RESEARCH ORIGINAL

Perceptions and practices of sexual and reproductive health in the health team of the Santa Teresita-Cerrillos Hospital and in women from the locality of Cerrillos, Salta, Argentina

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Abstract

This article presents a synthesis of research results from the study: ¨Perceptions and practices of sexual and reproductive health in the health team of the Santa Teresita-Cerrillos Hospital and in women from the locality of Cerrillos, Salta, Argentina: Multiparity in young women and local health actions linked to Sexual and Reproductive Health". The method chosen was qualitative, based on Grounded Theory. In-depth interviews were conducted with women who had more than two children, and with the health team of Santa Teresita Hospital, Cerrillos, Salta. Through the employment of diverse data collection techniques, as well as through Grounded Theory analysis strategies, the principle of right to health and respect towards others emerges as a relevant result. At the same time, discrepancies were found between individuals´ healthcare needs and their perception of the institution´ accessibility. I expect the results to serve as a foothold for the generation of local health policies that answer the needs of women while respecting the socio-cultural context, from a law and gender perspective. **Keywords:** Sexual and reproductive health counseling, perceptions and practices

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Introduction

According to the WHO[1], due to biological and social differences, the fact of belonging to one sex or another has a great impact on health. Thus, it proposes a gender-based approach to public health, which "involves addressing the influence of social, cultural and biological factors on health outcomes, in order to improve the efficiency, coverage and equity of programs" (WHO, 2011).

In Argentina, the National Plan for Sexual Health and Responsible Procreation,[2] was introduced by the National Ministry of Health in 2009. This initiative is not limited to education on contraceptive methods. Its approach, linked to development and human rights, also aims to address and reflect on public policies and actions that guarantee sexual and reproductive rights, through the participation of women in decision-making.

In both aspects of this initiative, the ontological dimension comes into play through the ways in which women who use the service, and the workers of a rural public hospital, relate to each other.

Thereof stem the following questions: 1) Does Cerrillos Hospital address women's health from the initiative's perspective?; 2) Does it take into account the psychosocial and cultural factors that influence decision-making in the community's daily life?; and 3) Are both perceptions put into play through practice and health actions?

This project was motivated by the evaluation results of the Santa Teresita Hospital (AO XXX). The APS Program covers a population of 13,690 inhabitants 1. There are 4,381 women of childbearing age, of which 19.84% use some method of contraception. Of the pregnant women, 36.86% are at risk, and 25.15% are under 19 years

old. The percentage of young women who did not finish high school, mainly due to maternity, reached 40%.

Despite the team's efforts to conduct sex education *talks* in schools, the offering of free contraceptive methods and the existence of a sexual and reproductive health clinic (with discontinuous functioning since 2014), *satisfactory* results have not been observed. This concern leads to the generation of different discourses around motherhood: "the universal assignation per child", "neglect", "lack of life projects". Engaging with this situation, this study asks: 1) Do sanitary actions respond to these preconceptions?; 2) Are proposals adapted to the context?

San José de los Cerrillos, the town where Santa Teresita Hospital is located, covers rural, urban and peri-urban areas. Its economy is based on agricultural production and the majority of people are employed in the public administration. The rest (39%) perform specific and temporary jobs or receive social welfare[2.] Between September and April (tobacco season), seasonal workers flock to the town, doubling the population for 9 months. In most cases, the hospital is the only gateway to health. Due to economic difficulties, even those on social welfare choose free care.

Methods

This study used the most appropriate methodological tools available to analyze and understand a complex reality through the discourses and practices of the people involved in the process. The study´s qualitative methodology allowed for an acknowledgment of the ways in which researchers intervene and form a part of the social reality studied and, thus, cannot place themselves in a position of exteriority.

The qualitative method selected was that of Grounded Theory, in which the construction of the theory is based on the empirical data that support it, through a deductive analysis procedure. Its methodological tools are the Constant Comparative Method and Theoretical Sampling (Vasilachis, 2006 [3]). The former guides the research away from data saturation by focusing on the ideas that emerge from data analysis. Theoretical sampling, on the other hand, is concerned with data collection, and consists of four stages: comparison of incidents applicable to each category, integration of the categories and their properties, delimitation of theory, and construction of theory.

