Comprehensive ADOLESCENT Health Care

Risk and Harm Reduction in Reproductive Health with GENDER EQUALITY

Pan American Health Organization
Regional Office of the World Health Organization

argerich

FUSA 2000

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TABLE OF CONTENTS

FOREWORD

Within the framework of the celebration of the International Women's Day, the Office of Gender, Diversity and Human Rights (GDR), and the Area of Family and Community Health (FCH) of the Pan American Health Organization/World Health Organization (PAHO/WHO), organized the III Best Practices in Gender and Health Contest for practices that incorporate a gender equality perspective in health of adolescents and youth.

This competition aimed to identify the experiences that best address the differing needs and opportunities of adolescent men and women in order to improve their opportunities to enjoy optimal health.

This year, a total of 71 submissions were received from 19 countries. The experience "Reducing the risks and harm in reproductive and sexual health in the context of comprehensive care for adolescents" was selected as one of the three best practices. This experience was presented by Agudos Cosme Argerich General Hospital and the Foundation for Adolescent Health 2000 (Fundación para la Salud del Adolescente del 2000, FUSA 2000) of Argentina.

It was developed to respond to the high rates of teen pregnancy, the scarcity of prevention in sexual and reproductive health, and the number of medical referrals due to induced abortions. The comprehensive program transformed waiting rooms into workshops that advise teens on sexuality, gender and rights, and that address daily life situations of adolescents.

The results show an increase in the number of boys and girls who seek advice, and a marked decrease in complications related to pregnancy. This program benefits 15% of migrant and local adolescent men and women in Buenos Aires.

This experience proves to be a best practice that tries to change the attitudes of men, women and health care providers, in order to improve their health.

Dr. Marijke Velzeboer Salcedo
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SUMMARY

This publication presents an experience from the Adolescence Service at the Cosme Argerich General Hospital in the City of Buenos Aires dedicated to providing comprehensive health care to adolescents. This experience is based on the search for strategies of health promotion and prevention with emphasis on sexual and reproductive health, gender and rights. Within the global context of care, these innovative strategies in a public hospital focus on waiting area workshops and pre and post abortion counseling. These activities were implemented based on the lacking or deficient reproductive health prevention among women, the scarce participation of men, low autonomy of adolescents regarding health care, and the growing number of consultations for unwanted pregnancy and for complications from unsafe abortions.

The statistical data on adolescent pregnancy, the number of induced abortions and the figures of maternal mortality due to unsafe abortions in Argentina, help to understand the reality of the country and the need to work on these health issues with adolescents. The model of risk and harm reduction provides a conceptual framework for approaching the activities.

The goal of the waiting area workshops is to transform the time spent in waiting areas into a space for health promotion and prevention with emphasis on gender inequalities and rights promotion. These workshops seek to empower adolescents, promote their autonomy and bring adolescent men closer to the health care system. Today these workshops are considered the first link in the chain of consultation, and consultations are enhanced by what is addressed in the workshops.

In pre-abortion counseling women are counseled on the different options when an unwanted pregnancy occurs in order to help them make informed and autonomous decisions in a context where confidentiality is respected. The staff only provides information and counseling without any participation in the abortion itself, since this would be against the law. Since adolescents began using medical abortion, and since 2004 when the Adolescence Service began to offer pre and post abortion counseling, complications and hospitalizations due to unsafe abortion have decreased.

Post abortion counseling seeks to improve quality of care, avoid institutional mistreatment and foster adolescents' compliance with the Sexual and Reproductive Health Program in order to avoid repeated unwanted pregnancies.

The lessons learned from this experience on adolescent comprehensive care include: a) the importance of having an interdisciplinary team that addresses consultations in a comprehensive way; b) the importance of achieving better communication with adolescents; c) the advantage of incorporating the concept of risk and damage reduction in reproductive health; d) the importance of health care professionals getting involved in the search for strategies to reduce unwanted pregnancies and unsafe abortions; e) the feasibility of replicating the risk and damage reduction model in other contexts; f) the need to generate changes to avoid the negative health consequences and deaths from unsafe abortions.

COMPREHENSIVE ADOLESCENT HEALTH CARE

RISK AND HARM REDUCTION IN REPRODUCTIVE HEALTH WITH GENDER EQUALITY

This publication presents the experience "Comprehensive Adolescent Health Care: Risk and Harm Reduction in Reproductive Health with Gender Equality", as implemented by the Adolescence Service in Cosme Argerich General Hospital in Buenos Aires in close collaboration with the Fundación para la Salud del Adolescente del 2000 (FUSA 2000). For more than twenty years, the Adolescencs Service has been dedicated to the health of male and female adolescents between the ages of 10 and 20.

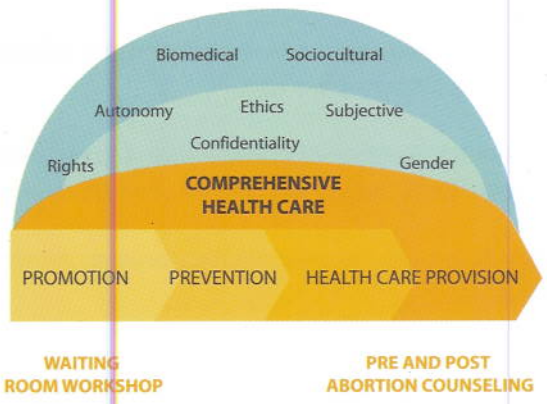
This experience is based on comprehensive care, moving away from the hegemonic medical model to include other disciplines and social actors, as well as the active participation of adolescents. In other words, the model used in this experience understands the health-illness-care process as an integrated process that involves a great deal of variables which must be addressed during the consultation.

The hospital's programmatic area encompasses the southwestern area of the city where many families with unmet basic needs reside. Also, a large portion of hospital users come from the southern suburbs of the greater Buenos Aires area, where many municipalities with large poverty sectors exist. The hospital also gives consultations to the populations of neighboring countries who have their own cultural idiosyncracies, a fact which has to be taken into account at the time of service.

