

CICRED'S SEMINAR

**Women, reproductive health and prevention :
individual practices and public actions**

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Introduction

The characteristic of Argentinean demographic dynamics has been the magnitude of European migrations towards the end of the 19th century and the beginning of the 20th, and the relatively early birth control, that began in middle and high socio-economic population strata during the 30s and later expanded to the rest of the population, mainly the urban one (Pantelides, 1989). Poorer population strata, instead, maintained high fertility patterns and an early initiation in sexual and reproductive life. This situation rapidly led middle population strata to adopt modern contraception methods during the 60s, when it began to be well known, while poorer population did so in a lesser degree, mainly guided by cultural reasons linked to installed values favouring numerous families (López, 1998; López, 2000; López and Findling, 1998), as well as to circumstances related to this sector's health care policies and services, an item that will be considered later on.

Health care regarding Argentinean women shows inconsistencies among some of its indicators. Although life expectancy at birth is higher than in many other Latin American countries (75.7 years during the first half of the 90s), maternal mortality rates are unusually high: 41 deaths for every hundred thousand live births in 1999, a certainly underestimated number, since many deaths originated in pregnancy, childbirth or postpartum complications are registered as originated by causes that are alien to these processes (Valdés and Gomariz, 1995; Ministerio de Salud, 2000). The level of maternal mortality rates in Argentina is higher than in Cuba, Uruguay, Costa Rica and Chile, and it surpasses nearly tenfold that of Canada and the USA (4 and 6.5 for every hundred thousand live births, respectively) (Valdés and Gomariz, 1995). The main cause for maternal mortality has been, for years, induced abortions that, being illegal punish nearly exclusively poor women who decide to interrupt pregnancy and cannot afford its cost.

The subject matter that guided this research answers to various questions. In the first place, data about maternal morbidity-mortality are worrying in spite of a relatively high contraceptive use prevalence by female population in the Buenos Aires Metropolitan Area - around 65% of women in union or having sexual relations (López and Tamargo, 1996); and in the second place, proof of deficiencies in preventive practices for cervical and breast cancer seem to indicate that, once the reproductive period is over, women lose contact with health care services.

In the world-wide struggle against cancer, prevention and early diagnosis have been emphasised, and this guidance is reinforced in the case of cervical and breast tumours. In cervical cancer, it is widely accepted that female examination by means of a cervical

exfoliation cytology (Pap smear) reduces the risk of carcinoma. In the case of breast cancer, a mammography (Mx) and a breast examination (EF) reduce death rates. These advances in cancer prevention techniques have not been followed enough by education and social communication components (Klimovsky and Matos, 1996a and 1996b).

Many studies have proved that the effects of prevention in reducing death rates due to cervical-uterine and breast cancers is higher than the one obtained with other types of therapeutic advances. In spite of this fact, the frequency of these diseases is still very important: breast cancer is the first cause of cancer death for women in Argentina and in 14 of its provinces, and cervical cancer ranks first in 8 provinces.

In most Latin American countries, cervical cancer is the most frequent one, although a simple, efficient and low cost technology has been available for more than 30 years to detect it in stages that are 100% curable (Restrepo, 1990). The importance of this problem lies in the fact that lower socio-economic strata are the most affected population sectors, and they are the most unprotected in access to health care services, severely deteriorated in the Region since the economic crisis began in the 80s (PAHO, 1994). Risk factors most frequently associated to this pathology are linked to sexual and reproductive patterns: early sexual initiation, high number of deliveries and prolonged use of oral contraceptives, as well as the existence of the human papilloma virus. The factor showing best protective effects still is secondary prevention by means of vaginal cytology. Studies carried out in Argentina show deep limitations in health care services regarding their capability to transmit adequate knowledge about cytological examinations and the importance of women's participation in the follow up of positive tests. Ramos and Pantelides (1990) point out that long waiting periods in hospitals (more than 3 hours) have a negative effect on further visits to health care services.

In relation to breast cancer, and similarly to what happens in other countries, in Argentina there is a positive association between death rate levels and provinces with a higher socio-economic development (Matos et al., 1995). The most frequently mentioned risk factors are heritage, age, reproductive behaviour patterns linked to first pregnancies after the age of 30 and smaller number of children, early menarche, nutritional factors related to consumption of fats and alcohol and the prolonged use of anovulatories (OPS-PAHO, 1994).

Death rates due to female genital and breast cancer have not decreased in Argentina in spite of preventive practices. A useful information for planning prevention strategies is to know the use that women make of these practices, because this is one of the obstacles they must overcome to succeed in early detection. Knowledge of plans and programs and the analysis of campaigns related to primary prevention will also help to avoid an overlapping of actions and to design policies where women's health care needs will be followed by quality standards in health care services.

In Argentina, there is no adequate co-ordination in the execution of Public Health Care Programs geared to decrease the consequences of female genital and breast cancer, in spite of the formal approval in 1996 of a Compulsory Medical Program for Social Security, and of the National Cancer Control Program, jointly designed by several Scientific Associations and the Breast Cancer Secondary Prevention Sub-program. Part of the problem lies in the country's federal political organisation and the health care system's fragmentation, that requires that programs must be first submitted to the Health Care Federal Council and then,

each provincial Health Care Minister decides to agree, or not, to the program's implementation in his jurisdiction.

When we think of reducing morbidity and mortality from the double standpoint of public policies as a supplier of prevention and promotion health care mechanisms and the population as a demander of services, it is useful to use the concept of risk social construction. In this sense, Nathanson (1996) proposes the analysis of social and political variables as determinant of the way in which health care policies are initiated, designed and implemented. She proposes three independent and interrelated variables: 1) the State's degree of centralisation (a greater possibility of "risk construction" as a threat to the political body more than to individuals or sub-groups corresponds to a greater centralisation); 2) the presence or absence of active basis organisations (that are more solid in the more fragmented states than in the centralised ones); and 3) "risk construction" differs according to each country, and that the author exemplifies this situation with maternal-child health care policies and nicotinism in France and the USA, two countries with different styles of "risk construction".

In France, maternal-child health care originated in the need to implement policies to favour prenatal care as a stimulus to increase the mean size of families, because fertility decrease and population ageing were a State concern; on the contrary, the French state adopted a disengaged behaviour regarding regulation of private behaviour linked to consumption of cigarettes and alcohol. On the contrary, in the USA, public maternal-child care is not considered a priority and it is associated with ethnic or social minorities (that can reach important magnitudes). The American society has been relatively insensitive to collective risks but is very perceptive regarding individual ones, and this is why messages against tobacco and alcohol are centred on the risks and rights of smokers' innocent victims, of heavy drinkers and of firms.

In the international population arena, changes also occurred in risk social construction. In the 1994 Cairo Conference on Population and Development the importance of "individual rights" was stressed more than the "prosperity of nations", a prevalent concept in the World Population Conferences of Bucharest in 1974 and Mexico in 1984, where that concept was understood as the fulfilment of demographic growth goals that would guarantee the road to development.

