SUBSEQUENT ADOLESCENT PREGNANCY: ADDRESSING ‘MISS END OPPORTUNITIES’ IN THE CITY OF BUENOS AIRES

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By

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SUBSEQUENT ADOLESCENT PREGNANCY: ADDRESSING ‘MISSED OPPORTUNITIES’ IN THE CITY OF BUENOS AIRES

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ABSTRACT

Adolescent pregnancy is a recurring topic within global health and international development, and improvements in adolescent pregnancy rates in Latin America have been fairly limited. Within this topic, subsequent adolescent pregnancy and the “missed opportunities” concept indicate an area where the health sector could more easily intervene but seemingly fails to do so. When an adolescent interacts with the health system and receives care for her first pregnancy and childbirth, this presents an ideal opportunity for the health system to present her with information, support, and a contraceptive method. Thus, if an adolescent has a subsequent unplanned or undesired pregnancy within a year and a half of her first, this can potentially be seen as a failure of the health system. This paper looks to understand current efforts within the Argentine public health system related to adolescent sexual and reproductive health (ASRH), determine potential gaps in health services working with adolescents, and provide insight into persistently high rates of subsequent adolescent pregnancy. The research concludes that a multiplicity of factors, broadly categorized into institutional and socio-cultural reasons, contribute to persistently high rates of subsequent adolescent pregnancies. The conclusions reached can provide relevant insight for programmatic and policy efforts across urban Latin America.
ACKNOWLEDGEMENTS AND DEDICATION

My sincere thanks to my thesis advisor for his guidance and support throughout the research and writing of this thesis, and to those interviewed who contributed their time and shared their unique insight to help shape my understanding of adolescent public health issues in Buenos Aires, Argentina, and wider Latin America.

The research and writing of this thesis are dedicated to my family for their unconditional love and support, and to young girls like Liz from Villa 21 across Latin America.

Many thanks,
Giselle M. Bello
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I. Introduction

Adolescent pregnancy is a recurring topic within global health and international development, and improvements in adolescent pregnancy rates have been fairly limited. Within this topic, subsequent adolescent pregnancy and the “missed opportunities” concept provide a particular field of research, and indicate an area where the health sector could more easily intervene but seemingly fails to do so. Stemming from a strong interest in the public health issues of urban youth, this thesis hopes to provide insight into the variables surrounding subsequent adolescent pregnancy in the city of Buenos Aires.

The research looks to examine the “missed opportunities” concept in the city of Buenos Aires, and determine potential gaps in health services working with adolescents. Unplanned adolescent pregnancies result from a multiplicity of complex factors. However, once an adolescent is interacting with the health sector during her pregnancy, childbirth, and follow-up appointments, this presents an ideal time for the health sector to provide her with information, support, and a contraceptive method. And yet, there are persistently high rates of subsequent adolescent pregnancies, often within two years or less of the first pregnancy.

This research looks to provide insight into the persistently high rates of subsequent adolescent pregnancy, and where and how these ‘missed opportunities’ continue to reoccur. Researching the available literature, assessing the regional Latin American and Argentine context, and assessing the current situation of adolescent pregnancy in Buenos Aires will hopefully provide greater insight for adolescent sexual and reproductive health (ASRH) in Buenos Aires, thus suggesting policy and programmatic recommendations.
II. Adolescent Pregnancy

A. Introduction

Adolescence is a time of rapid psychological and physiological change. The surrounding context and support network must work together to provide the support these teenagers and young adults to grow and develop. Furthermore, adolescent sexual and reproductive health is a critical aspect of overall growth and development, and “there is a growing recognition of the importance of addressing the sexual and reproductive health and rights” of this population.\(^1\) Efforts are ongoing, and the specific context and levels of success vary between regions and countries.

Looking at figures for American adolescents, fewer than 2% have had sex by the time they reach their 12\(^{th}\) birthday, but within 5 years 71% of 19 year olds have. On average, young people have sex for the first time at around age 17, but do not marry until their mid-20s. This then means that young adults could potentially be at increased risk for unintended pregnancy and STIs for nearly a decade or longer.\(^2\) In this respect, it is critical to ensure that adolescents are equipped with the information and access to services to allow them to make informed decisions.

Adolescent pregnancy is an area of particular interest, with extensive programmatic and policy efforts aiming to reduce this. The vast majority of literature on the topic concludes that early pregnancy, childbirth, and motherhood present risks, both medical and socio-economic, for both adolescent mother and infant. This is particularly relevant in the context of developing countries, where these risks are often exacerbated given the already difficult socio-economic and resource-limited context of these countries, and where the majority of adolescent pregnancies and childbirths occur.

Adolescent pregnancy, within the context of overall adolescent sexual and reproductive health, is a critical area for global health and development work. Young women, particularly those in developing countries, must be empowered to make informed decisions regarding their personal health. In order to benefit from longer schooling, gain productive experience in the labor market,

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\(^1\) WHO, Research and action needed for adolescent sexual and reproductive health and rights, December 2014

\(^2\) Guttmacher Institute, “American Teens’ Sexual and Reproductive Health,” May 2014
and develop a readiness for parenthood, they need better sexual and reproductive health services, information, and access to contraception to allow them to protect their health and avoid unintended pregnancies.

**B. Developing Countries**

Adolescent pregnancy is a global reality; around 16 million girls aged 15 to 19 and around 1 million girls under 15 give birth every year. However, the vast majority of these pregnancies (95%) are to girls in low- and middle-income countries. For many of these youth, adolescent pregnancy remains a major contributor to maternal and child mortality, and perpetuates the cycle of ill health and poverty.\(^3\) Expanding on this, it is important to first establish the surrounding context for these adolescents, and then identify and understand both the immediate physiological risks as well as broader development implications of adolescent pregnancy.

**Context**

For some adolescents, pregnancy and childbirth and planned and wanted. However, for many they are not. Adolescent pregnancies are more likely in poor, rural and uneducated communities. In some countries and contexts, becoming pregnant outside of marriage is not uncommon. In contrast, other girls face strong social pressure to marry, and once married to have children. Indeed, more than 30% of girls from low- and middle-income countries marry before they are 18 and around 14% before they are 15.\(^4\)

Although change has been uneven, there has been a marked decrease in the birth rates among adolescent girls since 1990. Nonetheless, around 11% of all births worldwide are to girls aged 15 to 19 years old. Of these, 95% occur in low- and middle-income countries, with the highest rates in sub-Saharan Africa.\(^5\)

For a variety of reasons, many girls do not know how to avoid getting pregnant. For one, sex education is lacking in many countries. With regards to contraception, girls may feel too inhibited

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\(^1\) WHO, Adolescent Pregnancy Fact Sheet, Fact Sheet Number 364, Updated September 2014  
\(^2\) WHO, Adolescent Pregnancy Fact Sheet, Fact Sheet Number 364, Updated September 2014  
\(^3\) WHO, Adolescent Pregnancy Fact Sheet, Fact Sheet Number 364, Updated September 2014  
\(^4\) WHO, Adolescent Pregnancy Fact Sheet, Fact Sheet Number 364, Updated September 2014  
\(^5\) WHO, Adolescent Pregnancy Fact Sheet, Fact Sheet Number 364, Updated September 2014
or ashamed to seek these services. Even if they do seek them out, contraceptives may be too expensive or not widely or legally available. Even when contraceptive services are widely available, sexually active adolescent girls are less likely to use them than adults. Finally, as girls they may be unable to refuse unwanted sex or resist coerced sex, which generally tends to be unprotected.

**Consequences: Medical**

In terms of medical outcomes and risks, alternate pregnancy outcomes (namely pregnancy or abortion) for these girls are highly risky. Complications during pregnancy and childbirth are the second cause of death for 15 to 19 year-old girls globally. These adolescents account for 11 percent of all births globally, but contribute 23 percent of the burden of disease related to pregnancy and childbirth\(^6\). At all socioeconomic levels, reproduction in adolescence involves greater perinatal health risks.\(^7\) Adolescents aged 10-14 are five times more likely to die as a result of pregnancy and childbirth than adult women. Maternal mortality and morbidity account for 16\% of all disability adjusted life years (DALYs), which measure the loss of healthy years of life due to disability and premature death).\(^8\) Many of these health risks stem from unsafe abortions, as adolescents account for 14 percent of all unsafe abortions in the developing world\(^9\). Every year some 3 million girls undergo unsafe abortions. This contributes to maternal deaths as well as lasting health problems.