The Service receives approximately 15,000 consultations annually, 75% of which are from adolescent women. These consultations are addressed in an interdisciplinary way through different areas: internal medicine, gynecology, obstetrics, nutrition, disability, etc. Comprehensive sexual and reproductive health care is one of the core areas of the Service. The Service is also a delivery point for the Sexual and Reproductive Health Program of Buenos Aires that distributes contraceptive supplies at no cost. In addition, it collaborates with the National Sexual Health and Responsible Procreation Program from the National Ministry of Health to provide technical assistance.

Two innovative activities are developed during promotion, prevention, and health care service provision:
-Waiting room workshops
-Pre and post abortion counseling

Figure: 1



Source: Self elaboration

Incorporating subjective and socio-familiar aspects, visualizing gender inequities, promoting autonomy and rights, and respecting confidentiality as well as the bioethical principles are fundamental principles of the clinical practice.

WHY DID WE DO IT?

Health is determined by socio-cultural aspects that are affected by gender, class, and age, among other factors. Therefore, taking a broad definition of health means generating actions that address these variables.
Our daily work with adolescents allowed us to observe the following:

- Low or deficient reproductive health prevention.
- Reproductive health is understood as something that only concerns women.
- Low male participation in reproductive health issues and low demand for health care services by male adolescents.
- Low adolescent autonomy to make decisions regarding contraceptive use.
- Growing number of consultations for unwanted pregnancy and for unsafe abortion complications.
- Significant gap between information and utilization of resources.

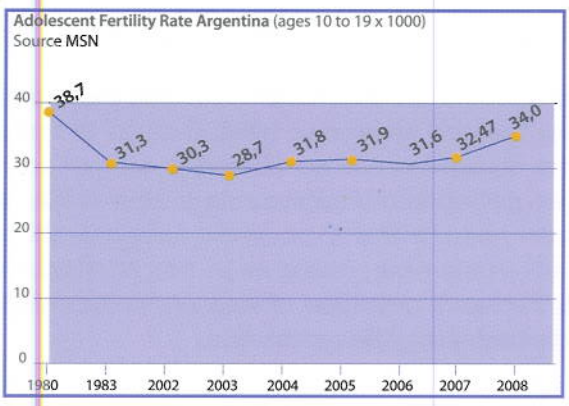
The statistical data on adolescent pregnancy, abortion incidence, and maternal morbidity and mortality due to unsafe abortion in Argentina, as well as data from the Argerich General Hospital, will help to better understand the situation in the country and the need for different actors, including health care professionals, to become involved in this issue.

ADOLESCENT FERTILITY DATA

The increasing adolescent fertility rate (10-19) in our country is a reality. It showed a decreasing curve since 1980 and began to increase again in 2003, as shown in Figure 2.

In 2007, of a total of 700,792 live births 106,720 were of adolescent mothers aged 15 to 19 years, while in 2003 this figure was 92,461[1]. Experience tells us that a percentage of these pregnancies are not wanted or planned. The implications that such circumstances can have on the health and future development of both mother and child are well known. In addition, many adolescent pregnancies end up in abortions and therefore are not reflected in the official statistics.

Figure: 2

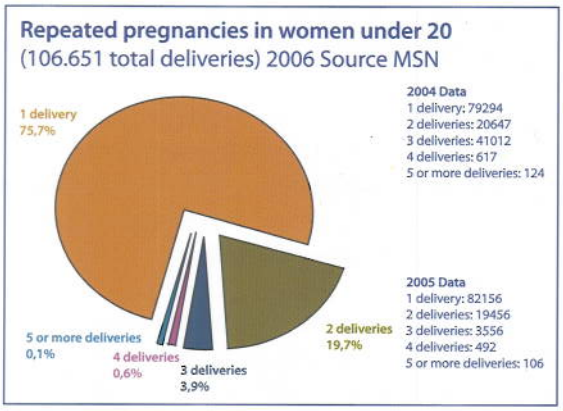


According to the most recently published data, the adolescent fertility rate in Argentina among women aged 15-19 years is 64 per 1,000. This is not uniform across the country. The lowest rate is in Buenos Aires (34 per 1,000) while in northern provinces like Chaco, Formosa or Misiones it is over 80 per 1,000 (UNFPA, 2009).
The percentage of deliveries in women under 20 years of age is 7.1% in the City of Buenos Aires (UNFPA, 2009). Yet, even within the same city differences can be great, considering that at Argerich General Hospital the figure is close to 19%.

(1) Dirección de Estadísticas e Información en Salud (DEIS). Ministerio de Salud de la Nación

Although the proportion of births in women under 15 is low –it is does not reach 3% in the whole country- in some provinces like Chaco it is as high as 5.5 % (UNFPA, 2009). These numbers are significant in consideration of how giving birth can deeply affect the physical and mental health of girls, especially since such pregnancies often result from nonconsensual sex.
Data from the Ministry of Health shows that 24% of mothers below age 20 have had two or more births.

Figure: 3



Abortion figures

Since abortion is a legally restricted practice, there is no precise data on the number of abortions that take place in Argentina. According to recent estimates, nearly 450,000 abortions are performed each year, which means more than one abortion per every two births (0.64 abortions per birth) (CEDES, 2007).

The following table shows data from a recent investigation (Pantelides & Mario, 2006) about the number of abortions in Argentina:

Abortion /live birth ratio and abortion rate (per 1,000 women aged 15-49).