Mary Douglas (1996), when reflecting on risk from the Social Sciences perspective, says that each society elaborates its own regulations on mutual responsibility, judgement and reward, and that a social system must ask itself about the kind of society it wishes to be and not about which risk is acceptable. In the answers to these questions, a vast range of ethical systems will appear, and conflicts will undoubtedly arise. The important issue for the understanding of social risk construction lies in the interaction between social processes and shared values. The perception of risk in everyday life goes hand in hand with the perception of health care and it is related to the capability to face situations, with responsibility and reciprocity. The more a person is isolated and the more disperse is his/her social network, the more he/she will tend to decide upon his/her own risk rules. On the contrary, communities tend to determine which damages may be prevented and to do so, they install a series of values that define whether different events may be considered severe or slight. Aspects acquired during the socialisation process influence the socio-cultural and economic differentiation that exists among a society's individuals, but this does not mean that they are unmoveable. Bourdieu's (1985) contribution, stating that

cultural productions historically accumulated in societies do not equally belong to all individuals, but to those who detain the means and knowledge to appropriate them, is interpreted in the same sense. This idea remits to a heterogeneity of ways by which access and accumulation of cultural goods determine different life styles, according to the possibilities of reaching them.

This study is part of the Project “Salud reproductiva, prácticas preventivas y acciones públicas”¹ (Reproductive health, preventive practices and public actions) and it has been financed by the University of Buenos Aires. The object is to study reproductive health care governmental programs and the preventive practices that women from different social strata have in the City of Buenos Aires (CBA), capital city of the Argentine Republic. Reproductive health care is defined as care during pregnancy, childbirth, postpartum, contraception, cervical and breast cancer, post-menopausal disorders such as osteoporosis, and sexually transmitted infections including HIV/AIDS. To fulfil the study’s objectives, in the first section Health Care Programs related to reproductive health care prevention are described and analysed, as well as in depth interviews to persons responsible for CBA Programs. The results of a quantitative telephone survey that questioned women aged 15 to 69, living in CBA, about their reproductive and preventive practices, are examined in the second part.

1. Reproductive Health Care Program in the City of Buenos Aires

1.1. The socio-spatial context and its influence area

The characteristics of socio-demographic dynamics in the City of Buenos Aires, whose population is nearly 3 million inhabitants (8% of the country’s total) are:

- a) health care indicators similar to those of developed countries;
- b) low or moderate fertility;
- c) larger middle classes, a more comfortable income level and occupational situation, high education levels, small sized families;
- d) families originated from European migrations (López, 1998).

The CBA government uses a large portion of its budget for health care of its more unprotected inhabitants and of those who live in suburbs but do not attend to their health locally, through a network conformed by 33 Hospitals and Health Care Centres (for primary health care).

1.2. Reproductive Health Care Prevention Programs in CBA

Table 1 shows a summary of different aspects of these Programs and of the CBA Reproductive Health Care Law, and Table 2, the characteristics of women attended by the Cervical and Breast Cancer Prevention Program.

¹ The research team is composed by Elsa López (Project Director), Liliana Findling, Andrea Federico, Carolina Peterlini, Marisa Ponce and Patricia Schwarz, who have collaborated in all the research stages.

Table 1. Programs and Reproductive Health Care Law, CBA

Program	Branch Office	Objectives and activities
Program of Reproductive Health (RHP)	Health Secretariat	To decrease morbidity and mortality in high bio-psycho-social risk sectors. Control and attention in health care centres, emphasising the use of contraceptives and their distribution, and education workshops.
Programs PAP and Breast (PBP)	Woman Office Social Promotion, by agreement with the Health Secretariat.	Access to PAP and Mammography in public hospitals (it does not include Health Care Centres), organising schedules and appointments by means of a free telephone line.
Adjunct AIDS Direction (SIDA)	Health Secretariat	Area created in December 2000. It co-ordinates and articulates all AIDS activities in the City, with a multidisciplinary approach, promoting prevention, assistance and laboratory networks, jointly working with civil society's organisations. It intends working with access to contraceptives and treatment and harm reduction.
Council for Children and Adolescent Rights	Conformed by health care, education, culture, social promotion and human rights areas.	To shelter "street children" and to prevent precocious pregnancies, as well as sexually transmitted diseases in adolescents. Workshops are carried out at schools, after classes, for students during their first years in secondary education.

Reproductive Health Care Law for the City of Buenos Aires: it was approved in June 2000. Its objectives are: to prevent, through education and information, induced abortions and unplanned pregnancies; to promote responsible parenthood; to attend adolescents in relation to reproductive aspects; to increase psycho-prophylactic childbirth services and to promote the benefits of breast feeding; to attend infertility and sterility problems; to disseminate information about prevention, and to provide early diagnosis and treatment for AIDS, STI and genital-breast pathologies.

This Law was approved in other Argentinean Provinces, but it has not yet been approved at a national level.

Table 2. Women attended by the Cervical and Breast Cancer Prevention Program (PPM) according to different characteristics. City of Buenos Aires. 1998 and 1999. In percentages.

Age	P A P SMEAR	Breast
15 – 24	17.0	2.4
25 – 34	28.2	24.7
35 – 44	26.7	30.4
45 – 54	18.8	28.2
55 or more	9.2	14.4
Place of Residence		
City of B.A.	56.8	60.7
Suburbs of B.A.	43.2	39.3
Social Security		
Does not have	86.1	86.5
Economic activity condition		
Inactive	51.8	58.1
Source of information		
Press	PAP SMEAR	Breast
	6.8	5.3
Publicity	33.0	31.5
Radio	3.0	4.9
T V	49.7	56.0
Other	7.1	2.2
Time term of practices		
Less than 2 years	20.3	No data
2 to 4 years	34.4	“ “
5 to 9 years	29.8	“ “
10 years and more	9.3	“ “
Never	6.2	“ “
Total	31.871	12.813
Total attended women	44.684	

Source: Dirección General de la Mujer (Woman Office), based on information from Dirección de Estadística de la Secretaría de Salud de la CBA. 2001.

The great majority of women (86%) who seek attention have no access to social security, half of them are economically inactive and 4 out of 10 do not live in the City of Buenos Aires. Information about Pap smear and mammography was mainly through television.

1.3. What do persons responsible for the Programs say?

Interviews were carried out with persons responsible for different Reproductive Health Care Programs, using an Interview Guide that questioned about the Program's background, target population, activities carried out, institutional ambits where they are carried out, achievements, difficulties in implementation, production of information, relations between the Program and other Health Care Public Administration levels or programs, results evaluation, dissemination, prevention campaigns and their evaluation, and the incidence of the Reproductive Health Care Law on the Program.

1.3.1. Programs' Background

The Reproductive Health Program (RHP) was created in 1986. It stated "*a perspective centred in the attention of adolescents from a point of view that combined medical aspects with bio-psycho-social ones*". This perspective was a conflicting one during the 80s, mainly because officers in charge of health care decisions were strongly influenced by anti-neomalthusian ideas and mistook the concept of reproductive health care, taking it for the experiences that guided birth control in developing countries during the 60s and 70s. This situation explains some of the reasons why neither World Fertility Survey nor Demographic and Health Survey were carried out in Argentina.

At the beginnings of RHP, AIDS was not a central axis among its activities: "*it was not a problem as important as it became later*". The situation of adolescents was also different, "*because as a result of precocious sexual initiation, there was an increase in the number of pregnancies in young girls, mainly aged 12 to 15, belonging to popular sectors*".