Finally, early childbearing increases the risks for both mothers and newborns. Babies born to adolescent mothers face a substantially higher risk of dying than those born to women aged 20 to 24. More specifically, babies born to mothers under 20 in low- and middle- income countries face a 50% higher risk of being still born or dying in the first few weeks. This is a linear relationship; the younger the mother, the greater the risk to the baby. Additionally, babies of adolescent mothers

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\(^6\) WHO, Adolescent Pregnancy Fact Sheet, Fact Sheet Number 364, Updated September 2014
\(^7\) ECLAC/UNICEF newsletter 6
\(^8\) Guttmacher Institute, “Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World,”
\(^9\) Guttmacher 3
have a 50-100 percent increased risk of mortality within the first month of life, and they suffer higher rates of perinatal morbidity compared with infants born to adult women. If the baby does survive its first weeks, it is more likely to have a low birth weight, which brings the risk of long-term effects.

**Consequences: Development Implications**

In addition to the substantial health risks, one can place adolescent pregnancy within a broader development context and understand the long-term implications.

There are various causes for concern around adolescent pregnancy and child-rearing. To summarize, in addition to the physical health risks, there are obstacles to continued schooling and training, disadvantages for the future of parent and child, higher risk of being single mothers, a lack of rights and gender equity, and higher fertility rates among poorer adolescents. Focusing on the final item, there is much literature on the intergenerational poverty cycle continued by adolescent pregnancy. Of the over 16 million births to adolescent women aged 15-19, 95 percent of these are in low and middle income countries. Furthermore, variations in patterns of marriage, contraceptive use and levels of unintended pregnancy among adolescent women are closely linked to their region and the level of poverty in their country.

Millions of children under 5 years of age from low and middle-income countries are not attaining their developmental potential, primarily because of poverty, nutritional deficiencies, and inadequate learning opportunities. Both “biological and psycho-social risk factors associated with poverty lead to inequalities in early childhood development, which undermine educational attainment and adult productivity, thereby perpetuating the poverty cycle.”

All this illustrates how “teenage fertility...is a problem which adversely effects and threatens progress toward the Millennium Development Goals relating to the reduction of poverty, expansion of education and improvements in mother-and-child health,” as well as reproductive rights and

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10 WHO, Adolescent Pregnancy Fact Sheet, Fact Sheet Number 364, Updated September 2014  
11 Guttmacher 1  
gender equity.\textsuperscript{13} As one study summarizes, “by impacting on education, employment and economic opportunities, pregnancy during adolescence can also have lasting socio-economic consequences which, in turn, contribute to poorer health outcomes, gender inequity and poverty of adolescent mothers, their families and communities.”\textsuperscript{14} Consequently, improvements in adolescent sexual and reproductive health contribute in particular to “the overall status of women, and eventually, reductions in poverty among families.”\textsuperscript{15} Adolescent pregnancy needs to remain a crucial public health priority, both to benefit the adolescents themselves and contribute to these broader development goals.

The “Why”: Risk and Protective Factors

Several social, cultural, and economic factors can affect adolescent sexual decision-making (and resulting adolescent pregnancy). Young people are often both unprepared for and lacking information about, the physical changes they undergo during puberty and throughout adolescence. In addition, community values and fears about sexuality in young people can limit the availability of the necessary basic information and education, leaving the transfer of knowledge about sex and sexuality to parents, families, and professionals. Unfortunately, these individuals (including health workers and teachers) can themselves also often lack such information, or do not feel comfortable communicating about sexuality. As a result, young people tend to enter into sexual relations without the necessary knowledge or skills to negotiate for their own sexual health and welfare.

What are some of the specific risk and protective factors associated with adolescent pregnancy? A comprehensive 2004 literature review from the WHO analyzes the risk and protective factors affecting adolescent reproductive health in developing countries\textsuperscript{16}. By definition,

\begin{footnotesize}
\begin{enumerate}
\item ECLAC/UNICEF newsletter 9
\item Kennedy 2
\item Guttmacher Institute, “Facts on the sexual and reproductive health of adolescent women in the developing world,” 1
\item Interestingly, this publication incorporated “relatively modest criteria for sample size and analytic sophistication” for studies related to adolescent risk and protective factors, rendering only 1.5% of the developing world’s literature over the past 14 years usable. This would indicate a continued need for increasingly robust studies in this area. There are also research limitations and paucity of data for certain regions, but thankfully for the purposes of this paper there is information on Latin America.)
\end{enumerate}
\end{footnotesize}
“protective” factors discourage health behaviors that might lead to negative health outcomes (e.g. sex with many partners) or encourage those that prevent them (e.g. using condoms and contraception). Similarly, “risk” factors either encourage or are associated with behaviors that might lead to a negative outcome, or discourage those that prevent them.\textsuperscript{17}

The publication summarizes the cross cutting factors that emerge from the literature. Although there are substantial limitations in the literature, the review shows that the following factors matter most: education and schooling; knowledge and attitudes related to condoms and contraception; perceived sexual behavior of friends; partner approval/support for using condoms and contraception.\textsuperscript{18}

Finally, analyses from developing country datasets and research from industrialized countries suggest the following set of critical factors:

<table>
<thead>
<tr>
<th>Family</th>
<th>Community</th>
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<tbody>
<tr>
<td>connection to parents</td>
<td>community/cultural norms, values</td>
</tr>
<tr>
<td>family size/child spacing</td>
<td>expectations</td>
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<tr>
<td>parenting styles</td>
<td>media exposure</td>
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<td>domestic violence</td>
<td>migration</td>
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<td>family mental illness</td>
<td>role models</td>
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<td>single parent</td>
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<table>
<thead>
<tr>
<th>School</th>
<th>Peers</th>
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</thead>
<tbody>
<tr>
<td>connection to school</td>
<td>social isolation</td>
</tr>
<tr>
<td>teacher expectations and support</td>
<td>perceived vs. actual peer behavior</td>
</tr>
<tr>
<td>being treated fairly</td>
<td>prejudice</td>
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<tr>
<td></td>
<td>positive peer models</td>
</tr>
</tbody>
</table>

\textsuperscript{17} Kirby, 2002
\textsuperscript{18} Blum, Robert, “Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries,” 7.
However, while these are shown to be important factors in industrialized countries, “current research in developing countries is too scanty to say.”

C. Latin America and the Caribbean

In addition to these shared recognized global challenges, there are regionally specific issues and context within Latin American and the Caribbean. Unfortunately research on public health in Latin America and the Caribbean is “sparse and scattered, especially with respect to the urban poor.” In saying this, Bitrán calls attention to the increasing evidence that in many countries, key health indicators for the poor are as weak in urban areas as they are in rural areas, in spite of the much wider availability of services. Studying the Latin America context will shed light on regional specifics, and bringing this together with issues particular to urban populations will especially be of relevance to Buenos Aires.

Latin America and the Caribbean: Facts and Figures

The adolescent fertility rate is the traditional indicator for global comparisons, and is included in Objective 5.B of the Millennium Development Goals. According to 2010 data, Latin America and the Caribbean (LAC) register at 68 births to mothers 15 to 19 years old for every 1,000 women of that age, a rate second only to those in Sub-Saharan Africa (with 109 per 1,000). Latin America and the Caribbean also stand out as the region with the second smallest decrease in adolescent fertility (-12.9%), again second only to Sub-Saharan Africa (-6.1%). For historical comparison, the average adolescent fertility rate between 1991 and 2010 was 73 births to mothers 15 to 19 years old for every 1,000 women of that age, again second only to those in Sub-Saharan Africa (with 117 per 1,000). This indicates a slight decline over the past decade; nonetheless, the numbers remain remarkably high, and significantly higher than the third highest region (Arab states, 48 for every 1,000).

19 Blum, 3
20 Bitrán, 2003
21 www.un.org/millenniumgoals/maternal.shtml
While this is already staggering enough, according the Guttmacher Institute each year adolescent women in Latin America account for 18 percent of all births in Latin America. This represents a higher percentage than both South Central and Southeast Asia (12 percent) and Sub-Saharan Africa (16 percent), and well above the world average (11.2%). This makes it the region of the world where births to adolescent mothers represent the largest fraction of total births.\textsuperscript{22}

How has this happened? Over the past decades, overall fertility in Latin America has decreased. This decrease in total fertility can be attributed to increased contraceptive use and improved sexual and reproductive health services. However, this decrease has not been matched with a corresponding decrease in adolescent pregnancy, resulting in the current (stagnant) statistics.

\textbf{Latin America’s Ambiguous Position}

Looking at this in further detail, in 2007 teenage fertility rates in Latin America had not decreased despite overall decreases worldwide.\textsuperscript{23} Fertility rates among adult women have been dropping globally since the 1970s due to socio-economic (industrialization, modernization, urbanization), cultural (secularization, new family styles, individualization of life plans), gender (increasing role of women in labor and social protagonism), and technological (contraception) changes. Some countries have also had additional public family planning policies and campaigns.