Argentina, 2004 - 2005

Figure: 4

	Abortion rate AR (1)	General abortion rate x 1000 women (2)	Nº of abortions per year (3)
Alternative with Ca1	2,13	60,8	485.974
Alternative with Ca2	2,29	65,4	522.216

- (1) The abortion rate represents the average number of abortions that a woman from a hypothetical cohort would have by the end of her fertile life. It is assumed that she is not exposed to mortality during her fertile life, and that the abortion rates specific to age are the same in the population of interest at the time of calculation.
- (2) Number of annual abortions per every 1,000 reproductive aged women
- (3) Corresponds to urban population residing in areas with more than 5000 inhabitants, representative of 84% of the total population and 96% of the urban population of the country.

According to Ministry of Health data, 16% of hospital discharges due to abortion complications are women under the age of 20 (2008).

Maternal mortality and unsafe abortion

The reduction of maternal mortality is essential to the progress required to fulfill the international commitments adopted by our country. In the last 20 years, the maternal mortality ratio (MMR) has generally decreased, with some oscillations, but from 2000 on it began to increase and reached 4.4 deaths per 10,000 live births in 2007. If this tendency persists, Argentina will have difficulty in reaching the Millennium Development Goal of reducing the 1990 maternal mortality rate by three quarters by 2015, which is a MMR of 1.3 x 10.000 live births (Abdala, 2009).

The causes of maternal mortality have also remained invariable during the last 15 years, with abortion complications as the leading cause of death (DEIS, 2007). It is worth noting that the proportion of maternal deaths due to abortion (24%) more than doubles the World Health Organization´s estimation for the entire region (11%) (WHO, 2007).

Figure: 5

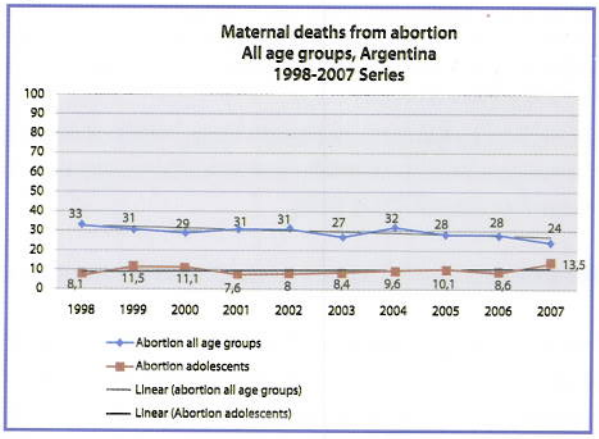
PROPORTION OF ABORTION RELATED DEATHS OVER THE TOTAL OF MATERNAL DEATHS:

- 2004: 33.2% (94 DEATHS FROM ABORTION)
- 2005: 26.7% (79 DEATHS FROM ABORTION)
- 2006: 27.9% (93 DEATHS FROM ABORTION)
- 2007: 24.2 % (74 DEATHS FROM ABORTION)

Each year in Argentina nearly 100 women die from abortion related complications. These deaths are due to unsafe abortion procedures and delays in seeking medical attention. Another factor contributing to maternal mortality is the inability or unwillingness of health care services to respond to the needs of women seeking medical care in an effective and timely manner (Ramos, 2004).

The distribution of maternal mortality according to age shows that every year girls and adolescents die from unsafe abortions, and the number has increased in the last years. Of the 68 abortion-related deaths in 2008, 8 were adolescents.

Figure: 6



Source: Women´s Health Link based on Vital Statistics, DEIS, Ministry of Health

HOSPITAL OVERVIEW

In a health care service that addresses such diverse demands as seasonal infectious diseases, eating disorders, metabolic syndromes, chronic diseases, etc (Berner, 2009), the consultations on reproductive health issues play a predominant role.

The growing number of pregnant adolescents who come to the hospital alone with no relative or partner, and who are unsure about what to do and voice their doubts and fears about continuing or terminating the pregnancy has been an issue of concern for the health care team for a number of years.

A research study carried out by the Adolescence Service found that of all of the adolescents who were pregnant when they consulted the hospital, 16% had an abortion. Of the 74% that continued with the pregnancy, 34% accepted the child with resignation as part of their "destiny as women". These women continued their pregnancies out of fear of abortion or because it was their partner's will, but never due to their own desire for motherhood (Calandra, 1996).

This reality led us to design preventive strategies, and in 2002 we started offering waiting area workshops focused on issues of sexuality, gender and rights. The idea was to transform the time spent in waiting areas into a space for health promotion and prevention where, in addition to providing information, gender issues, women's empowerment and male participation in reproductive health were addressed.

Years later, we observed that a growing number of adolescents were seeking consultation for diverse symptoms after using misoprostol for self-inducing an abortion. Since most women were no longer using high-risk abortion methods there were less infections and serious abortion complications had decreased, but other complications that required hospitalization still occurred.

This led us to investigate the methods these young women undertook before coming to the hospital. We concluded that they were using the medication in inadequate ways in terms of dosage, administration, and gestational age, usually based on information provided by friends and relatives (Vázquez, 2004).

These findings were the main reason why we decided to implement reproductive health counseling for adolescents focused on pre- and post-abortion.

WHAT WERE WE LOOKING FOR?

We looked for reproductive health promotion and prevention strategies with a comprehensive care approach that takes into consideration the existing gender inequalities.

In order to do so, we gave priority to:

•Making the relationship between professionals and adolescents and between adolescents and the health care service horizontal, in order to improve communication and active listening regarding adolescent issues.

•Transforming the unutilized space of the waiting room into a prevention-focused space with participatory activities to:

-Visualize gender inequalities
-Empower adolescents in terms of their sexuality
-Promote autonomy
-Promote the exercise of rights and appropriation of resources
-Prevent risky sexual relationships
-Promote male commitment to the prevention of sexually transmitted infections and unwanted pregnancy, and to their responsibility in child rearing.

•Create a space for pre-abortion counseling which favors informed and responsible decision making and ensures confidentiality.