The Pap Smear and Breast Program (PBP) began its activities in 1998 as a result of an agreement between the Woman Office and the Health Secretariat: "*the agreement was to extend schedules for Pap smears and mammography until 7:00 in the evening in 6 Buenos Aires hospitals; at the same time, when it became clear that women did not frequently have these examinations taken, a free telephone line was opened 0-800-Mujer (Woman)*". At the beginning, this telephone line was used exclusively by the Program, "*although later on it was used for other matters and, at present, it includes a call centre for cases of violence in general, violence and maltreatment to minors, general information, prevention and AIDS*".

1.3.2. Programs' Organisation

60% of the female population attending RHP live in the City of Buenos Aires and 40% in its suburban area. At the beginning of the Program, contraceptives distributed among women were laboratory donations. At present, a special budget, with funds originated in the Buenos Aires Bingo, is used to buy supplies for all contraceptive methods approved by the Reproductive Health Care Law (last generation hormonal methods, mechanical and barrier methods), and these are freely distributed in all public health care establishments. Also, sifting material for early detection of sexually transmitted diseases are bought.

RHP operates in all public hospitals and health care centres in the City of Buenos Aires, although with different human resources and organisation profiles: "*some establishments mainly work in assistance, while others do so in prevention; in some of them, there are more physicians who work in Gynaecology or Obstetrics and are in charge of assistance; in other ones, there are more social workers and psychologists that guide women in health care promotion and prevention issues; there are some Medical Internships participating in this Program, such as Health Care Education or General Practice*".

RHP prevention activities include workshops in hospital waiting rooms, in Paediatric and Adolescent Departments, in Health Care Centres and community ambits: *“there are activities for adolescents, for women, and for mothers during prenatal, childbirth and post-partum periods. Health Care Centres mainly work with adolescents because they are easily located there”*.

Human resources are scarce: *“there is not enough staff for education activities, RHP does not have its own human resources, and this means that work in all hospitals and health care centres must be carried out with funds from the general budget and with professionals belonging to their own staff. There are no special teams, and in many places, primary prevention activities are not adequately co-ordinated; each Director or Department Chief operates according to his own criteria and certain Program guidelines”*.

The responsible persons in charge of Pap smear and Breast Programs (PBP) in each hospital are the Gynaecology Department Chief and a Co-ordinator from the Woman Office: *“once a woman phones through the free line and obtains an appointment, she is received by a person from the Woman Office, who waits for women during the extended timetable; with this extended schedule women assist more frequently. This proves that one of the factors of why women did not have their examinations done, was the exclusively morning timetable, because it was difficult to go to Hospital to ask for an appointment that would take place 2 or 3 months later. At present, delays are a week to the most. The Program’s expenses depend from the Health Secretariat’s budget (gynaecologists’ overtime, use of mammography equipment, disposable elements) and the Woman Office”*.

There are no access limitations to PBP: *“women come from the Municipalities that surround the City of Buenos Aires and from the City itself. Between 60% and 80% of demands attended by the City’s Health Secretariat come from women who live in the suburbs, and the same proportion is registered in calls to the Woman Office against family violence. This is an extremely difficult situation to face in the City of Buenos Aires due to the extreme poverty of suburban population and to the relative proximity of some City Hospitals located on the limits of the Province of Buenos Aires”*.

The original idea behind the Smear and Breast Program was to cover 180 thousand women in 3 years, but this goal has not been fulfilled: *“until 2000, 50 thousand women demanded to be attended by the Program, possibly due to the fact that it had not been extended to Health Care Centres. People who attend Health Care Centres near their dwellings do not go to Hospital unless they suffer a severe pathology. It would have been desirable for professionals to go to Health Care Centres, but this was not achieved. In spite of the fact that there were no campaigns, demand grew either from mouth to mouth communication, or by Hospital brochures or women sent by their physicians”*.

1.3.3. Programs’ heterogeneity and diversity

The difficulties implied in the lack of having its own team, deems it quite impossible for RHP to design an homogeneous action line: *“at times there were hospitals where Responsible Procreation Programs were impossible due to a decision taken by its Director. At the same time, the same Director would not hinder the development of those Programs if they were developed in the Hospital’s Health Care Centre. If someone would insist on the existence of a Law, arguments would be that there were no speculums, ultrasound equipment or human resources. Since then, work is carried out by being more flexible, understanding and self assured”*. Changes have been progressive, and *“professionals are*

now more open and permissive. It is the doctor's right to refuse to put an IUD or to advise against the use of contraceptives, but this does not stop other physicians from doing it". (RHP)

"Results are not obtained from one day to the next in changing women care patterns either. Different peculiarities must be taken into account. In the City of Buenos Aires, each person has a different way of taking care and different beliefs that cannot be changed from one day to another. It is important to stress that the application of reproductive rights in hospitals depends from the Director's ideology, and this is the determining factor for the implementation, or not, of policies and programs. Nevertheless, or precisely due to this, Health care Centres advise on the use of contraceptives even if the Director is against them. It is a kind of transgression and everybody knows it". (PBP)

1.3.4. Inter-institutional co-ordination

During the 15 years in which RHP has been working, changes have been produced in prevention, mainly through connections with other health care sectors and other Buenos Aires Government areas, *"but, there are still no formal policy agreements –that should be a priority- with the public education sector, so that activities are carried out through agreements with school authorities in different areas, who have contacted us after finding pregnant students aged 12 to 16"*.

A matter that must be pointed out is that the establishment of formal agreements between different government areas complicates actions: *"it seems that there are structural, formal, administrative and bureaucratic matters and the result is that everything is a standstill". (RHP).*

This opinion is sustained by almost all persons responsible for Programs: *"the experience of joint work indicates that the union of different administration sectors sounds marvellous in documents and speeches, but when it comes down to everyday work, there are always conflicts". (PBP)*

In spite of conflicts, team work is good: *"Co-ordination with the Council for Children and Adolescent Rights is a good one, because Law 114 establishes the creation of a specific organisation for it. Work is jointly carried out with the AIDS Direction, for training and they also receive support in the provision of supplies until they can start buying, there are workshops in Woman Centres, and advice is given on the management of Reproductive Health Program to groups working on violence. There are contacts with the National Health Ministry". (RHP)*

1.3.5. Achievements, problems and challenges

It is difficult to separate achievements from problems because there are strong connections between them. The following matters are pointed out by RHP: *"the most important achievement is a growing demand for reproductive health care consultation, in spite of the fact that there is still a long road ahead: first, to improve the program's operation regarding its organisation and, second, to attend demands with quality standards to all those who require it, enlarging attention timetables".* Undoubtedly, interdisciplinary team work has been an achievement *"because since the beginning, there was much resistance; RHP was managed with a low profile, not making much noise and this seems to be the secret of the Program's success: to survive since 1986 up to now with difficulties and scarce supplies".*

Another difficulty is related to RHP organisation: *“we are trying to achieve a continuous debate within the team, but these activities are often seen by physicians as a quality control auditing, and it has taken us 3 years to convince them that that was not the objective”*.