Theoretical sampling refers to the modality of data collection that will generate the theory. It marks the difference between the necessary initial sampling and the rest of the data collection process, which is guided by the emerging theory. The criterion that brings the process to an end is theoretical saturation; that is, when the researcher cannot find additional information for the development of more properties within a category.

The tools used were the field notebook, participant observation, in-depth interviews and focus groups.

Population

Young women, 15 to 29 years old, who live in the town of Cerrillos, and have more than two children.

Members of the AO XXX health team, Salta.

In order to determine the sample, I followed the concept of theoretical saturation, considering the criteria of theoretical purpose and relevance.

Results

Based on the data obtained through qualitative methodological tools, two categories of analysis were constituted:

1-*Accessibility of the health team´s sanitary actions in relation to the SRH of young people in the town of Cerrillos*

2- The practice of motherhood in vulnerable social sectors

3-Accessibility of the health team´s sanitary actions in relation to the SRH of young people in the town of Cerrillos

In a strict sense, sanitary actions refer to the implementation, application, or simply the exercise of the knowledge conferred. Following the APS strategy, this practice should be universal, integral and integrated. It should emphasize prevention and promotion, and guarantee the user's first contact with the system, taking families and communities as a basis for planning and action (WHO 2005). [4,]

At the same time, these practices are spaces of agreement/disagreement with the other (patient, client), who becomes subjectified or objectified. Through these spaces' institutional regulations, welfare models, cultural values, subjectivities and

ideologies are configured and materialized in the daily work of health services.

Authors such as Montoya Montoya [5] (2007) stress the importance of the bond between the health team and patients, especially regarding SRH. To this end, the concept of care ethics becomes helpful as a theoretical and practical construct that proposes a relationship based fundamentally on emotionality and respect. Its working strategy is the bioethical dialogue, through which the reciprocity of knowledge and information generates empathy and humanized treatment. The ethics of care require, as a basic condition, adequacy and technical competence, especially in regard to the promotion of sexual health.

> Few areas in medical science tend to have as many ethical tensions as those related to sexual and reproductive health. In Latin American countries, there are marked social polarizations on issues such as abortion, emergency contraception, the rights of homosexual people, the use of condoms and strategies for sex education, to mention just a few (Montoya Montoya, 2007, p.175).

We conducted focus groups and interviews with different members of the AO health team: health agents (HA), nurses (N), doctors (D) and cleaning and maintenance (MP) personnel, many of whom belong to the locality of Cerrillos.

The following subcategories were identified:

The SRHC in the XXX AO

SRHC require an interdisciplinary and intersectoral approach, as well as the necessary institutional support to carry it out. We found that the SRHC in Cerrillos works in an isolated manner. Workshops (lectures and classes) are held at the request of each institution. Compounding this is the unfamiliarity or neglect of the health team with the SRHC office.

In general, we observed a critical gaze towards the SRH of the community and, especially, that of youth.

> *They do not take precautions when they fuck (make gestures) with just about anyone and become pregnant...* (D1). *No, today sex is not planned, and then they come for the "morning after" pill (D1). What happens here is that the 14-year-old* (...) *they don't know who the father is* (D1). *The 14-year olds, from the ages of 12 to 17 you can have them for just the price of a sandwich. Misery has a heretic´s face* (D1).

For counseling to be effective, it is essential to modify existing power structures in health systems with respect to men and women, girls, boys and adolescents who attend services (National Ministry of Health 2010).

> *(...) Men do not want them to protect themselves. Because they think that then they will cheat on them. In the culture, that´s how it's understood: "why are you going to protect yourself? To be with someone else." In addition, they worry about the men leaving them ...* (N2).

The SRHC must approach the theme in an integral way, by focusing on the whole person (their life story, needs, and beliefs), instead of on one part of the body.

