]; 22(2):283-97. Available from: https://doi.org/10.1590/S0104-12902013000200003

26. Pérez-Urdiales I, Goicolea I. ¿Cómo acceden las mujeres inmigrantes a los servicios sanitarios en el País Vasco? Percepciones de profesionales sanitarias. Aten Primaria [Internet]. 2018 [cited 2019 Aug 20];50(6):368-76. Available from: https://doi.org/10.1016/j.aprim.2017.05.011

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