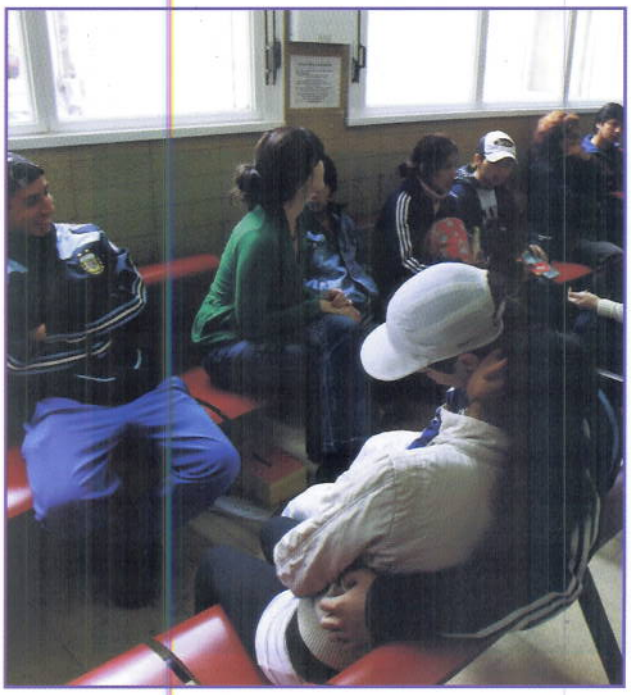
•Improve post-abortion care and adolescent contraceptive use under the Reproductive Health Program in order to prevent repeated unwanted pregnancies.

•Train professionals in comprehensive health care with a gender and rights perspective.

•Apply the concept of lost opportunities.

THESE STRATEGIES SEEK TO REDUCE RISKS AND HARM IN SEXUAL AND REPRODUCTIVE HEALTH

We started offering pre-abortion counseling in 2004, and since then the number of users has gradually increased. In 2008 we began to keep statistical records of the consultations. In July 2009, we began working with the project "Implementation and Expansion of Comprehensive Sexual and Reproductive Health Care Services in Argentina" that includes a standardized clinical history form developed by the International Planned Parenthood Federation.



HOW DID WE DO IT?

A- Risk and damage reduction concept

Throughout life, people will be exposed to risks according to their age, environment, gender, and degree of exposure.

The model of risk and damage reduction within the context of comprehensive health care seeks to reduce the exposure to risks, or when risks exist, to mitigate their damage.

The theoretical framework of risk and damage reduction is based on the bioethical principles of **autonomy**, in terms of making informed decisions, **nonmaleficence** and **beneficence**, fundamental to medical acts and respect for individuals, and **justice**, based on access to health care without discrimination of any type.

Reducing harm resulting from risky sexual behavior requires undertaking educational and promotional actions as well as counseling.

These actions require the commitment not only of the health care professionals, but also of the institutions and political decision-makers who are key to enabling and promoting such actions.

In order for the model to be sustainable in health care services, users must have access to the information needed for decision-making. This is the reasoning that led us to implement our workshops and offer counseling.

B- Workshops

We assumed that the hospital waiting areas could be transformed into spaces for non-traditional group communication for health promotion and prevention.

In 2000 we began working with the health workshops, and as part of an agreement with the Council for Children and Adolescents Rights (CDNNyA), in 2002 these activities focused on sexuality, gender and rights. Since then we maintain a statistical record of the workshops.

An interdisciplinary team of professionals, adolescents and their companions meet in this space to talk about health-related issues with emphasis on sexual and reproductive health from a gender and rights perspective, since often these rights are violated by the health care system.

These communication spaces eventually turned into workshops. We adopted the workshop methodology because we consider it the most appropriate for establishing a dialogue, exchanging experiences, listening to each other, and reflecting. Different tools for engagement based on references to individuals' own history and daily experiences are used to enable access to health prevention knowledge, resources and rights.

Each group of participants is different. During the workshop we address topics such as pregnancy and STI prevention, contraceptive methods, emergency contraception, condom use, abortion, discrimination, rights, etc.

The workshops are a collective space in which the issues that are addressed would rarely arise without the intervention of an experienced coordinating team. The exchange generated during workshops opens up the debate about gender inequalities and fosters a critical view of gender roles.

This methodology is innovative and differs significantly from the classical model based exclusively on the dissemination of information, and it encourages the active participation of adolescents through engaging and participatory activities.

Why the waiting area is an appropriate space to talk with adolescents:

•We see it as the **entrance door** to the health care service, the first link in the chain of consultation.

•We **give participants a voice** and enable a dialogue that has a starting point which is common and familiar to most participants.

•We promote **listening to each other**, both adults and adolescents. This fosters intergenerational and intrafamilial dialogue.

•We offer **information** about sexual and reproductive health.

•We are open to conflicting opinions and opposing ideas, emphasizing the value of different points of view.

• We promote **gender equity**, highlighting existing inequalities as well as the need to **empower women**.

•We recognize the ways in which **personal and institutional resources** can help reduce risks and harm.

•We strive for the recognition of **rights** and development of **autonomy.**

•We promote **male involvement** in reproductive health.

- How we address gender issues

Even though the construction of gender identity begins during the first stages of life, it is not until adolescence that the bodily changes associated with reproductive capacity take place.

Why talk about gender in the waiting area? Because we want to dismantle the social constructions created around being male or female; gender stereotypes that reproduce health inequalities, whether in prevention, health care, or the ways that adolescents seek medical care.

Gender issues are addressed in workshops through:

- Daily life situations such as condom use, male reluctance to wear condoms, unwanted pregnancy, coercion, etc. For example:

- What does a guy do if his girlfriend is pregnant? The first reaction is usually "he runs away" or "he disappears". Considering that in practice the burden of pregnancy prevention is placed on the woman, discussing these answers provides an opportunity to talk about pregnancy prevention from a gender perspective.

- What do people think about a woman who carries condoms in her purse? Using terms like "preventive woman" instead of a "fast woman", as young people usually do, helps to think differently about this issue.