> *Oh yeah! Here there is a lot of promiscuity, a lot. Pregnant women arrive at my office, and they demand to know the exact date of conception* (...) *and when they start like this, you know that they´ve cheated on the husband and don´t know who the father is* (D1).

We observed rapid generalization based on some cases observed in the outpatient clinic. This may be, above all, to university education, where induction constitutes a way of thinking and acting. Thus, the issue arises when a particular situation is generalized and taken as the truth.

There are strongly rooted, naturalized social prejudices, based on cultural conceptions and representations about sexuality, especially that of women. However, we must consider that these are health personnel, who belong to a public institution that, in many cases, is people´s only access to health. While these health workers are also part of society (and, hence, conditioned by culture, social representations and their own prejudices and resistances), their professional role should allow them to make space for the patients´ own knowledge and conditionings. However, we observed that during patients´ visits, they base themselves on their own personal beliefs and ideology.

> *(...) a part of society, for 500, 600 pesos they make a living out of having children ... these are people who live off welfare ... and that*

money, they don't even use for the children. Here, we give them medicine; if there is one we don't have, we ask them to buy it, but they don't buy it ... instead, you see them show up on a new motorcycle, with shoes that look like boats ... and you see that their little ones are all dirty ... (D1).(...) On top of that they are criminals, they´ll file a complaint for any little thing (N2).

The SRHC´s work is rooted in a gender and rights perspective. Autonomous decision-making implies an exercise of rights, which should be accompanied from a place of respect for individual preferences, options and living conditions. Hence, the type of bond established between health personnel and the community where they work is of great importance.

In girls, there is a lot of promiscuity; before there was more control over the body; now, they get in the mood and go to bed with as many as they want (O).

We were also able to observe a dichotomous and socially differentiated profile; on one hand, men are rarely considered part of the problem and, on the other, multiparity is seen as a product of ignorance and poverty. In this case, poverty is considered an intrinsic quality of people, not a condition. This perspective implies stripping it of its social, economic, and cultural determinants.

There is a lot of gender violence ... The boy does not grow up in a healthy environment, and through transmission he will do the same thing ... Men are like anteaters, they will put their snouts in any hole; hence, there are many STDs; for example, since I arrived, I have seen three cases of syphilis and it was because they had all been with the same woman ... (D1).

Including a gender perspective implies addressing the relationships that are established between services and people based on their gender. This implies recognizing and analyzing the power relations at play in the approach to each situation.

The crystallization of reproduction as an "exclusively" female arena reinforces women´s responsibility in reproductive decisions. Even when the relational dimension of gender intrinsic to family planning issues is referred to as important, the actual practice contradicts this perspective.

The accessibility of counseling implies the construction of a bond between subjects and services. It arises from a combination of the services´ conditions and discourses, and the subjects´ conditions and representations. Moreover, it is manifested through the particular modality of service use. Here, active listening and the revision of individual preconceptions is of essence.

I believe you are not asking the right questions. Do you know that homosexuality is a mental illness? That abortion is murder? That the patch, the IUD and other contraceptive methods are a business? That some stupid gynecologist said they were good, and that's why we use them? (D1).

The achievement of such accessibility requires, not only availability of equipment, but also interdisciplinary work, sensitization and articulation workshops (referrals, schedules, messages and clear physical spaces).

On the motherhood of the young Cerrillanas

We identified several areas that have recently undergone changes which have had a negative impact on the SRH of young people. In the family, for example, through the ways in which parents educate their children; in the sphere of youth life, the new ways in which young people spend their free time; in a more general social context, the greater strength and influence of the media and the lower perception of risk in relation to STDs and; at the institutional level, preventive and sex education policies.

Health team members have different explanations, which include: individual causes (behaviors, ability to measure risk and/or project a different future, relationship with parents), social causes (conditions of exclusion, cultural expectations), and causes related to public policies (counseling, promotion and prevention strategies).