It was expected that these reductions (which effectively happened in the 1980s) would also extend to adolescents. However, teenage fertility rates in Latin America contradicted this tendency, even as fertility rates dropped for adult women in the region. Despite a slight reduction in the 1980s, most of the countries in the region (all but four) show little to no reduction in percentages. This places the region in a unique position; while fertility levels are below the world average and that of developing countries, its adolescent fertility levels undoubtedly pass the world average.

\textsuperscript{22} Guttmacher 1. Footnote from ECLAC/UN press release 2007: “Even if adolescent mothers still have, on average, more children at the end of their child-bearing years than mothers who start their family after their twenties, this is not associated with a high number of total births; the birth of the first child increasingly brings adolescents in contact with sexual and reproductive health services and, thus their control of reproduction following their first early pregnancy.”

\textsuperscript{23} ECLAC/UN press release 2007, 5
average (and are only exceeded by African rates). In fact, Latin America’s virtual stability in adolescent fertility despite a fall in the general fertility rate (GFR) is “virtually unprecedented.”

A CEPAL (United Nations Economic Commission for Latin America) report highlights this unique, conflicting situation present in Latin America. In short, the rate of adolescent fertility is higher, and its reduction much slower, than what one would expect given both the intense and sustained decrease in overall fertility and the improving quality of life indicators, particularly those related to education and the overall health of the population, which place Latin America above average compared to the rest of the developing world. The factors behind this paradox are:

“…complex and varied: combining psychosocial specific to this stage of life; economic, social and cultural determinants; patterns of early sexual initiation; institutional components; ideological variables; and weakness in public policy.”

Classic demographic transition (the transition from high birth and death rates to low as a country develops) is generally followed by a “second demographic transition,” which includes a later start to the first sexual relationship and first pregnancy. This is not the case for the region. While the number of children that Latin American women have over the course of their life (“la intensidad reproductiva”) has decreased across social sectors (corresponding with the above-mentioned decrease in the region’s overall fertility), the age at which women have their first child remains quite young, particularly in poorer socioeconomic sectors.

Delving further into the numbers, the percentage of adolescent mothers indicates the number of mothers from 15 to 19 years old with relation to the total number of women of that age. Incredibly, there was an increase in this percentage between 1990 and 2000. The percentage has since decreased between 2000 and 2010, from 14% to 12.5%. However, this is not enough to counteract the increase of the previous decade, such that the current level is nearly the same as 20 years ago.

24 ECLAC/UN press release 2007, 6
26 Note conflicting data: A 1991 publication cited that across a sample of countries in Latin America and the Caribbean, “the likelihood of [an adolescent women] having a first child before the age of 20 ranges from 30 percent to 50
A similar trend is observed with young women from 19 to 20 years old. While the percentage of these women who at that age were already mothers fell from 32% in 2000 to 28% in 2010, this is still essentially the same as the 1990 rates of 29%. Finally, the CEPAL report also provides figures for motherhood among girls under 15 years old. Although these levels do not go above 0.5%, it is worrisome that these figures tend to rise, given the extreme vulnerability these very young mothers face.

The countries with the highest rates of adolescent maternity rates are Nicaragua (19.9%), the Dominican Republic (19.7%), and Ecuador (17%), while the lowest rates are in Uruguay (9.5%), Costa Rica (11.1%), and Peru (11.5%). However, all of the above are much higher than the levels found in Western Europe, which average around 2%.

**Socioeconomic Background**

The aforementioned intergenerational poverty cycle is also strongly present in the Latin American context, with various articles further detailing case studies and demonstrating this cycle throughout the region. Most recently, a November 2014 press release from the CEPAL confirms that “nearly 30% of young adolescent women in Latin America have been a mother before turning 20 years old, and the majority of them belong to lower socioeconomic levels.” The age at which women have their first child remains quite young, especially in poorer socioeconomic sectors.

Specifically, of the 7 countries with available data, the percentage of mothers between 15 and 19 years of age was between 3 to 4 times greater in the lower socioeconomic bracket than the highest.27 Other analyses of the countries in the 2014 study produced further revealing correlations; over half of adolescents with low levels of education became adolescent mothers, and the percentage of adolescent mothers was higher among indigenous adolescents as compared to non-indigenous.

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27 CEPAL, “Casi 30% de las jovens latinoamericanas ha sido madre adolescente,” 2014
**Socioeconomic Implications**

Aside from any medical risks, adolescent motherhood in Latin America produces serious obstacles to further schooling and training as well as disadvantages for the future of parents and child. Mothers do not usually enter the labor market either in lieu of continuing their education, or if they do, it is generally on a casual basis. Economic independence is exceedingly difficult for adolescent mothers, as most live with their parents or in-laws and carry out domestic work. In Latin America and the Caribbean there is generally family support, such as “child-rearing grandmothers.” However, this is by nature uncertain and places increased pressure on the household budget of the mother’s parents, who also play a large role in the work of child-rearing.

Teen mothers also have a higher risk of being single mothers. According to 2007 CEPAL data, males both adolescent and adult “tend to be absent fathers and partners, taking no responsibility” and thus increasing financial pressure and care load for the grandparents. All this fuels the reproduction of intergenerational poverty, compromises the autonomy of women to seek their own life projects, and shows the need for sex education and reproductive health services to be a priority for public policy.

**Rights and Gender Equity**

Addressing adolescent pregnancy has important human rights and gender equity implications. According to UNFPA in 2006, between 35 and 52 percent of teen pregnancies in the region every year are unplanned. More recently, a September 2014 study found that the highest proportion of unintended pregnancies globally was in Latin America and the Caribbean at 56%. While this is a decline from 2008 (76%) and 2012 (68%), at the current 56% it is still substantially above the global average (45%) and the second highest percentage (North America at 51%). This would indicate that a large number of births to adolescent mothers are unwanted (although this varies

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28 ECLAC/UN press release 2007, 7  
29 CEPAL, “Casi 30% de las jovenes latinoamericanas ha sido madre adolescente,” 2014  
30 Cevallos  
31 Malter, Jessica, “New Study Finds that 40% of Pregnancy Worldwide are Unintended,” September 2014
between countries and social groups). These high indices of unwanted pregnancies suggest that the reproductive rights of adolescents are not being exercised.

Denial of the exercise of rights and the resulting unwanted fertility also gives a clear example of gender inequity, given that women suffer the worst consequences of unwanted births. This is manifested in several ways: males (adolescent or adult) often shirk their parenting responsibilities; responsibility for prevention is unjustly and unilaterally placed on the woman; sexually active adolescent girls who take precautions are often stigmatized and insulted by male peers and other women. Finally, although hard to quantify, a proportion of births to teenage mothers result from sexual violence and abuse, or from an adult male having taken unfair advantage of the girl.

Former PAHO (Pan American Health Organization) director Dr. Mirta Rosas stressed the importance of initiatives that promote gender equality and address the needs of both male and female adolescents:

"For women, cultural and social norms on gender restrict their access to basic information and condemn them to an unequal and more passive role when making important sexual decisions. This undermines their autonomy and exposes them to sexual coercion, producing undesired pregnancies, abortions, and infections. On the other hand, traditional expectations about masculinity also lead to behaviors that increase risks, such as HIV infections due to higher numbers of sexual partners; drug and alcohol consumption; violence; traffic accidents; and refusal to seek medical attention. Consequently, to improve the lives and health of adolescents, we need also to sensitize and positively empower adolescent boys."  

Adolescent sexual development is linked to economic and social justice and human rights. These issues of reproductive health rights and gender equity are central to both understanding the problem and how to best address it. We must understand and promote adolescent sexual development and social justice where all people have a right to their sexuality and lives with dignity, self-respect, and self-determination.  

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32 PAHO: Greater Gender Equality is Good for Teens Health  
33 Defining sexual health, 8
Contraceptive Use

A 1994 study analyzed data from the World Fertility Survey and Demographic and Health Surveys, and examined recent trends and determinants of contraceptive use in five Latin American countries: Colombia, Dominican Republic, Ecuador, Mexico, and Peru. These countries all experienced a substantial increase in contraceptive prevalence throughout the survey period. However, this was not experienced evenly across all social and demographic groups. Interestingly, this study actually found that “relatively disadvantaged groups experienced greater gains in contraceptive use.” The study revealed that certain shifts in population composition – including increased proportions of urban women, better educated women, and a growing proportion of mothers who wish to discontinue childbearing – substantially contributed to an overall increase in contraceptive prevalence in most countries.