- Why would a woman agree to have sex without a condom? Answers stating "love" or "being in love" are the most frequent and prevail over "not being able to say no if he does not wear a condom".

- Statements made by participants in other workshops:

- "Women are told to take care of themselves so that they don't do it. Men are told to take care of themselves when they do it" (Female, age 17).

- "Women who have condoms in their purse are fast women" (Male, age 20).

- "Whoever says that he always wears a condom is lying" (Male, age 19).

During workshops facilitators foster participant interaction to discuss these statements.

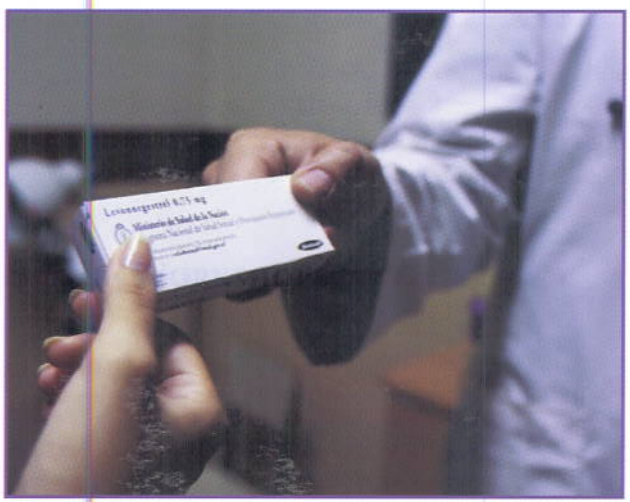
- How we address rights issues

We believe that talking about rights in this space provides young people with the tools to defend their rights in cases when they are not respected. The exercise of rights is an essential process for all areas of life, including health.

We explain that adolescents have the right to receive health care even if they are minors, making explicit the different laws that protect them despite their age.

During the workshops we distribute copies of the main relevant laws. We are aware, however, that disseminating information about the law is a very important step, but not enough on its own.

For example, we inform adolescents about emergency contraception and their right to request it . Adolescents must know that if a health care worker violates laws and regulations for any reasons, they are still entitled to demand their rights.



- How we address the issue of abortion

In the beginning of this experience, when an adolescent referred to abortion as a solution to an unwanted pregnancy, the health care team did not dare to speak freely about abortion since they were in an open and public space. Self-censorship was an obstacle. As time went by, the issue of abortion in adolescents became a more common topic in the exchanges of workshop participants, brought up as something that had happened to a friend or as a question. Thus, we saw the need to create a space for reflection within the group of facilitators and other health care professionals in order to adopt a coherent criteria on this topic. Since the end of 2003, we no longer avoid the issue of abortion, In fact, we intentionally use trigger questions to facilitate talking about abortion, knowing that evidence has clearly showed that it is a well-known practice among adolescents. The following testimony of a workshop participant is quite eloquent:

"I´m against abortion, but if the time comes I don´t know what I would do".

When asked about what they think should be done when someone decides to terminate a pregnancy or has already done so, the vast majority responded that the woman should see a doctor.

Most responses, however, also reflected a fear of criticism and punishment that might prevent women from seeing a doctor. Some reasons given were: "because it is illegal", "they fear they will be reported to the police", "because they treat you badly", "because they cannot solve your problem". In these situations, the facilitators reassure the participants that the counseling space is a friendly place where they will be listened to, not judged or denounced.

We believe that opening up the workshops to talk about abortion allows us to address the issue of confidentiality during the medical visit, the professional's obligation to maintain confidentiality, the existence of

counseling, and the need for a post-abortion follow-up and contraception.

c- Reproductive health counseling

The Adolescent Health Service makes consistent efforts to prevent unwanted pregnancy. In many cases, however, adolescents reach the service already with an unwanted pregnancy, whether due to lack of contraceptive use, incorrect contraceptive use, or contraceptive failure.

We believe that every young girl facing an unwanted pregnancy who is unsure about what to do has the right to be heard and counseled on the different options she has in a language that she can easily understand. We concluded that we could not let any young girl who contacted the health care system go without first offering her the prevention tools that medical knowledge can provide, knowing that without them she would possibly become part of a high morbidity-mortality risk group.

In countries like Argentina, where the legislation on abortion is restrictive, making the decision to open a counseling space where adolescents can share options about their unwanted pregnancies, including the possibility of abortion, was a real challenge.

During this group process, we were motivated by reading the book written by Faúndes and Barzelatto (2004) where –among other considerations – the authors refer to the public condemning of abortion and the private acceptance of it by health care professionals, particularly when the person involved is emotionally linked to him/her. In our daily practice we confirmed this, since it is common to observe how doctors have a greater commitment with women who are thinking about having an abortion when it is the case of a relative, a friend, or a patient they have seen for a long time with whom they have a good relationship.

Another thing we considered when thinking about implementing counseling was the experience of our Uruguayan colleagues, who have implemented a system of counseling for safe motherhood called "Sanitary Initiatives against Unsafe Abortion." In Uruguay, as in Argentina, abortion is illegal except in a few situations. Therefore, they based their intervention on providing pre-abortion counseling and information and improving post-abortion care. Their efforts have significantly reduced maternal mortality (Briozzo, 2007).

In our work we do not actively promote abortion, we provide information about the existing medical and legal risks. Through counseling we seek to create a space for joint adolescent/professional reflection in order to:

•Advise on the different possible options when an unwanted pregnancy has occurred. We refer to this as "options counseling" since we offer information about possible choices, such as adoption or the existence of support networks in case they decide to continue the pregnancy. In this way we are able to increase the amount of factors to think about, beyond the ones that are typically considered under emotional duress.

•Gain knowledge about the information that women count on in order to carry out their decisions. We provide the necessary guidance to help young women make informed decisions about their life and body, avoiding or minimizing possible harm.