In most interviews, we observed a moralistic perspective which conceives of an external subject (the community), and an internal subject (the health team), through a hegemonic discourse that generates and spreads meanings and stereotypes around poor people. This perspective justifies the execution of severe educational and transformational processes through mechanisms such as health education, habit changes, and mistreatment in consulting and waiting rooms.

Medicine has constituted itself over the years through a discourse that differentiates the normal from the abnormal, the healthy from the

pathological, the true from the false, and the moral from the immoral. In this sense, one of its most common prejudices is that of "hypersexuality", especially regarding women.

> *The mothers also eroticize the girls, they are only 14 years old and already they are dressing them with short skirts and cleavage, they go out dressed provocatively. And they already have a first boyfriend, and they call him ´husband´, and now this husband has rights over that woman, for everything. In this way, the mothers start to push them out, in order to not take care of them anymore* (O).

In the same way, a highly demanding ideal of motherhood also appears in the discourse. Thus, we observed a shift from a technical-scientific authority to that of a moral nature.

Welfare plans and their relationship with SRH

The moralization of poverty appears not only in comments on the community´s sexuality, but also through a more in-depth conversation on the causes of multiparity. In many cases, it was not even necessary to ask about welfare plans; they were immediately related to the issues mentioned above.

> *(...) youth nowadays do more in order to access welfare plans, young people do not have much responsibility* (MP2). *They get more or less between $600 and $800* (MP2). *They get paid, more or less, $800 for universal allowance* (MP1). *They are paid more than us (MP2).*

The incorporation of the AUH into already existing group of welfare plans enabled the resurgence of a deeply rooted discourse on poverty, vulnerable communities and their behavior in relation to social assistance. The salaried middle class´ discourse on this issue is reproduced - along with the accompanying prejudices and stigmatization - by the majority of health personnel.

> *Look, I'm honest, I detest welfare plans, you take a look and see that there are people who sleep all day and, cool as a cat, they just go collect once a month, and they do it to go out and party, because it is not for the child. And look at me; I work all day, every day and get up early to go to the bank, and I have to be here, waiting for them (N1).*

In terms of the interviewees, youth have a perception of low vulnerability to risk, are complacent about the possible consequences and do not rationally consider the costs and benefits of their decisions and behaviors.

> *There are other priorities: with welfare plans, they have Direct TV, cell phones, they spend it on beer, on fun, instead of taking care of the children as they should* (N2). *They definitely apply for all the plans they can possibly collect, and end up earning more than us, who work* (D1).

One of the risks that arise when working in communities with these characteristics comes from an ignorance of the experience of extreme poverty. Such conditions lead people to concentrate permanently on the tasks necessary for survival, leaving no room for emotional needs. Moreover, the experience of time is marked by "urgency" and a continuous present; everything happens here and now, and must be solved in the same way.

Here, unlike in other research, the morbidity and mortality of young women as a product of multiparity did not arise as a problem or concern.

2-The practice of motherhood in vulnerable social sectors

For this section, we carried out in-depth interviews with multiparous women between the ages of 17 and 28, who had between 2 and 7 children. We chose women who belonged to urban, peri-urban and rural areas, in order to factor in the cultural and social determinants of each case.

The interviews were divided into three dimensions: 1) the institutional (knowledge of the legal framework, the spaces offered by the health system and its circuit); 2) the socio-cultural (context, conditions and life patterns); and 3) the personal-relational (perceptions, expectations and modalities of resolution).

Institutional Dimension

Most women do not know SRH Law, their rights and where to consult; they relate SRH to gynecology.

In general, the level of knowledge of BCM is quite good. This, in great part, is thanks to the work carried out in schools, the second space of influence being the friend group. However, the fear of contraceptives´ potential side effects was remarkable.

Women do not demand information about the different interventions to which they are exposed,

maintaining a passive attitude towards healthcare professionals.