Different conceptions about human reproduction seen in Hospitals and Health Care Centres may also be perceived in the testimonies of people in charge of Programs: *“there are still conscientious objectors among professionals working in these departments and we will have to wait until they change or someone new will come in and change practices from inside. It is very difficult to produce these changes from outside. One cannot be unmoved by a woman with five previous caesarean sections who goes to Hospital demanding a contraceptive method and the answer is that she has to have a Pap smear, a colposcopy and an ultrasound before we can indicate a method because, in the meantime she will get pregnant again (RHP)*.

A pending task is to improve practice, particularly in sexually transmitted infections and AIDS: *“ this is difficult to achieve among professionals who have practised for over 30 years because of their more conservative conceptions”*. Another important difficulty for the Program’s effectiveness is the lack of budget to pay salaries for full time professionals. (RHP)

The problems faced by the Pap smear and Breast Program mainly refer to its limited action radius and to lack of adequate working spaces: *“ the Program could not be extended to the rest of Buenos Aires Hospitals and the co-ordinator works in a hall where the computers we have bought cannot be installed”*. It is also important to improve training of the health team in gender issues. A study carried out among obstetricians-gynecologists showed marked differences in the relations established between physicians and patients from different socio-economic sectors (López and Findling, 1998): *“because among health care professionals, independently from the fact of whether they are male or female, there is a tendency to undervalue persons. A person is identified by the pathology he/she suffers and when a woman goes for a consultation and is told “madam, open your legs” there is no explanation as to what she is consulting about. There are many situations that hinder women from seeing a physician because they find it extremely aggressive and this has an influence on prevention”*. (PBP)

1.3.6. Evaluation and production of information

Statistical production constitutes a central problem in the Program’s implementation: *“some RHP services send monthly statistics and others haven’t done it for a year”*. Available statistics provide information about service providers, number and type of supplies distributed through RHP but, *“ unfortunately there are no resources to make an adequate analysis of information, although some establishments use a contraceptive method more frequently than others and this is related to Hospital or Department regulations, because the rule is a general one, but indications are given by the service provider”*. *“There has been no follow up and assessment in PMP. The Health Secretariat elaborates statistics about the number of patients who have had tests done (see Table 1, further up). Each Hospital sends the Health Secretariat defined diagnoses and risk factors, such as number of sex partners, sexual initiation, family background, number of children and jobs”*.

1.3.7. Dissemination and organisation of campaigns

Reproductive health care prevention campaigns are not periodical: *“RHP has no resources for campaigns, this does not mean that we don't do them”*. There are different opinions about their effectiveness: *“campaigns are effective if they are followed by a meticulous work that must include contacts with the community. It is very well to put up posters about AIDS but it is not enough; it also requires the creation of spaces for professionals and to re-think professional practice”*. (RHP)

“A campaign to remind the Program's permanence was not implemented. If this were done twice a year, it would help to install care awareness. Patterns and habits that are deeply rooted must be changed and publicity campaigns help to reinforce changes. But one must remember that publicity campaigns are closely linked to the political agenda and to the elections for the City's Head of Government. It was very valuable that the Head of Government at that time was De la Rúa (later on, President of Argentina who resigned in December 2001), and that he considered that the campaign was important and a government policy. (PBP)

“Condoms and brochures are given out, and a yearly campaign is foreseen bearing in mind budget restrictions”. (Aids Program)

1.3.8. Incidence on Prevention Programs of the promulgation of the Reproductive Health Law

The approval of this Law improved the professionals' information, because a legal framework is necessary for better implementation: *“service providers began to demand periodical meetings, and this is being done because not all professionals know the Law well; for them, it has highly contributed to legitimise their professional practice, because it enables them to attend adolescents, and this implies providing information and recommending methods to avoid non convenient pregnancies and sexually transmitted infections, including AIDS, as well as to health care promotion and prevention”*. (RHP y PBP)

2. Telephone Survey on Reproductive Health Care and Prevention

A telephone survey was designed to gather information about prevalent preventive practices in women aged 15 to 69. This methodology was mainly used due to growing insecurity in the City Of Buenos Aires, turning access to households very difficult. The City of Buenos Aires has an important proportion of inhabitants who live in flats with telephone services.

The sample of women aged 15 to 69 who live in the City of Buenos Aires was designed in a probabilistic manner. Due to the difficulty of finding younger women at home, the data collecting strategy was modified and, the third day after field work began, it was redesigned assigning quotas for every five-year age group, proportional to the City's female population (see Table 3). Since telephone coverage is considerably reduced in low socio-economic levels, a coefficient was applied to weigh the size of the sample.

2.1. Socio-demographic profile of interviewed women

Tables 3 and 4 compare the composition of female population, by age and education levels, produced by the Reproductive Health and Prevention Survey with the Buenos Aires official statistical data in 2000 and 2001. The profile of Table 3 coincides with what was expected because the Survey tried to represent differently aged women proportionally. The educational level comparison shows a more advantageous situation for women in the Survey. The differences may be due to the methodology used, because it excluded women living in the city's shanty towns, where 106.140 inhabitants, belonging to both sexes, live (approximately 3% of the city's total population, according to provisional data from the National Population and Housing Census, 2001) and women who live in households with no telephone, who are the poorer ones and with lower education level. The interviewed women's education level is high: 73% completed secondary education or surpassed that level and only 1% did not finish primary education.

Table 3. Women aged 15 to 69, by age. City of Buenos Aires and Reproductive Health Care and Prevention Survey. 2000 and 2002. In absolute numbers and percentages.

City of Buenos Aires			Reproductive Health and Prevention Survey	
Age	Population	%	Population	%
15-19	107300	9.4	56	9.2
20-24	126700	11.0	67	11.0
25-29	122200	10.7	66	10.9
30-34	111400	9.7	59	9.7
35-39	104800	9.1	56	9.2
40-44	104100	9.1	56	9.2
45-49	103700	9.0	53	8.7
50-54	101300	8.8	53	8.8
55-59	95200	8.3	50	8.2
60-64	84200	7.3	45	7.4
65-69	86500	7.5	46	7.7
TOTAL	1147300	100.0	607	100.0

Source: Proyecciones de Población. INDEC/Celade, 1998 and Dirección de Estadística, Gobierno de la Ciudad de Buenos Aires and Encuesta de Salud Reproductiva y Prevención, 2002.

Table 4. Women aged 15 to 69 by education level. City of Buenos Aires, 2001 and Reproductive Health Care and Prevention Survey, 2002. In absolute numbers and percentages.

Educational level	EPH		ESR	
	Population	%	Population	%
Incomplete Primary	22	2.1	8	1.3
Complete Primary	142	13.4	62	10.2
Incomplete Secondary	191	18.1	91	15.0
Complete Secondary	231	21.9	136	22.4
Incomplete Tertiary	28	2.6	35	5.8
Complete Tertiary	101	9.6	78	12.9
Complete University	172	16.3	115	18.9
Incomplete University	169	16.0	82	13.2
Total	1057	100.0	607	100.0

Source: Encuesta Permanente de Hogares (Employment Household Survey) -INDEC, Ciudad de Buenos Aires, octubre 2001; Encuesta de Salud Reproductiva (Reproductive Health Survey), 2002.

The marital status of interviewed women shows that a fourth part of them are single, most of them aged 15 to 24; 49% are married, with a higher relative weight of those aged over 30; 12% live in consensual unions, more frequently between 20 and 39 years old; 9% is separated or divorced, mainly those aged over 35 and, finally, 5% are widows, mainly those aged over 55. These data are consistent with official statistics on women's marital status in CBA (López and Federico, 2000).