Thus, we provide information about the different ways to discontinue a pregnancy with minimal risks and harm.

•Try to understand the causes which lead to the desire to discontinue the pregnancy, since often times relatives and close acquaintances have a strong influence in the decision.

•Emphasize the benefit of including the woman's partner in this reflection, always making clear that the ultimate decision will be the woman's to make autonomously.

•Include the patient in the comprehensive care clinical protocol. When necessary we refer to the interdisciplinary group to provide social and psychological support.

OUR JOB IS TO PROVIDE INFORMATION AND COUNSELING, NOT TO INDICATE ANY METHOD.
IF WE DID SO WE WOULD BE ACTING AGAINST THE LAW.

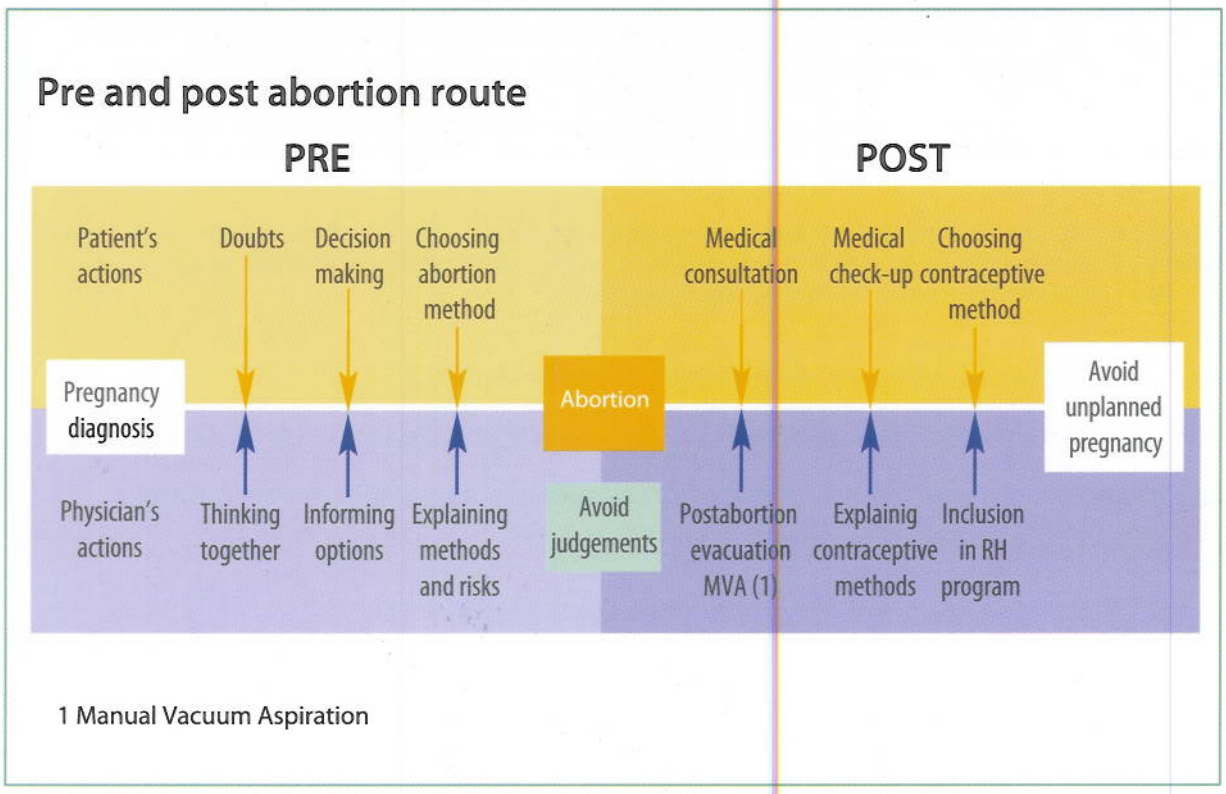
In post-abortion care, frequently the illegal status of abortion shapes the medical assistance process to disadvantage women that have undergone an abortion. Unfortunately, institutional mistreatment is common.

The health care assistance model privileges motherhood even when it is not the woman's autonomous decision, thus women who have abortions break the motherhood mandate; this negatively affects their chances of receiving the emotional support and humane treatment required.
All of this is even more worrisome since adolescents are a particularly vulnerable group.

Therefore in our model we give priority to:

- Providing quality care after an abortion
- Ensuring humane treatment by professionals and all staff that has contact with the adolescent
- Reducing psychological and physicial complications from unsafe abortion
- Enrolling the woman in the Sexual and Reproductive Health Program to avoid another unwanted pregnancy

Figure 7



The fact is that abortion has a "before" - beginning the moment the woman considers the possibility of having an abortion until that actually takes place– and an "after" –from the moment when the abortion takes place until the complete recovery of the woman (Briozzo, 2007). The table above explains the medical interventions before and after an abortion.

WHO PARTICIPATED?

This experience was possible thanks to a highly dedicated interdisciplinary professional team and the adolescents who find in our service a friendly space for medical care.

THESE ACTORS INCLUDE:
a) The interdisciplinary team of workshop facilitators that has extensive academic training in gender issues.
b) The professionals who provide clinical care who have a comprehensive care perspective as well as a gender perspective that they apply to their work and pass on to the new generations of professionals.
c) Adolescent users who find a place where they are not discriminated, where they receive information, counseling and care, and where they can talk about their sexuality in a way that they would not be able to do in other places.
d) Adolescents with an unwanted pregnancy who reach a health care service that offers counseling without judging them and helps them make informed decisions. Both gynecologists and internists adopt strategies to reduce risks and harm within the current legal framework.
e) The male partner of a pregnancy who is included in the reflection space.
f) The public health system and hospital authorities who acknowledge and support the experience.
g) The national and international organizations that have supported and continue to support our work.

WHAT HAVE WE ACHIEVED?