How does this fit in with recent data on both overall and adolescent fertility rates? This study holds that the poor had greater gains in contraceptive use, but does not mention adolescents. Comparing the findings of this 1994 study coincides with more recent data stating a decline in overall fertility, but would suggest gains in contraceptive use did not particularly apply to adolescents. This 1994 study also says the poor had more overall gains in contraceptive use; while statistically true that year, further examination is needed to then understand why (adolescent) pregnancy remains much higher among lower socioeconomic sectors.

Sociocultural Factors

The following excerpt from a 2002 WHO report provides a succinct and comprehensive overview of the region’s context:

“Despite a predominantly common language and historical factors, Latin America is a heterogeneous region, economically and ethnically diverse both within and across countries. Throughout the region, however, common structural and social factors influence sexuality and

35 Expanding on this question, does this not apply to poor adolescents, or is that that while greater gains were made among the poor, it is still comparatively higher?
sexual behaviour. Poverty, the Catholic Church and the media directly affect how sexual and reproductive health is addressed by individuals, families and communities, and at the local and national government levels. Current constructions of sexuality are affected by indigenous culture and traditions, Spanish and Portuguese colonialism, and African traditions brought with the slave trade. Intermarriage and time have inextricably linked these traditions, forming sociocultural barriers to sexual health promotion related to gender issues, individual perceptions of the body and sexuality, levels of interpersonal violence, and complex belief systems. These constraints are further exacerbated by poverty, illiteracy, rural residence and political strife. As a result, problems such as unintended pregnancy, sexually transmitted and reproductive tract infections in adolescents, sexual violence and gender disparities persist in the region. Key to addressing these issues is comprehensive sexuality education in schools, as well as for adults and parents through the media.”

As detailed in a book by Bonnie Shepard, a complex array of political, cultural, and organizational dynamics “pose an obstacle course to sexual and reproductive health,” presenting difficulties in unified decision-making and therefore decisive political action. This coexists with the fact that despite the religious conservatism typically present across Latin America, 22 percent of adolescent girls reported having sex before the age of 15, the highest rate of teen sex in the world according to a 2011 UNICEF study. The resulting disparities between reality and rhetoric speak for themselves.

**Influence of Religion**

Shepard cites a “double discourse system that keeps repressive laws in place and punishes public opposition to political norms that are based on religious doctrine.” Progress in the realm of sexual and reproductive health is often determined by the power of the Catholic Church across the continent. In many parts of the region, “conservative Catholic views on social issues continue to dominate the public and educational discourse, often to the detriment of the region’s poorest women and youth.” Though the extent of the Church’s influence varies, it remains the single most unifying cultural factor in Latin America, with “its belief-system woven deeply into the history

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36 Edgerton
37 Edgerton, “Sex and the Barrio: A Clash of Faith in Latin America”
and traditions of the region.” There is seemingly a ‘tug of war’ between the social conservatism within Catholic doctrine and the realities of the modern world, with political leaders attempting to walk the line between the Church’s traditional power and compliance with international agreements and scientific research.

The Church’s influence can manifest itself both on a broader policy scale as well as at the individual level. Even when adolescent-friendly services and information might be present, young people could still find their requests denied by health workers acting out of their own moral convictions. The position of teachers, doctors, and nurses can make young people uncomfortable to speak about sex with the professionals that are meant to advise and help them.

Nonetheless, sexual and reproductive health need not always need to be at odds. For example, there are groups like Católicas por el Derecho a Decidir (CDD), an offshoot of the North American nonprofit Catholics for Choice. This group reconciles faith with contemporary views on sexuality and reproductive rights, and work to fill gaps in family planning services and sex education. Actions include extracurricular programs on “responsible sexuality” to disseminate information and help train young leaders to educate their peers. In order to appeal to the younger generations, the Church will need to examine its stance on reproductive rights and sexual health.

The current Pope, Pope Francis, has somewhat shifted the Church’s emphasis away from a ‘hardline’ approach, criticizing the Church’s “obsession” with gays, abortion and contraception and instead wanting to focus on its larger mission of being a “home for all.” Others however have criticized him for not addressing women’s reproductive wellbeing as part of his movement towards a Church that prioritizes the needs of the poor. Already applauded by many for his progressive opinions, it will be interesting to see how much the dialogue within the Catholic Church will continue to change with direction from Pope Francis.

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38 Edgerton
39 Huffington Post, “Pope Francis: Gays, Abortion Too Much of Catholic Church’s Obsession,” Sept 2013
40 Beattie, Tina, “Pope Francis has done little to improve women’s lives,” Aug 2014
Lack of Sex Education

Perhaps stemming from a combination of religious influences and a lack of strong effective public policies, the lack of appropriate and comprehensive sex education is certainly a contributing factor to adolescent pregnancy rates. In 2003, a United Nations Population Fund (UNFPA) study on 21 countries in Latin America and the Caribbean found that Brazil, Colombia, Cuba and Mexico were the only countries with widespread implementation of sex education in the school system. Although many countries in Latin America have laws requiring sex education in primary and secondary schools, implementation is often patchy or non-existent. This lack of information contributes to “child sexual abuse, the spread of sexually transmitted diseases, teen pregnancy and the birth of millions of unwanted babies.”41

It is the responsibility of the state to provide comprehensive sex education and services. However, government inaction and laws negatively affecting adolescents (such as those prohibiting under-18s from getting tested for HIV without a parent or guardian present) can be attributed to broader faults which are deeply embedded in the Latin American societies’ morals.42

Conclusion: The Need for Comprehensive Adolescent Health and a Lack of Life Plan

What are the solutions? Contributing factors bring together “a marked insufficiency of sex education in many countries, a lack of public policies on sexual and reproductive health for adolescents and single young women and a lack of consideration for adolescents’ sexual and reproductive rights.”43 The CEPAL report highlights the need for comprehensive sex education to allow adolescents to exercise their rights and make informed decisions, access to adequate sexual and reproductive health services, and for these services to include the provision of contraceptive methods.

Finally, the report also calls attention to the external (socio-cultural) factors that may also lead to adolescent pregnancy. These include a lack of opportunities, restrictions on developing

41 Cevallos, “Let’s (Not) Talk About Sex”
42 Hildebrand, Mikaela et al, “The barriers of sexuality in Latin America” 2014
43 ECLAC/UN press release 2007, 5
personal projects, and cultural patterns, and can often lead to girls believing that motherhood is a way to rise above poverty. This further calls attention to the need for robust policies around education and insertion into the labor market, to widen opportunities for development for these girls.  

44 CEPAL, “Casi 30% de las jóvenes latinoamericanas ha sido madre adolescente,” 2014
III. Subsequent Adolescent Pregnancy

Within issues of adolescent sexual and reproductive health, and indeed within adolescent pregnancy specifically, lies the occurrence of subsequent adolescent pregnancies. This in short is when an adolescent has a repeat pregnancy shortly after her first. The specific time-frame observed varies per study, but ranges within one to five years.

The rates of subsequent pregnancies of course vary per country, region, and socioeconomic group. A 2005 Fact Sheet from the FSU Center for Prevention & Early Intervention Policy cites a study indicating that 24% of all teen mothers had a second birth within two years of their first. For teens whose first birth occurred at age 16 or younger, nearly 31% had a closely spaced second birth.45

Causes for Concern

Repeat pregnancies in adolescent mothers are a cause for concern primarily because subsequent pregnancies and births exacerbate the problems caused by the first. Adolescents with multiple pregnancies often face difficult physical, social, economic, and psychological outcomes. Additional births are also associated with a reduced ability for the mother to complete her education and attain economic self-sufficiency. As detailed in Klerman’s flagship publication, “the likelihood that a teen mother will finish high school, break the cycle of welfare dependency, and rise above her social standing, all diminish rapidly with the arrival of each succeeding infant.”46

Teen mothers with rapid second births have “substantially poorer socioeconomic and familial outcomes” than those who delay them.47 Even after background characteristics were statistically controlled, one study found that early repeat pregnancies were “associated with a number of

45 FSU Center for Prevention &Early Intervention Policy, “Subsequent Pregnancies and Births Among Adolescent Mothers”
47 FSU Center for Prevention &Early Intervention Policy, “Subsequent Pregnancies and Births Among Adolescent Mothers”
negative short-term consequences in the areas of education, employment, and welfare dependency, even after background characteristics were statistically controlled.48

Rapid repeat pregnancies also exacerbate risks for the infant. Teenage mothers are more likely to delay seeking prenatal care for their second pregnancy than those who delay until adulthood. Adolescent mothers with subsequent births also have higher rates of preterm delivery, low birth weights, and infant mortality. The children are also more likely to have poorer health, worse educational outcomes and more behavior problems, and are more likely to become teen parents themselves.49

Risk Factors, Motivators, and Predictors

Many teen mothers face issues of poverty, cultural and familial norms, disengagement with school, and lack of employment prospects. Teens with a second birth have “confounding factors associated with relationships, mental health, and previous parenting experiences.”50 Several risk factors have been correlated with a second adolescent pregnancy within 18 months of a first birth. These are various and include individual, partner, and community level predictors. Three particular factors of interest are returning to school within six months, marriage or cohabitation with a male partner, and “life plans” and goals.