Regarding women's economic activity condition, 55% of the interviewed women is active (46% employed and 9% unemployed) and 45% is inactive. Employment registers the highest levels between 25 and 44 years old (two thirds of these women are employed). Unemployment mainly affects women aged between 25 and (14% of them) and inactivity to those between 15 and 19 (90%) and those between 20 and 24 (40%), because they are students, and it reaches more than 45% in those over 50 years old.

Regarding social security, 80% have a health insurance. The younger ones and singles (from 15 to 24 years old) in a lesser degree (74%), those who live in consensual unions (64%), those who did not finish secondary school (67%) and unemployed (51%), against those who are employed and those who are inactive and have a higher health insurance coverage level because they are either working or are covered by their spouse. Regularity in employment (their own, their spouse's, or their parents') could explain this behaviour. Health insurance is clearly differentiated according to education levels, favouring the more educated ones.

Further from the comparatively better magnitudes for female population sectors in CBA in relation to their fellow-sisters in the rest of the country, data on social security show a social vulnerability nucleus that has been more evident during the last few years but has reached alarming proportions during 2002. During that period, employment loss and the consequent reduction in family income must be added to lack of health insurance. The most

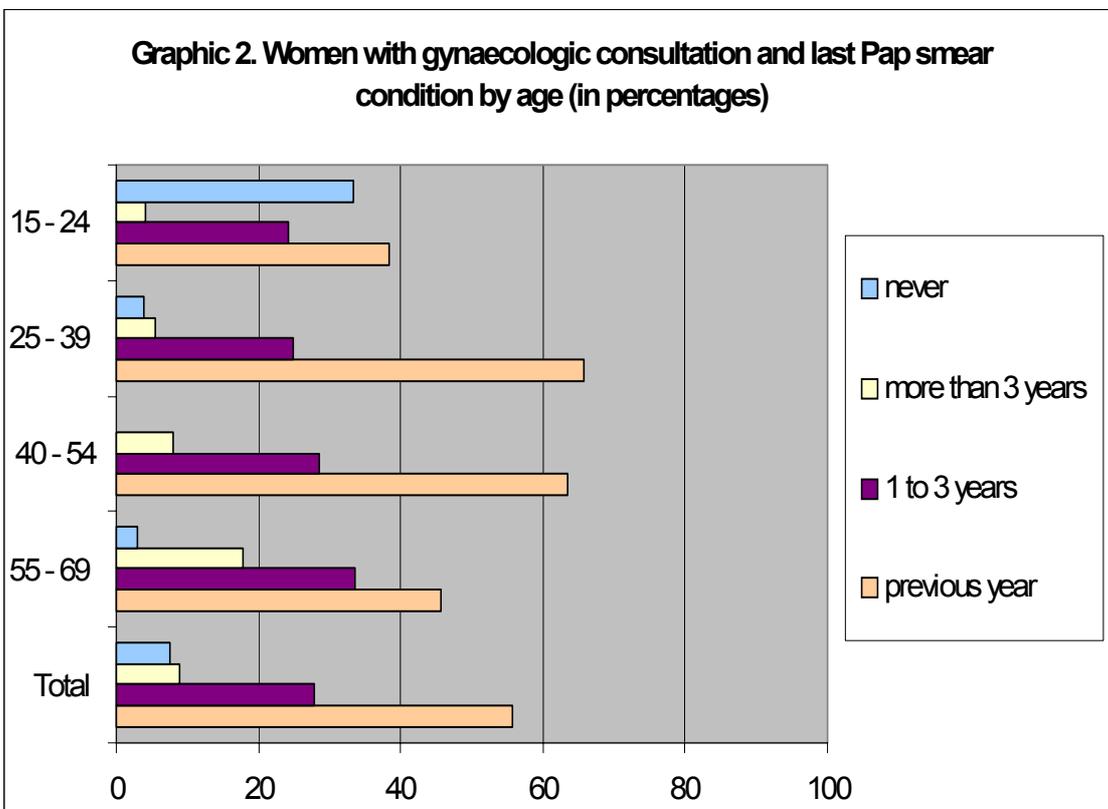
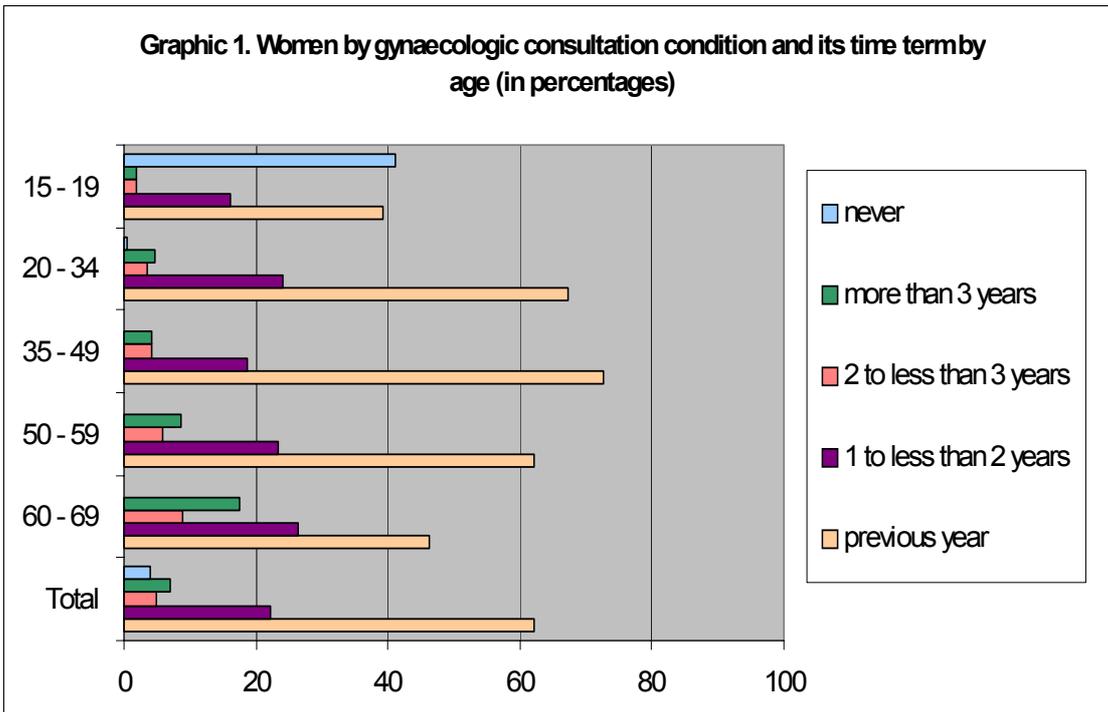
visible consequence of these changes has been a massive movement towards the public health care system that is free in Argentina. This situation has been described in several studies about life conditions (López, 2000; López and Federico, 2000; Altimir and Beccaria, 2000) as an emerging phenomenon of “new poverty”, that drags population sectors whose origins and life styles were particular of an urban middle class towards situations of need to which they have to adapt at a great material and symbolic cost.