After almost 10 years of implementing waiting area workshops we can say that participants of this activity are often surprised since they are not used to this type of activity in the hospital environment. At the same time, they are pleased and highly value the knowledge that they acquire, as well as the opportunity to express their opinions and be listened to. At the end of each workshop, we submit a brief survey for participants to provide their impressions and comments, which allows us to make a quantitative and qualitative evaluation.

STATISTICAL DATA OF WAITING AREA WORKSHOPS BETWEEN JUNE 2002 AND MARCH 2010

TOTAL WORKSHOPS: 542

APPROXIMATE NUMBER OF PARTICIPANTS:

6,780 ADOLESCENTS (5,480 FEMALE, 1,300 MALE) AND 1,990 ADULTS

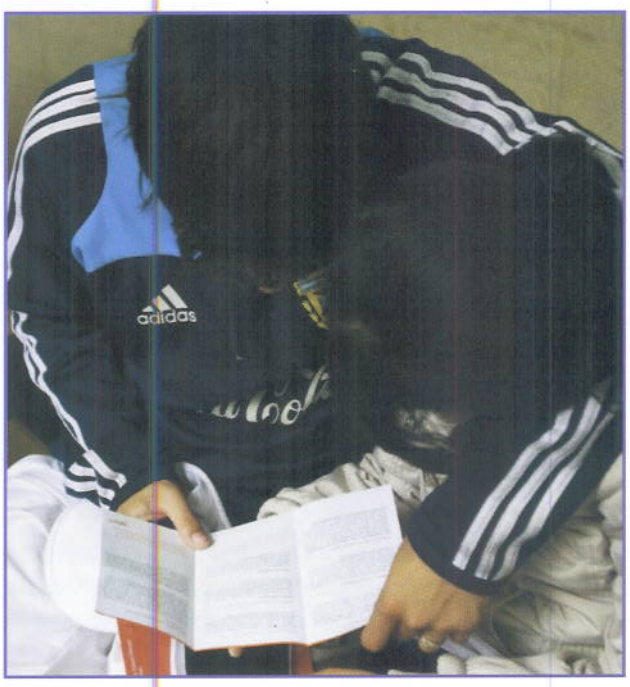
In 2004, a research project to evaluate the waiting area workshops was carried out (Zingman, 2004). Results show that workshop participants have greater adherence to the health care service, have greater number of follow up visits, and share the information received during the workshop with their peers and close ones.

The impact of workshops was measured after a three-month period through semi-structured interviews with a small number of workshop participants. Most interviewees clearly remembered the information provided.

It is important to note that workshops are considered the first link of the medical consultation. They add value to it since often times, after participating in the workshop while waiting, both male and female adolescents discuss other issues beyond the original reason why they went to the hospital that day.

TESTIMONIES OF ADOLESCENTS

- "I liked it because we can say what we think" (Female, age 15)
- "We can talk about things that we do not dare to talk about at home" (Female, age 17)
- "In the heat of the moment you don't think about using one, but then you catch on fire and burn yourself" (Male, age 20)



TESTIMONIES OF ACCOMPANYING ADULTS

- "It's good, keep it up, I never saw these talks in a hospital" (Adult female)
- "After an abortion, girls are afraid to come to the hospital; they fear that the doctor will reprimand them, or that they will be reported to the police" (Adult female)
- "When you sleep with someone you are sleeping with all the people he/she has slept with before" (Adult male)

There has been a gradual increase in the number of users of the pre- and post-abortion counseling services since they began in 2004 due to:

- Word of mouth among adolescents.
- Because it is mentioned in the waiting area workshops.
- Through referrals from other professionals who know about the counseling we provide.

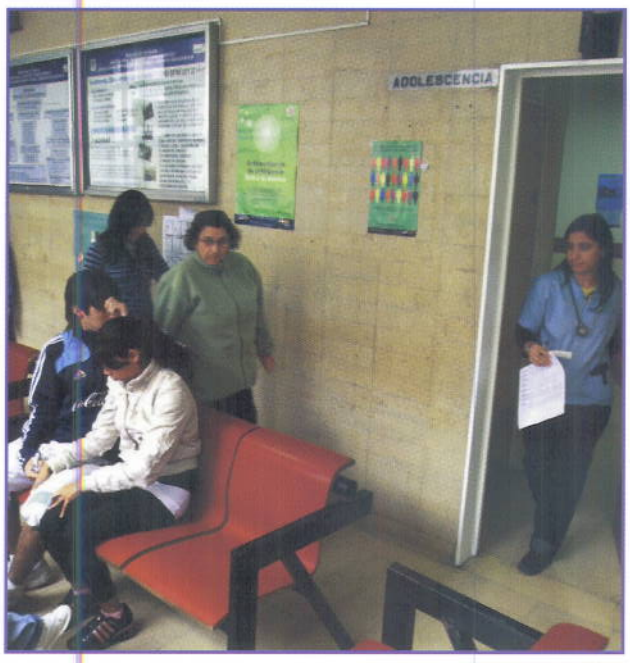
In July 2009 we started an "Implementation and Expansion of Comprehensive Sexual and Reproductive Health Care Services" project that includes a standardized clinical history form for data collection.

TOTAL USERS IN 2008: 70

TOTAL USERS INCLUDED IN THE PROJECT BETWEEN JULY 2009 AND MARCH 2010: 75

We can state that since we began offering counseling, hospitalizations due to unsafe abortion complications, as well as dilation and curettage (D&C) procedures have decreased.
Some of the quantitative data from the period in which records have been kept (for 75 users) shows that:

- 7 patients decided to continue the pregnancy (some due to the advanced stage of their pregnancy and the information they received about the risks of abortion at such gestational stage).
- 68 patients decided to use misoprostol for abortion.
- Only 5 cases required hospitalization.
- For 93 % of users it was the first time they had an abortion.
- 78 % received the service during the first trimester of pregnancy.
- 57 % of the pregnancies resulted from not using any contraceptive method and 40% had inadequately used contraceptives.
- There were no infectious post-abortion complications.