48 Polit, Denise F. et al. “Early Subsequent Pregnancy among Economically Disadvantaged Teenage Mothers,” 1
49 Family & Youth Services Bureau, “Reaching Out to Young Mothers to Delay Subsequent Pregnancies”
With regards to education, young mothers who quit school after giving birth have subsequent pregnancies much sooner than those who return to school. Independent of educational attainment at first birth, mothers who continued schooling after their first birth were less likely to have a rapid second birth.

Regarding marriage or cohabitation with a male partner, several studies show that teens living instead with a parent are less likely to have a second and/or closely spaced birth. Another study details parental monitoring as a protective factor. Interestingly though, others describe how when the grandmother is the primary caregiver of a child born to a teen mother, there is an increased likelihood of a subsequent birth during adolescence. This could be because the teen mother does not fully participate in the responsibilities and challenges of parenthood. Active parenting can

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### Factors associated with Subsequent Teen Pregnancies:

- Dropping out of school
- Failing in school
- Having a first pregnancy at 16 years of age or younger
- Returning to school or employment soon after a first pregnancy
- Having an intended first teen pregnancy
- Having a first teen pregnancy with a poor outcome
- Having a positive parenting experience with a first pregnancy
- Lacking future education or career goals
- Coming from a disadvantaged background
- Belonging to a culture that views early pregnancy as a social norm
- Experiencing domestic violence or depression
- Having a live-in partner
- Being married
- Having a new partner
- Having an older partner
- Living with her mother after having a first child, and relying on them for childcare assistance

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provide the incentive for young mothers to abstain from sexual activity or use contraception. The conflicting data within this factor alone exemplifies the complexity from such a multiplicity of factors.

Finally, research indicates that teens from disadvantaged backgrounds are more likely to accept pregnancy and parenting as a viable life option, due to factors such as familial poverty, a lack of educational or employment possibilities.\(^{53}\) This will be of particular interest when assessing the Latin American context.

**Intended versus Unintended Pregnancies**

It is important to clarify that most of the literature on teen pregnancy prevention and subsequent pregnancy prevention generally assume that teen pregnancy is unintended and/or unwanted. However, some research does reveal a higher level of intention; teens might either plan a second pregnancy, or not actively avoid one.

For some, the second pregnancy "just happened." Indeed, one study on adolescent pregnancy found that 15-30\% of adolescent females reported a degree of ambivalence towards becoming pregnant relative to their peers\(^{54}\). These attitudes were predictive of the occurrence of pregnancy one year later, and additional demographic correlates were also identified and included differences due to ethnicity, age, mother's education level, relationship status, and whether the adolescent came from a one or two parent home. These findings could feasibly apply to subsequent adolescent pregnancies.

For others however, they have chosen to have a closely spaced second pregnancy for a variety of reasons. Some reasons are similar to those of any adult mother (have children while they are young and energetic, have siblings who are close in age, etc.). Some may want to have children before pursuing educational or career goals; others prefer motherhood to what they consider to be limited ("dead-end") employment opportunities; others may comment that their mother followed the same path.

\(^{53}\) Corcoran & Pillai, 2007

\(^{54}\) Jaccard, James, Tonya Dodge, and Patricia Dittus. "Do adolescents want to avoid pregnancy? Attitudes toward pregnancy as predictors of pregnancy." 2003
Indeed, the concept of subsequent teen pregnancy as a problem has been addressed and even criticized by some. Some argue it reflects the values of a mainstream middle-class culture, marginalizing the values of other communities and cultures. As summarized by Davis,

“Looking at young motherhood and repeat pregnancies through middle-class assumptions… fails to recognize that, for adolescents for whom few good things happen, childbearing offers the possibility of change and the feeling of success.”

Future research should work to better understand the thoughts, feelings, and motivations of teen mothers. Given the important distinction, consideration of the intendedness of repeat pregnancies among teenagers could help create more appropriate and effective family planning interventions.

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55 Davis, 2002
56 Boardman, Lori A. et al. “Risk Factors for Unintended Versus Intended Rapid Repeat Pregnancies among Adolescents”
IV. Argentina and the “Ciudad Autonoma de Buenos Aires”

A. Introduction

Having introduced some of the issues surrounding adolescent sexual and reproductive health (ASRH) and adolescent pregnancy in Latin America, the next level of analysis is the Argentine context and specifics of the city of Buenos Aires.

Adolescent Pregnancy in Argentina

Alongside the rest of the region, Argentina shows persistently high rates of adolescent pregnancy and motherhood. According to a 2013 UNFPA publication, the adolescent birth rate in Argentina per 1,000 women aged 15 to 19 is 68.\textsuperscript{57} This is lower than the Latin American regional average of 73 per 1,000. Nonetheless, Argentina has experienced the same stagnation and inability to significantly reduce teenage pregnancy rates over the years. The adolescent fertility rate showed a decreasing curve since 1980, but began to increase again in 2003. Of a total of 700,792 live births in 2007, 106,720 were to adolescent mothers aged 15 to 19, while in 2003 this figure was 92,461.\textsuperscript{58} Furthermore, data from Argentina’s Ministry of Health indicates that 24% of mothers below age 20 have had two or more births.

Additionally, the rates of adolescent pregnancy vary significantly between different regions within Argentina, and even within different neighborhoods in the city of Buenos Aires. The lowest rate is in Buenos Aires (34 per 1,000) while in the northern provinces like Chaco, Formosa or Misiones it is over 80 per 1,000.\textsuperscript{59} Similarly, while the proportion of births to women under 15 is low (under 3% in the whole country), in provinces like Chaco it is as high as 5.5%.\textsuperscript{60} These numbers are significant considering how giving birth can deeply affect the physical and mental health of these girls, particularly since these pregnancies often result from nonconsensual sex.

\textsuperscript{57} UNFPA, “Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy,” (2013), 100
\textsuperscript{58} Direcccion de Estadisticas e Informacion en Salud (DEIS).  Ministerio de Salud de la Nacion, Argentina.
\textsuperscript{59} UNFPA “Situcion de la poblacion en la Argentina”.  Buenos Aires: Programa Naciones Unidas para el Desarrollo-2009; PNUD-UNFPA
\textsuperscript{60} UNFPA “Situcion de la poblacion en la Argentina”.  Buenos Aires: Programa Naciones Unidas para el Desarrollo-2009; PNUD-UNFPA
Census Data and Statistics

The following data from the most recent census shows further information detailed by province.

Recent data from 2013 shows 114,125 live births to mothers aged 15 to 19; of these, 2,894 are from the city of Buenos Aires, and 37,791 from Buenos Aires province, of which 27,122 are considered ‘Gran Buenos Aires’ (see Table 1 in Appendix 1). Although interesting to get a sense of the numbers, the adolescent fertility rates for each province provide more indicative information.

The adolescent fertility rate for different provinces across the country shows an interesting picture. The city of Buenos Aires and Buenos Aires Provincia are below the national average (to varying degrees). The highest rates are in the Northern provinces such as Misiones and Formosa (see Table 2 in Appendix 1).

Adolescent Fertility Rates

Las “ni-ni”

Taking a closer look at the situation of these young adolescents, the outlook is often quite dire.

A large number of adolescents in Argentina are part of what sociologists refer to as the “ni-ni” (neither-nor): adolescents who neither work nor study, nor are looking for a job. According to the 2007 UN World Youth Report, about 18 percent of those between the ages of 15 and 19 in Latin America were neither studying nor working. (Looking also at an older demographic, about 27
percent of those between 20 and 24 were in a similar situation). Indeed, with regards to employment and income levels Latin American youth are worse off today than 15 years ago.\textsuperscript{61}

One cause of “ni-ni” populations are when youth from low income families need to drop out of school to help support their families, thus cutting their education and future career opportunities short. Others include social issues, apathy and not wanting to study or work, difficulties in finding work, and informal employment (such as housework). For girls, early motherhood is a major cause.

In Argentina, estimates as to the size of this population vary depending on the sources cited, and range from 756,000 in 2007 (IPS) to 900,000 in 2010 (CEPAL and OEI). According to 2010 census data, of Argentina’s population of 40 million, just over 6 million are between 16 and 24 years old. Of these, approximately 975,000 are “ni-ni,” or about 16%. This is an increase from 13% over the past decade.