2.2. Genital-breast health care

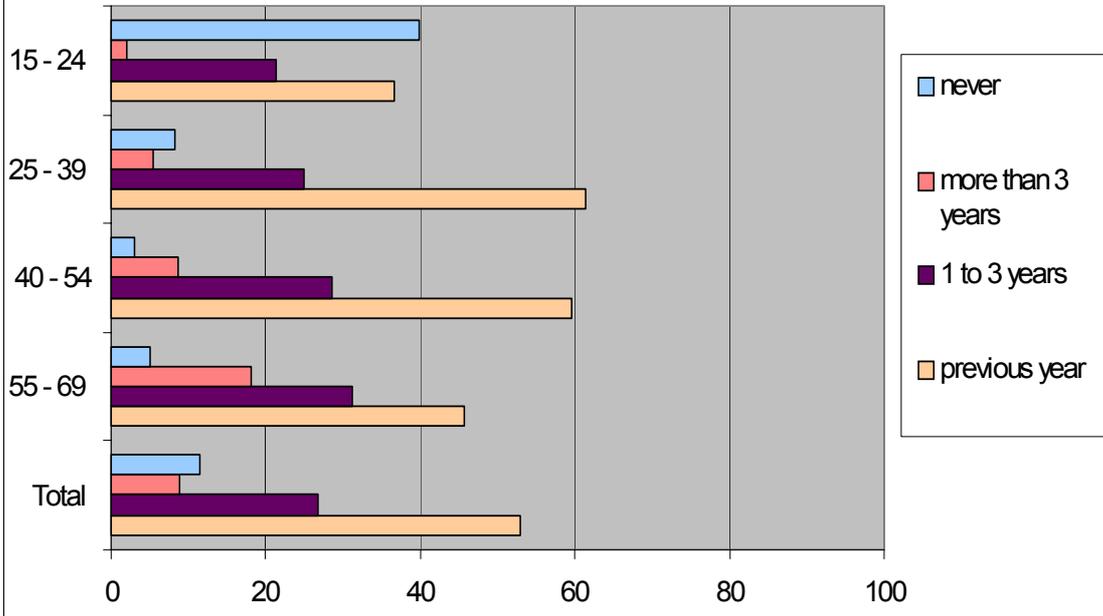
Gynaecologic consultation, a preponderant factor in the prevention of genital-breast disorders, was carried out a year before the survey by nearly two thirds of women aged 15 to 69. Graphic 1 shows, nevertheless, that 9% of women aged 50 to 59 and 18% of those aged 60 to 69 had not consulted a gynaecologist for more than three years, considering that in these age groups it is relevant to control female tumour processes. This situation might indicate that women consult the gynaecologist more frequently for pregnancy controls or the follow up of their children’s health, this being an attention call about insufficient prevention for elder women who face growing risks of suffering genital-breast pathologies. Women were asked about the reasons for their last gynaecologic consultation and 77% answered that they did so for a preventive control (percentages increase for those aged over 25 and decrease slightly after 60 years old); 13% consulted for some kind of disorder or disease, 5% for pregnancy control and 5% for treatment.

Graphics 2 to 6 show the percentages of women who consulted a gynaecologist and had tests done in relation to prevention. The results show that:

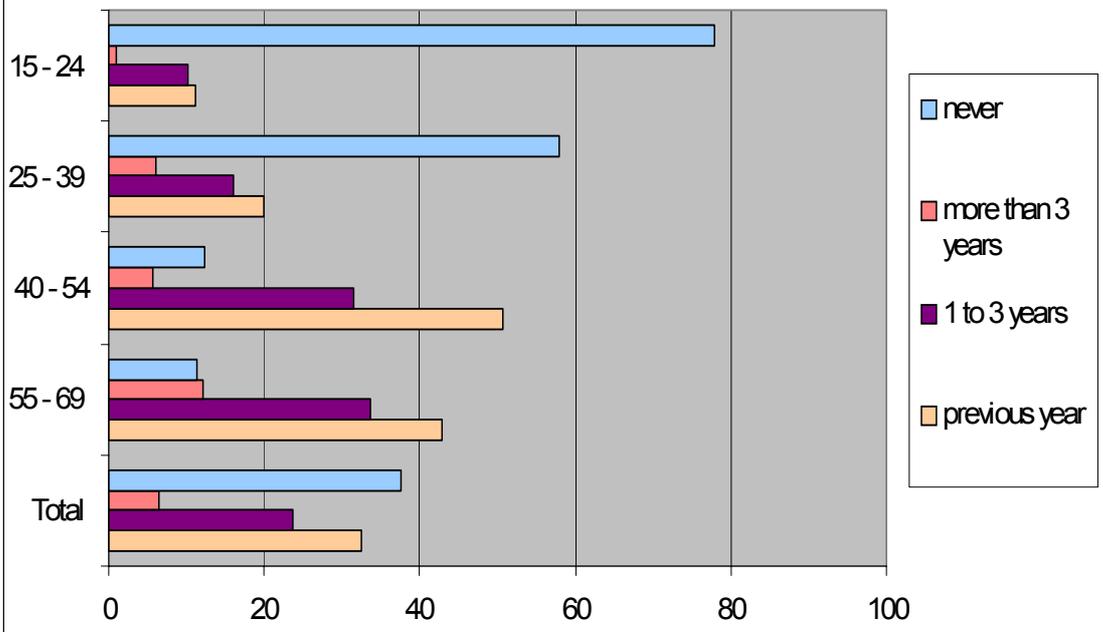
- a) Pap smear smear: nearly two thirds of women aged 25 to 54 had it done during the previous year. Except for the younger ones, who in general terms are those who have had less tests, the lowest levels correspond to women aged 55 to 69. Colposcopy presents a similar profile, but with somewhat lower values;
- b) Mammography: there is a larger number of tests as age increases, but it decreases after 55 years old. It is important to note that 12% of women over 40 have never had a mammography;
- c) HIV: it is important to note that nearly half the women never had a test done, with differences according to age. In those between 15 to 24 years old, the number reaches 50%, although there are differences among those between 15 and 19 years old (76%) and those between 20 to 24 (36%), the percentages increase in those over 55 years old up to nearly three quarters of surveyed women. The higher frequency of this study is evident in women aged 25 to 39 years old, probably due to sexual and preventive practice;
- d) DEXA techniques (to measure bone density): a low proportion of women have had one done.