TESTIMONIES

- When I started my professional life it was common for women to be hospitalized for abortion infections. The day that I saw an adolescent die due to generalized infection after an abortion, my mind changed. It really affected me. That's why I believe that counseling is important for women who want to have an abortion.
  ObGyn Doctor
- I did not want her to come to the hospital because I was afraid that they would treat her badly for what she was going to do, but you understood what was happening to us, that we were in no condition to have a baby, you treated her well, you gave us advice.
  (Adolescent male, boyfriend of pregnant adolescent girl)
- Doctor, you have no idea how good it was to talk to you. When I saw the two lines I panicked.
  Adolescent female who after counseling decided to continue with her pregnancy

HOW DO WE SUSTAIN IT?

Sustainability of both workshops and counseling was possible because these take place in a public hospital and therefore use its infrastructure and partially rely on its human resources.

Waiting area workshops were sustained for several years (2002-2007) thanks to an agreement with the CDNNyA, and afterwards they were sustained by the volunteer work of facilitators (who are not part of the stable hospital staff). Since July 2009 workshops have been included in a FUSA/IPPF risk and damage reduction project. However, the main obstacle for the sustainability of the workshops is lack of continued funding.

During nine uninterrupted years of work, we were able to raise awareness of sexual and reproductive rights and gender inequalities among the adolescents who use the service.

The space for reproductive health counseling, particularly for pre and post-abortion counseling, was created and sustained thanks to the hard work of the health care professionals working in this area and their deep commitment with adolescents' right to choose.

The signed agreements were also important for the sustainability of our activities. One of them, a tripart agreement between the National Ministry of Health, FUSA 2000 and IPPF, aimed to contribute to the reduction of maternal mortality in the country, included sensitization and training of health care providers on the reproductive health risk and damage reduction strategy.

This is particularly important because it signals the official support of the Ministry of Health, a crucial factor in places where the environment and prejudices make addressing sexuality issues very difficult. These places are also where adolescents are disproportionately affected by unwanted pregnancies, sexual abuse, and all types of inequalities. Nine interventions where carried out in jurisdictions of the Greater Buenos Aires Area and we plan to reach several provinces in the future.

For a two-year period starting in July 2009, we also have the IPPF project "Implementation and Expansion of Comprehensive Sexual and Reproductive Health Care Services". Its goal is to strengthen our model of risk and damage reduction and replicate it in three public health care centers of the City of Buenos Aires. This project is being evaluated by the Sexualities Studies Group from the Gino Germani Research Institute at the School of Social Sciences of the University of Buenos Aires.

Replication in other contexts

The experience of the waiting area workshops was disseminated through five interdisciplinary, practical and theorethical training courses with 32 participants who were professionals working in different fields, many of whom replicated the acquired experience. The experience has also been disseminated through presentations in scientific conferences and through the mass media.

This innovative counseling approach was also presented at two trainning workshops organized by the Ministry of Health where delegates from different regional Sexual Health and Responsible Procreation Programs participated. So far, we do not have any additional information about its replication in other health care centers.

In June of 2008 the "Latin American Meeting on Risk and Damge Reduction: Working Holistically" was held in Buenos Aires with support from IPPF and FUSA 2000. Representatives from different countries participated of this three-day meeting that focused on adolescent heath care provision.

Currently, the Adolescent Service together with FUSA 2000, are important referents in risk and damage reduction in reproductive health. Its members are often invited to present the experience in meetings, conferences and workshops.

WHAT HAVE WE LEARNED?

The experiences presented in this document about good practices in sexual and reproductive health within the context of comprehesive health allow us to make considerations about the achievements and obstacles we have encountered, as a way to encourage its replication in other contexts.

Important considerations:

•Create adolescent-friendly, adolescent-specific spaces for health care provision that are respectful of user privacy and confidentiality.

•Include the perspective of other disciplines in the consultations in order to incorporate knowledge that goes beyond the exclusively medical perspective.

•Include different medical specializations in order to bring together internists, gynecologists, and nutrition specialists, since most consultations have to do with these areas.

•Foster a comprehensive approach in consultations, including not only reasons for the consultation but also the socio-familiar and cultural environment, considering these are significant determinants in the health/illness process.

•Use non-conventional communication spaces present within different contexts to carry out promotion and prevention activities. This serves as a way to expand the opportunities for exchange with adolescents, as well as to provide health information and counseling.

•Implement pre and post abortion counseling in health care centers in order to reduce risks and harm associated to unsafe abortion; it is not necessary to have a specific space devoted to this task because we are aware of the institutional difficulties that this may bring, and also because counseling should be a tool that every health professional can use at any time.

•Address adolescent reproductive heath, and particularly the issue of abortion. This can be controversial in some legally restrictive contexts, even when it is framed within the current laws, and can become an obstacle by generating resistance and criticism from certain fundamentalist sectors of society. However, we are convinced that no adolescent who has contacted the health care system should leave without receiving counseling and reproductive health care. If she has decided to discontinue her pregnancy, we must offer her all the information we have that can help her to reduce the risks that she may be exposed to.

•Sensitize and train health care professionals on the specific aspects of adolescent reproductive health care, including pregnancy prevention and counseling for adolescents who express their desire to discontinue their pregnancy. Health professionals play a very important role in these situations, and it is therefore essential that a greater number of them are sensitized and trained.

TO DIMINISH THE INHERENT HEALTH RISKS AND HARM OF UNPROTECTED SEXUALITY AMONG ADOLESCENTS AND YOUTH, INCORPORATING ASPECTS RELATED TO GENDER AND SOCIAL INEQUALITIES SHOULD BE ONE OF THE OBJECTIVES OF HEALTH PROFESSIONALS' ACTIVITIES.

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