More recently, an article citing a 2014 INDEC survey holds that of the 4.5 million youth between 18 and 25 years old, 55% are unemployed.\textsuperscript{62} Another 2014 article cites that nearly 1.5 million youths do not study or work, or if they do they do so informally.\textsuperscript{63} Although the numbers vary, what is certain and most worrisome is that incidence of “ni-ni” among youth has not decreased from 2003 to the present.

Of this group, approximately 70 percent are girls or women between the ages of 15 and 24.\textsuperscript{64} Boys in this age group tend to either leave school to seek informal sector employment or are drawn into crime. Conversely, the girls stay at home, making them the invisible majority of this group. Many of these girls come from female-headed households, and drop out of school when their mother finds work to take care of the home and their siblings. However, early pregnancy is often the leading reason that these girls drop out of school. Following a pregnancy, these girls often find

\textsuperscript{61} World Youth Report 2007, “Young People’s Transition to Adulthood: Progress and Challenges,” 1
\textsuperscript{62} Encuesta Permanente de Hogares del INDEC; from Clarin “Jovenes ‘ni-ni’: ideas y propuestas para sacarlos de la exclusión”
\textsuperscript{63} Perfil.com, “Con los ‘ni ni’ la Argentina se juega su futuro.”
\textsuperscript{64} Valente, Marcela. “Argentina: Hundreds of Thousands of Teenage Girls ‘in Limbo” cites at 73%; Paz, Jorge “Los ni-ni en la Argentina” cite at 63%.
themselves restricted to the domestic sphere and child-rearing, “and are condemned to a sort of limbo of inactivity and resignation.”

**ESI: Programa Nacional de Educación Sexual Integral**

Sexual education is a right guaranteed by law since the creation of the National Program of Sexual Health and Responsible Procreation in 2002. In 2006, the city of Buenos Aires passed a municipal law reiterating the right of all students to an integrated sexual education. And in 2006, Argentina passed a sex education law establishing the Programa Nacional de Salud Sexual Integral (ESI). This made it mandatory for public and private schools to teach a program of “sexual health and responsible procreation” which includes “biological, psychological, social and emotional aspects.”

While this was a very important step, there is still much work to be done. Some statistics show that births to mother’s age 15 to 19 remained at 15 percent from 2005 to 2009, and more recent numbers do not necessarily reflect a significant change since the implementation of this program.

**Cultural and Socioeconomic Context**

Argentina can be considered fairly progressive compared to the rest of the region. For example, same-sex marriage has been legal since 2010, and students by law have a right to an integrated sexual education. In terms of sexual and reproductive health, Argentina provides free birth control at schools and hospitals, and abortion, though illegal, is permitted in emergency situations.

With regards to religious influence, about three quarters of the population is nominally Catholic. However, only 20 percent of Argentines are actively practicing. This change has happened over the past several decades, with correlations to higher levels of education and a more urbanized population. As reflected in other parts of the world, “religion’s hold on society in [the Latin

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65 Valente, Marcela. “Argentina: Hundreds of Thousands of Teenage Girls ‘in Limbo’”
66 Diebel, Linda. “G20 Girls, Argentina: Where sexy leads to sex, even for kids,” 2010
67 Edgerton, Anna and Ina Sotirova
American] region seems to diminish as the population becomes better educated.\textsuperscript{68} For Argentina specifically, the Church’s apparent complicity with the “dirty war” during the military dictatorship from 1976 to 1983 also plays a role.

Nonetheless, although waning, the Catholic Church and conservative sectors still hold significant influence. And conservative opposition is only one of various important obstacles within the realm of sexual and reproductive health, and to fulfilling the goals set in the National Program of Sexual Health and Procreation. As a result of these compliance issues, access to information and sex education are not as widely available as mandated by law. Many women and adolescents are unaware free birth control is available at public hospitals. Furthermore, many girls remain ignorant about birth control and how it works.

\textbf{A Closer Look: The City of Buenos Aires}

While Argentina’s averages present improved statistics than some of its regional neighbors, as mentioned previously this is not uniform across the country. Taking a closer look at the country’s capital, there are similar differences and stark contrasts.

The Autonomous City of Buenos Aires (CABA) has an estimated population of 2.89 million, while the wider Buenos Aires province has a population of approximately 15.6 million\textsuperscript{69}. Of these, approximately 10 million live in Greater Buenos Aires (GBA), the metropolitan areas surrounding CABA. While CABA’s population has hovered around 3 million since 1947, the surrounding districts have seen a fivefold expansion.\textsuperscript{70}

In 2007, the city’s poverty rate (measured in terms of income) was 8.4%, but including the metro area, was 20.6%. Measuring poverty rates in Buenos Aires provides widely varying figures depending on the source; while official INDEC figures in 2011 cited the poverty rate as 15.2% (around 2 million people), estimates from the Social Debt Observatory at the Argentine Catholic

\textsuperscript{68} Edgerton, Anna and Ina Sotirova
\textsuperscript{69} Buenos Aires Provincia, Ministerio de Economia, Subsecretaria de Coordinacion Eocnomico, Direccion Provincial de Estadistica
\textsuperscript{70} World Population Review
University (UCA) stated 34.9% (4.4 million people) live below the poverty line. Critics of the official INDEC survey hold that both the inflation rate used to measure poverty and the official baseline household budgets are understated.

There are an increasingly important number of immigrants in both CABA and the surrounding province. According to 2010 census data, of the 381,778 people in CABA who were born abroad, 297,325 are from the Americas; the greatest numbers are from Paraguay (80,325), Bolivia (76,609) and Peru (60,478) (see Table 3 in Appendix 1). This figure includes the homeless, or those ‘en situacion de calle.’ This massive surge in immigration is primarily since 2002; of the total number of immigrants from the Americas, 28.5% came before 1991, 25.7% from 1991 to 2001, and 45.8% from 2002 to 2010 (see Table 4 in Appendix 1). However, these figures only consider those in ‘viviendas particulares,’ or private homes. It is unlikely that these figures accurately capture the expansive population of the ‘villas miserias,” shantytowns located within or surrounding the city.

In Gran Buenos Aires (GBA, or Buenos Aires Province), immigration from the Americas has also steadily increased. Of the current immigrant population in Buenos Aires Province that was born in the Americas, 35 percent arrived between 2002 and 2010, as compared to 22.2 percent between 1991 and 2001 (see Table 5 in Appendix 1). According to 2010 data, 756,560 (of the total 941,941 immigrant population born abroad) are from elsewhere in the Americas. Again, the majority is from Paraguay (392,697), Bolivia (147,781), Uruguay (70,659) and Peru (69,395) (see Table 6 in Appendix 1).

To address the mass numbers of undocumented immigrants, in 2006 the Argentine government launched the “Patria Grande” program (“Greater Homeland”) to regularize the status of these immigrants, and encourage movement to other areas of the country instead of Capital Federal, Buenos Aires. For every citizen from a member of the Mercado Comun del Sur (MERCOSUR) or associated country, the program facilitated the attainment of regular residence in

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71 MercoPress, “A third of metropolitan Buenos Aires live below the poverty line claims Catholic Church,” November 21st 2011
Argentina, through a procedure based on nationality of the applicant and their lack of a criminal record. In 2007, over 670,000 applications had been processed under this program.\textsuperscript{72}

**Adolescent Pregnancy in Buenos Aires**

Understanding the demographics of CABA and GBA is relevant for subsequent analysis of significant differences in adolescent sexual and reproductive health statistics. For example, the percentage of deliveries in women under 20 years of age is 7.1\% in the city of Buenos Aires.\textsuperscript{73} However, for one city hospital serving some of the poorer neighborhoods in the southwestern part of the city (with large numbers of immigrant populations), the figure is close to 19\%.\textsuperscript{74}

The types of statistics and census data provided by the city of Buenos Aires and Buenos Aires Province vary. Below is some of the relevant and available recent data for these two populations.

**Ciudad de Buenos Aires**

For the city of Buenos Aires, the data below shows that the percentage of births to women age 15-19 increased between 2000 and 2010. It has since decreased somewhat from 2010 to 2013, but remains higher than in 1990. (See Table 7 in Appendix 1 for full data set.)

### City of Buenos Aires: Percentage of births by mother’s age

\textsuperscript{73} UNFPA “Situation of the population in Argentina”. Buenos Aires: Programa Naciones Unidas para el Desarrollo-2009; PNUD-UNFPA
\textsuperscript{74} Berner, Enrique. “Comprehensive Adolescent Health Care: Risk and harm reduction in reproductive health with gender equality” (2010), 2
Gran Buenos Aires

For Greater Buenos Aires there are similar trends, according to the 2010 census data. Overall, fertility rates have seen a slight decline since 1996 (from 60 to 58.4 per 1,000). But for adolescents aged 15 to 19, overall fertility rates have increased. From 56.1 per 1,000 in 1996, they dropped to 44.5 in 2002, but increased every year since, spiking at 62.3 in 2009 and most recently to 58.1 for the 2010 census. (See Table 8 in Appendix 1 for full data set.)