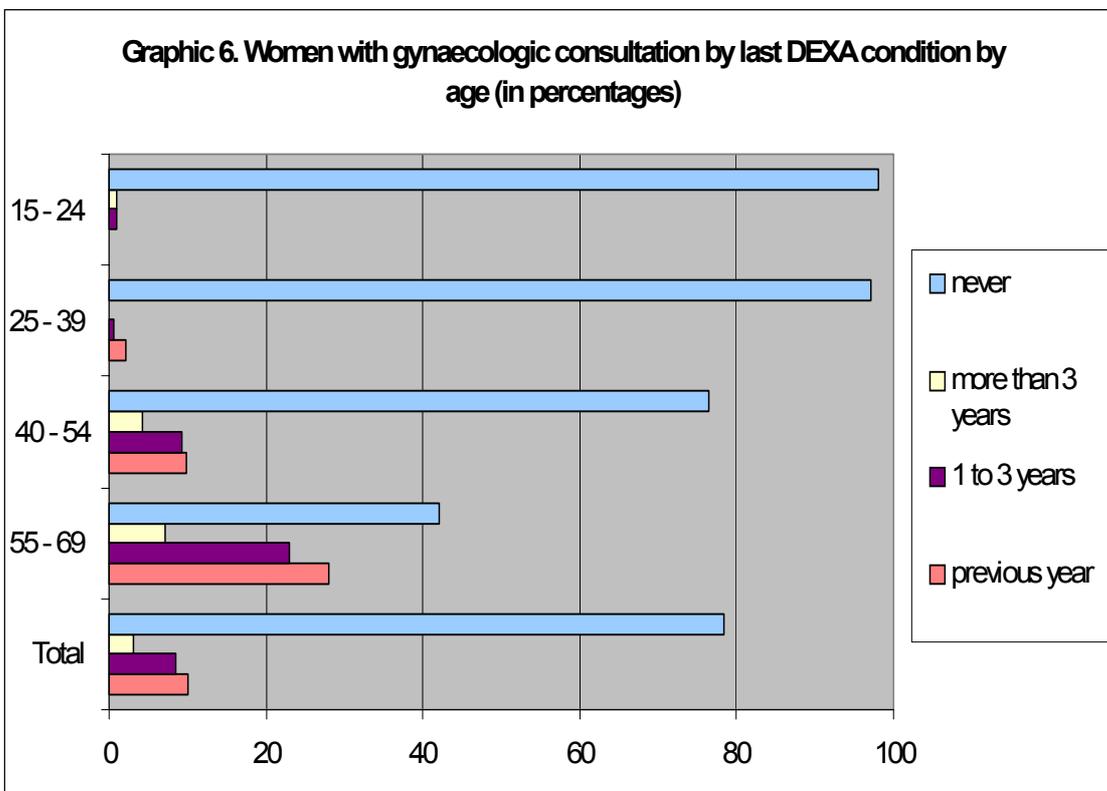
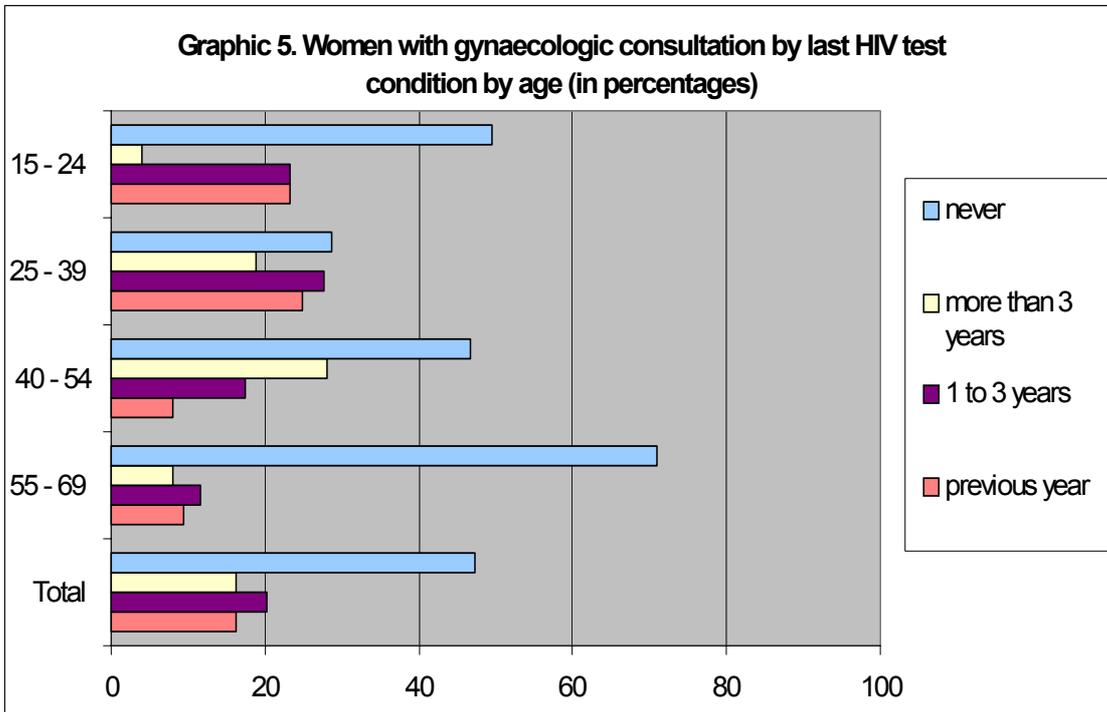


Graphic 3. Women with gynaecologic consultation by last colposcopy condition by age (in percentages)



Graphic 4. Women with gynaecologic consultation and last mammography condition by age (in percentages)





2.3. Fertility

2.3.1. Live born children

Fertility data refer to women aged 15 to 69. They show that 38% of them is childless (none of those aged under 20, 82% of those aged 20 to 24 and 64% of those aged 25 to 29), 17% has one child, 28%, has two and 13%, has three. Only 4% of surveyed women has 4 children or more. These values indicate a practice of reproductive patterns that are strikingly lower than those found in other Argentinean cities with high poverty levels (Salta and Resistencia), where one out of three women has 4 children or more (López and Tamargo, 1996).

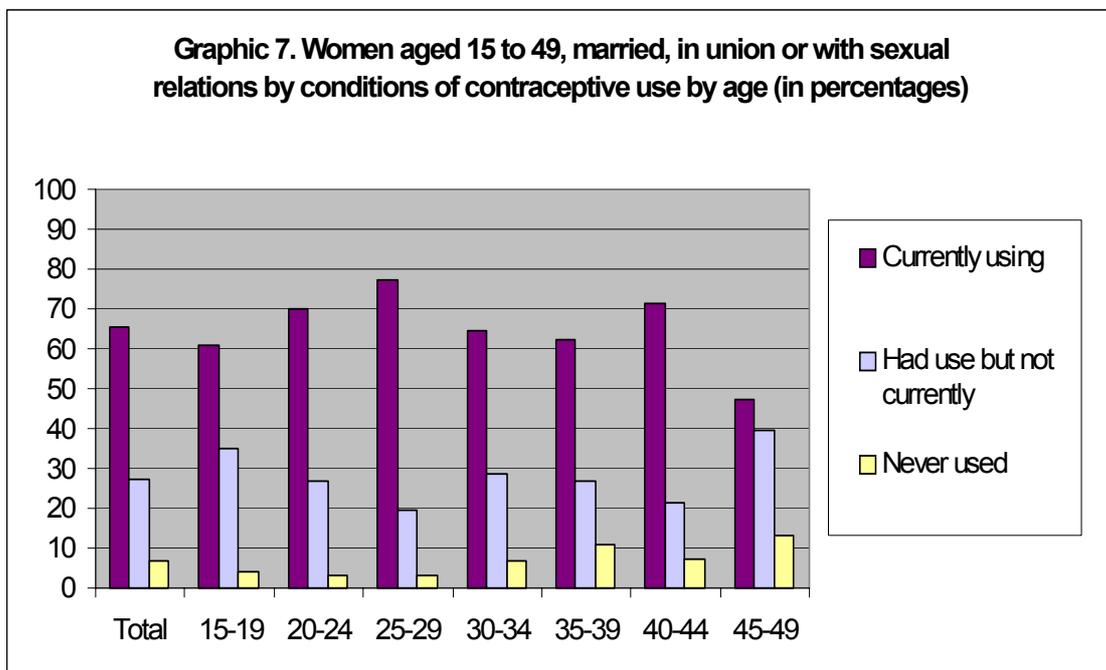
The more frequent number of children is 2, both for married women (40%) and widows (42%), separated (divorced) (33%) and in union (25%). The mean age for the first birth is 26 years old and the median is 25 years old, this points at a later fertility calendar than the rest of the country and it is one of the distinctive characters of reproductive life of Buenos Aires City inhabitants.