"*I never asked anything." "It was always like that, when I do not know what to do, only then I go. It has to be really bad for me to go*." *"The first visits are terrifying."*

The reaction of health personnel to the relationship between age and number of children appeared as a recurrent theme:

"They treated me like a dog." "I can't stand that doctor; when I was about to have my first baby she would say: "I hope you're ready to give birth "," Well, mama, go ahead and hurry up because you are the one who has to give birth, not me ". "Gynecologist Z is a depraved pig. He told me that I had many children because I slept with many men." "A nutritionist scolded me, she told me that it was the third time, that not even two years have passed and I already have another one". "Dr. Z does not respect women: ah, but when you opened up your legs it didn't hurt?".

Socio-cultural dimension

In addition to fears of contraceptive methods´ potential adverse effects, some of the main cultural factors at work are: the idea of women´s duty to give children to men, and the influence of the spouse and of the family on their decisions.

"And if ... look, I have seven boys, they always tell you that it's a lot, or that you're not going to be able to do it, that you're irresponsible ... I take care of all my children, I do not know why they give me their opinions". "I really don't understand what is supposed to be ok, I had the first at 20, and they told me I was too old to be a mom ... and then I was a mom and they told me to stop ... in the end who knows (laughs)". "I had my first baby at 21 years old, we had been trying but I hadn't been able to conceive".

For women, there are emotional and economic consequences that limit their development and psychosocial maturity, diminishing their opportunities for growth.

Personal-relational dimension

The onset of sexual relations, on average, was 15 years. At that time, they had been unfamiliar with the BCM or trusted that the man "was going to take care of them". Most of the subjects had a gestational interval of two years or less, and live with their extended families. Although the man of the house is the one who contributes money from his work and decides its use, the women are the ones who manage the UCA: in this case, the woman decides how this money is spent.

In relation to housekeeping and childrearing, we observed a cross-over of gender dynamics:

"Actually, I think I'm indispensable, because once we had an argument and I went to my mother's house, and he did not last five hours alone." "I decide everything about the kids, he never got involved. I am the one who stays with the kids."

Discussion

Here are some relevant points for discussion obtained from our analysis of the results:

1. When they begin their sexual activity, young women are unaware of crucial aspects of sexuality and its care.
2. Despite the lack of knowledge of BCM, the association with their harmful effects has the most importance.
3. Young Cerrillanas do not consider the hospital -and its team- a possibility for accessing SRH.
4. Motherhood in young Cerrillanas has economic, social, cultural, familial and demographic consequences that result in the limitation of women in education and employment. Their autonomy is reduced, mainly due to the personal and social dimension.
5. Citizen empowerment is weak; there is no intersectoral or interdisciplinary work in relation to SRH.
6. There is a repetition of precocious maternity or a large family, and a tendency to conform extended families. Both motherhood and multiparity conspire against women's personal fulfillment outside the domestic sphere, diminishing their expectations and reducing them to the satisfaction of seeing their children´s happiness.
7. The health team´s training places emphasis on the biological, leaving aside interdisciplinary and multicausal approaches. In local health

services, there is gender inequality and violation of sexual and reproductive rights, as well as the rights to life, freedom, and health.

8. The social representations and attitudes of the health team affect the perceptions of women, becoming determinants of access to SRH practices.

The permanent and continuous training of personnel in psychosocial and cultural aspects, as well as the possibility of constituting a private and confidential space, are crucial factors to consider in the approach to local SRH policies. This training, based on situated learning, implies an adjustment between the ideal professional model (taught in universities), the real model (which is constituted through practice), the model demanded by health services, and the model based on the local community´s needs

The local and institutional ideological context has effects on the implementation of policies by limiting or enabling certain practices. Hence, it is essential to address the prejudices, attitudes, and information of the health team.

In this sense, thinking through practices, questioning health actions, stressing subjectivity, and including community participation, are options that social medicine presents as alternatives to liberal and biological medicine.

Finally, we must bear in mind that all people are faced with a set of possibilities (not all of which are necessarily realized). Therefore, we cannot produce abstract reflections that isolate the human being from its environment and eliminate its relationships to things, to people, and to itself (situated knowledge).

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