Buenos Aires Province: Fertility rates by mother’s age

B. Argentine Plans and Programs

There are a variety of national and city entities and programs relevant to the realm of adolescent sexual and reproductive health. There is certainly overlap in some of the target populations and program objectives. However, it is unclear how these programs effectively interact, communicate, and overlap. Below is a brief overview of the most relevant entities and programs at the national, municipal, and hospital level that address adolescent pregnancy, and subsequent pregnancy specifically where applicable (see Appendix 2 for a full listing).
National Entities and Programs

In terms of national government entities, within the Ministry of Health is the Directorate for Maternity and Infancy, whose strategic priorities include perinatal health, comprehensive child health, and comprehensive adolescent health.

Of the various Ministry programs that interact with adolescents, the most relevant is the National Plan for Comprehensive Adolescent Health, created in 1993. Its development was driven by PAHO resolutions urging governments to develop or strengthen initiatives to promote comprehensive adolescent health. While other national initiatives included adolescents in their target population, this “Plan Nacional de Salud Integral de Adolescente” solely focused on adolescents of both sexes and specifically sought to “promote and protect adolescent health through an increased coverage in quantity and quality of service.”

The Program assumes health as a human and social right, and frames it actions on: the International Convention on the Rights of the Child (1989); Argentina’s Law 26.061 on Comprehensive Protection of Children and Adolescents, which guarantees their right to health; and Law 26.529 on Patient rights, medical history, and informed consent. Interestingly, the website stresses the importance influence of comprehensive adolescent health, urging inter-sectoral efforts from education, justice, social welfare, and labor to name a few.

Initially, it “was not considered relevant” to elaborate a specific plan on reproductive health, as each province was instead meant to formulate their own program under the general directives of the National Plan. Instead, there is a section on reproductive health stating the “need to promote responsible sexuality and procreation and information,” given that “this aspect is particularly neglected in the care of adolescents.” This has seemingly since changed; as of 2012 the leadership had placed strong emphasis over the past 3-4 years on SRH; focusing on lowering adolescent pregnancy rates and increased contraceptive production. In terms of shortfalls, the Plan includes no mention of the need to encourage male responsibility in sexuality and

contraception, or of adolescent girls’ autonomy in reproductive decision-making. There is a lack of a ‘rights-based’ approach, and only vague references to gender equity.\textsuperscript{76}

Nearly a decade after this program launched, a series of guides were published for health professionals working with adolescents (see List 1 in Appendix 2 for full list). Of these nine, two are particularly relevant to subsequent adolescent pregnancy, “Guide with Recommendations for Integrated Adolescent Care in Friendly and Quality Health Environments” and “Recommendations for Adolescent Clinical Care.”\textsuperscript{77} The first was developed through collaboration between the Ministry of Health, UNICEF and the Argentine Society for Pediatrics, and is meant to improve access to quality adolescent services by either providing tools for the instalment of new spaces for care, or improving current points of contact within the health system. The guide provides general recommendations on adolescent-friendly spaces, resources, and the consultation process, and includes contraceptive recommendations. The second guide “looks to contribute to improving adolescent access to quality health care services. It provides tools for comprehensive medical attention to pathologies and/or common situations in adolescence.” The guide gives procedural standards for various medical situations, including follow-up and prenatal checks for pregnant adolescents. Subsequent pregnancies are briefly mentioned twice:

- Childbirth: “Before childbirth a contraceptive method should be given (not interrupting lactation) and the adolescent will resume their relationship with the health service by making a follow-up appointment”
- Puerperium\textsuperscript{78} should include “the prevention of a second unplanned pregnancy”

There is also a mention of reenrollment in school. Many of the interviews with health professionals across public hospitals in Buenos Aires included conversations around whether these guides were used in their service, and if they were effective.

\textsuperscript{76} Gogna, 33 \\
\textsuperscript{77} Original titles: Guía de Recomendaciones para la Atención Integral de Adolescentes en Espacios de Salud Amigables y de Calidad” and “Recomendaciones para la Atención Clínica para Adolescentes” \\
\textsuperscript{78} The period of about six weeks after childbirth during which the mother’s reproductive organs return to their original non-pregnant condition
Municipal Entities and Programs

The City of Buenos Aires similarly has a Program for Comprehensive Adolescent Health (2008). The website does not have extensive information apart from listing hospitals and primary health care centers (CeSACs) with adolescent services, but presumably it coordinates with the City’s Program for Reproductive Health and Responsible Procreation, which includes adolescents as a target audience (see List 2 in Appendix 2 for a full listing of municipal entities).

Interestingly, for many years, the city of Buenos Aires did not have a specific adolescent health program. Prior to this program, a 1996 proposal for a “Programa para la Atencion Medica integral y adolescentes en el Gobierno de la Cuidad de Buenos Aires” failed due to “cultural and religious barriers.” Critics place the blame on the Catholic Church’s influence, blocking sexual education and programs seeking to provide information and contraceptive methods to adolescents.\(^{79}\)

Finally, there is also a city-wide Network for Adolescence. From 1993 to 1997, groups that attended to adolescents formed part of this ‘Red de Adolescencia’ in order to exchange experiences, successes, and challenges, and to consolidate complementing services within hospitals, organize trainings, research, etc. The network was discontinued in 1997 due to administrative and political changes, and competition for patients between adolescent and pediatric specialists. From then, the ‘Red de Adolescencia’ was included in the ‘Red de Pediatria’ (pediatrics).\(^{80}\) Interviews with medical professionals at Buenos Aires public hospitals (detailed later) mentioned monthly meetings of a ‘red de adolescencia’ where every hospital and CeSAC is represented (that wants to attend). It is unclear whether this ‘red’ remains part of the ‘Red de Pediatria,’ though the adolescence network is not listed online as a “Red Conformada” (official network).

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\(^{79}\) Indeed, for this reason in 1995 a Reproductive Health Law, which would have provided adolescent reproductive health and provided IUDs as a contraceptive option in public hospitals) did not receive Senate approval despite approval in the Camara de Diputados. (Gogna 278)

\(^{80}\) Gogna 2001, 30
Hospitals in the City of Buenos Aires

Different hospitals have different types of adolescent services. Some services within general hospitals have their own separate clinic with a division head, whereas others have a working group or team within pediatrics. Others are maternity hospitals with an adolescent section (see List 3 in Appendix 2 for full list).

From the research and hospitals interviewed, two hospitals had specifics programs to address subsequent adolescent pregnancy. These are a training held at the Argerich General Hospital, and the PROAMA program at the Sardá Maternity hospital.

The Argerich training (to be later described in further detail) essentially brought together other services within the hospital (such as obstetrics/gynecology and pediatrics) and trained them on adolescent–friendly services. It also raised awareness and encouraged other hospital services to refer their adolescent patients to the adolescent service.

Since 1988, the Sardá Maternity hospital created PROAMA: Programa de Apoyo a Adolescentes Embarazadas, a support program for pregnant adolescents. The program brings together an interdisciplinary team to prevent STI transmission and subsequent unplanned adolescent pregnancies by providing support for adolescent mothers and their children. Their experience reflects the importance of interdisciplinary teams working together. For them, the principle factor to keep in mind with adolescent pregnancy is the “organization of the family structure.”

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81 Hospital Materno-Infantil Ramon Sardá: PROAMA
V. Case Studies across the City of Buenos Aires

A. Introduction, Methodology, and Case Studies

“Missed Opportunities” in the City of Buenos Aires

As discussed, subsequent adolescent pregnancies exacerbate physical, social, economic, and psychological outcomes for both the mother and children. The multitude of risk factors largely overlap for first and subsequent births. However, it can be argued there is one differentiating factor: the health sector. When an adolescent is interacting with local health services to attend her first pregnancy and childbirth, these are opportunities for health providers to provide the adolescent with information and ultimately (ideally) a contraceptive method. Otherwise, these are “missed opportunities” that lead to rapid repeat adolescent pregnancies within 12-24 months of the first birth.

Data indicates that this is a serious problem both in Argentina generally, and parts of Buenos Aires. As aforementioned, 24% of mothers in Argentina below age 20 have had two or more births. Under this premise, this thesis sought to evaluate if and where there were “missed opportunities” in public health services across Buenos Aires.