2.3.2. Recent mothers

A fourth part of women with live born children (92 women) had their last (or only) child during the past five years. Nearly the whole of them (96%) began their last pregnancy control during the first quarter, half of them in social security consulting rooms or clinics, a third of them in private or pre-paid medicine systems' consulting rooms or clinics (more concentrated in those over 35 years old) and the rest (14%) in public hospitals (predominantly younger women, a third of them aged between 20 and 24, and a fourth of them between 25 and 29 years old), a modality that is maintained when analysing age and the place where the childbirth took place.

Although not a novelty, it is important to stress the association between the place where the childbirth took place and the type of childbirth, because in Public Hospitals 93% are natural ones and, by contrast, both in social security and in private clinics 62% are natural and 38% are by caesarean sections. This trend has already been established in studies on the Buenos Aires Metropolitan Area (López and Tamargo, 1995; López and Federico, 2000) showing the different characteristics of women with caesarean sections: mainly married, with less children and using more contraception than average, with a high education level and social security. The excess of caesarean sections is a worrying subject for Latin American Health Service officers due to the magnitude it has acquired and the consequences on maternal and infant morbidity and mortality (OPS-PAHO, 1994). How should these differences be explained? An answer may be found in the paying capacity of women with more resources, and in certain modalities used by social security and pre-paid medicine firms that charge differentially natural and surgical childbirth. It has been demonstrated that caesarean sections imply more health risks for women and infants, as well as higher costs for the health care system. It seems important to research into these matters more deeply, because health service suppliers have strong corporate and economic interests.

2.3.3. Contraception



Graphic 7 presents the current condition of use of contraception in women aged 15 to 49 (369) in union or who have sexual intercourse. The use of contraceptives is high in women aged between 20 and 29, and this could explain the late maternity pattern prevailing in the City of Buenos Aires, also, it is important to note that adolescents who have sexual intercourse use these methods in a high proportion. According to what should be expected, these uses decrease after 45 years old. The educational level has a positive influence also and women who have finished secondary education show higher values than those who are less educated (67% against 56%), and the percentage of those who have never used contraceptives is much smaller (7% against 17%).

Among currently using (244), around 80% of women aged between 15 and 29 used, during the previous month, more than one contraceptive method (between two thirds and three quarters of them used condoms in the first place and pills in second place) while nearly all the rest used only one method: half the women aged 30 to 39 preferred condoms in the first place and, in second place, pills (those from 30 to 34 years old) and IUD (those from 35 to 39 years old). Women aged 40 to 49, equally used condoms and IUD. The use of pills decreases substantially after 35 years old. The main sources for guidance and information about contraceptive methods were private social security consulting rooms, family or friends, and educational centres.

Women who had used contraceptives (had not used them during the previous month but had used them before) were asked for the reasons of not using them, and their reply was “age”, “because they do not become pregnant or because they are sterile” or “because they want to become pregnant”.

Women who had never used contraceptive methods (only 9% out of a total of 369) were asked the same question and the answers were “because they wanted to become pregnant”, “because they did not succeed in becoming pregnant” or “because they were scared about collateral effects”.

2.4. Campaign remembrance

A little over a third of interviewed women (38%) remembers at least one reproductive health care campaign. There are differences according to age, and remembrance decreases as age increases (Table 5). In one of the statistical tables, not presented here, we can see that 75% of women who did remember, evoked in the first place Aids campaigns referred to contagion, use of condoms and the need for controls during pregnancy: In the second place, although at a considerable distance, campaigns for the prevention of genital and breast cancer (15%) and the use of condoms without relating it with Aids (15%) were remembered. Campaigns about the use of contraceptives were less frequently remembered (9%).

Table 5. Remembrance of reproductive health care campaigns according to age. In percentages.

	15-24	25-39	40-54	55-69	Total
Remembers	43	45	36	28	38
Does not remember	57	55	64	72	62
Total	100.0 (123)	100.0 (181)	100.0 (162)	100.0 (141)	100.0 (607)

3. Conclusions

At a national scale, the country's federal organisation conditions the Health Ministry's participation in specific actions in each one of the provinces, deepening the health care policies' heterogeneity and fragmentation, within a increasingly absent Welfare State; an example of this situation is that the Reproductive Health Care National Law has not been approved yet.

A first set of conclusions that emerge from the interviews carried out with persons responsible for Reproductive Health Care Programs in the City of Buenos Aires, leads to think that the advances obtained during 18 years of democracy have been very slow, as a result of a large number of obstacles linked to conservative political lobbies strongly influenced by the Catholic Church, as well as to deficient organisation aspects inherent to the local governments' own structures. In spite of the difficulties, the rhythm of achievements has increased during the last two years, due to the approval of the Reproductive Health Care Law that legitimised many practices being carried out in a concealed manner. The contribution of health care teams and the support given by young professionals is undeniable. Nevertheless, in spite of the fact that the Law and Program regulations are in force, everything seems to indicate that reproductive health care largely depends from criteria, convictions and conceptions of Department Chiefs and Hospital Directors. The scarce importance given to the Programs' evaluation process and to the production of good quality information must be added; within this panorama, the lack of a budget assigned to the Programs' human resources is no less important.

The second set of conclusions refers to the Reproductive Health Care and Prevention Survey. The information gathered shows that, although preventive practices are used by an important percentage of women, they do not reach elder ones; the relatively low prevalence of cancer control practices in this age group indicates a central matter that must be solved. It is difficult to think that these women may produce a change in health care practices on their own: they are the less formally educated, they are more alone, because of their age they do not take their children to medical consultation, they are not sufficiently informed and they have a lower perception of preventive campaigns, they

may consider other health problems as more important or they may feel modesty, fright or shame towards a gynaecologic consultation. Once the problem's origin has been found, a strategy oriented to modify these practices in elder women should be designed.

A last observation that arises from the Survey refers to the abuse of caesarean section childbirth in women belonging to middle population strata that, although not a novelty, constitutes a constant worry in different health care ambits.

A third set of conclusions intends to propose some ideas to advance in the social construction of risk in Argentina. The notion of prevention is still little established in a country marked by a strong foreign debt, low productivity, increasing poverty levels and high unemployment rates. Omissions are evident in policies centred in individuals, as for example those for tobacco and alcohol or traffic accidents control –persons not using car safety belts or motorcycle helmets are scarcely penalised– as well as in policies centred in State matters such as poverty decrease, improvement of maternal-infant health care, a greater access to health care and prevention services. Although non governmental organisations have a growing presence in Argentina, they only try to alleviate partial aspects to make up for the State's continual withdrawal in vital social policy areas.

It's time to promoting the notion of risk and the need for prevention.

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