In summary, various initiatives on the national and city level have only fairly recently prioritized adolescent health and considered this demographic and their specific needs separate from both pediatrics and adults. However, implementation is inconsistent and depends largely on each individual hospital and health professional. Only a handful of public hospitals have adolescent-specific services. Of these, the Hospital ‘Cosme’ Argerich has been at the forefront of establishing and promoting adolescent services and taking a “comprehensive approach.” However, despite important changes and bold leadership in this area, lack of quantifiable data makes it difficult to specify if and how much subsequent pregnancies have been affected. Furthermore, speculative evidence from interviews conjectures that while rates may have slightly decreased, the strong
influence of factors external to the efforts of the medical community and the lack of “alternate life plans” are ultimately stronger.

**Methodology**

Given the current programs and guides in place, this thesis sought to establish if and how these protocols had been implemented in the City of Buenos Aires, and if they had impacted on rates of subsequent pregnancy.

**Qualitative Research: Justification for Interviews across Comparative Case Studies**

Statistics surrounding adolescent pregnancy rates help illustrate the current situation across the globe, and indicate statistical changes. Data can be drawn together and analyzed on a young mother’s age, income level, life expectancy, and the like. However, a strong research design requires both qualitative and quantitative research components. Indeed, exploring the multiplicity of causal factors behind adolescent pregnancy would require an in-depth qualitative component, speaking with adolescents themselves as opposed to observing increases or decreases in rates. Similarly, assembling comparative case studies and structuring conversations with doctors across public hospitals in Buenos Aires provided initial insight into ‘missed opportunities’ and causal factors contributing to rapid subsequent adolescent pregnancy.

The reasoning behind the ‘missed opportunities’ concept holds that the health sector should maximize its interactions with adolescent patients throughout their first pregnancy and childbirth to ideally prevent a rapid subsequent pregnancy, but does not do so effectively if at all. Indeed, interactions with the health sector can be viewed as the single differentiating factor between first and subsequent pregnancies, as the adolescent may not have had much regular interaction with local hospitals and clinics prior to her first pregnancy. This premise concludes that if the health sector was made aware of these ‘missed opportunities’ and shortcomings, and structured appropriate programs and interventions to address these, subsequent pregnancy rates would decrease dramatically.
To further investigate the missed opportunities concept in the City of Buenos Aires, research and publications available through public domain gave a first look at whether subsequent pregnancies were included in adolescent pregnancy efforts. These indicated some programmatic efforts at the federal and municipal level. The information gathered in this initial review however did not provide insight into what was occurring at the hospital level; the existence of national policies did not illustrate why subsequent pregnancy rates remain high and largely unchanged over the years. Research at the hospital level however provided this evidence.

Comparative case studies investigated through interviews as the main data collection technique were the ideal method of qualitative research. If the missed opportunities concept holds that the health sector is not sufficiently intervening to prevent rapid subsequent pregnancies, it follows that actors within the health sector should be approached to provide their experiences of what is actually occurring on the ground. Interviews with open questions “[allowed] respondents to express themselves in their own words… [and allowed] complex motivational influences and frames of reference to be identified.”

In short, primary research would be incomplete without interviews at the hospital level. Holding interviews with open questions provided insight into if and how the national and municipal policies were being implemented at the hospital level, and provided a forum to learn of other individual efforts at the hospital level, whether historic or ongoing. The ‘missed opportunities’ concept very simply concludes that the health sector is failing it what is a seemingly obvious opportunity to prevent subsequent pregnancies. Interviews with medical professionals provided a forum to discuss the concept, and whether this was a fair conclusion of what was occurring in Buenos Aires public hospitals.

**Specific Research Design**

In terms of sampling, this thesis focused on medical professionals (primarily doctors) at public hospitals in the City of Buenos Aires; specifically, public hospitals in the city either with a separate

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82 Foddy, William, “Constructing Questions for Interviews and Questionnaires,” 128
adolescent service, or history of working in adolescent sexual and reproductive health. There were a total of 16 interviews with 12 medical professionals working specifically in the adolescent service of 7 health institutions; these included 3 general hospitals, 1 infectious disease hospital, 1 maternity hospital, 1 children’s hospital, and 1 community health clinic. The hospitals interviewed and doctors included were representative of adolescent services across the city; 4 of the 7 general hospitals with adolescent services in the City were interviewed, the maternity hospital and children’s hospital are widely recognized in the city for their work with adolescents, and the community health center provided an alternate perspective from a smaller health institution. The interviews were completed over the course of three months, from June to August 2012 (see Appendix 3 for Interview Details).

The interviews were semi-structured conversations with various medical professionals. The schedule of questions followed similar general topics and structure. Relevant topics were introduced by the researcher, and the doctors in turn discussed the situation at their particular hospital or medical center, and gave their personal opinions on subsequent adolescent pregnancy and adolescent health in the City of Buenos Aires. Conversations varied slightly between each hospital depending on the flow of the conversation and topics of interest to the doctor. There was a need to phrase these questions sensitively to avoid any implications that current hospital efforts were ineffective, and instead create an opportunity for conversation and discussion. As such, questions were open-ended to create an opportunity for doctors to describe the work being done at their hospital and provide their qualified opinion on subsequent pregnancy based on experience (see Appendix 3 for Schedule of Questions.)

It was expected that interviewing these medical professionals would provide first-hand insight into how the ‘missed opportunities’ concept played out in practice. Is it the case that programs and protocols are not in place? Or, are these in place but ineffective? What are the barriers and circumstances they have encountered with regards to adolescent pregnancy and subsequent adolescent pregnancies? How does the adolescent service within this particular public hospital fit
into wider city and national efforts and programs directed towards adolescent pregnancy? These questions, among others, were weaved into open questions to allow for fruitful conversations and enlightening insights, providing a basis for future research and even programmatic interventions. Details of the interview content are outlined in the sections below.

**Case Studies across the Ciudad Autonoma de Buenos Aires**

In order to gain a better understanding of how adolescent health was addressed in Capital Federal, particularly sexual and reproductive health and pregnancy, several doctors working in public hospitals in the Ciudad Autonoma de Buenos Aires (CABA) were interviewed. These conversational interviews provide an insight into the landscape of adolescent care in the city.

For context, in 2012 Argentina had adolescent pregnancy rates of 15.7%, but with rates as high as 24% in provinces such as Chaco in the north. Similarly, in Capital Federal rates are at 6%, but within certain neighborhoods (and where most of the hospitals interviewed are located), rates are closer to 23-24%.

The City of Buenos Aires has 33 hospitals and 40 health centers, which depend on a particular hospital and provide primary care. There are few recognized adolescent units or adolescent services in CABA. These are established by the interest of each hospital; services were established with time by the hospitals that felt it was necessary to have differentiated attention and hospital culture for adolescents.

Of the 33 public hospitals in Capital Federal, 18 have some form of adolescent services. Of these, only 3 have specific differentiated units within the hospital. The remaining have working groups (‘grupos de trabajo’) dedicated to the area. (Several doctors noted the importance of this distinction, as this has implications for the importance placed on adolescent health at that hospital and the resources available.)

The research began at the Argerich hospital, renowned for its “Servicio de Adolescencia” throughout the years. The doctors from Argerich suggested which hospitals to contact for further research, identifying those with important experience working with adolescent populations.
The patients that attend the hospitals interviewed are generally from high-risk and extremely precarious socio-economic living situations. (Perhaps their adolescent services at these hospitals were created and pieced together other the years in response to a need amongst these populations.) The patients often included a large percentage (if not majority) from the provincia of Gran Buenos Aires. As introduced previously, these populations face often worse situations than those of the Capital Federal. Several recurring themes emerged from these conversations, leaving lingering questions and problems still to resolve.

Recurring Themes: An Uphill Battle

The conversations discussed the adolescent services of that hospital, the patient demographics, adolescent pregnancy, sexual and reproductive health, and rapid repeat pregnancies. Doctors were presented with the ‘missed opportunities’ concept and the research interest behind examining the health sector as a clear differentiating factor between first and subsequent pregnancies. However, extended discussion showed these doctors felt this proposed dichotomy did not translate to simple health-center led solutions, even while various had already taken measures with varying degrees of success.

All the hospitals interviewed identified the persistence of high adolescent pregnancy and repeat pregnancy rates, despite efforts and health sector interventions from the adolescent services. Opinions on why varied from one end of the spectrum to the next. Some felt the health sector was doing everything possible, and the results were outside of the hospital’s control. Others insisted that the health system was clearly failing and needed to find a way to better meet the needs of its patients. All cited to varying degrees the obstacles to attending adolescent health from both the macro (government) and individual (patient) level.

Approach to Adolescent Health from the Gobierno de la Ciudad

In terms of government support and municipal context, adolescent health has only fairly recently been considered separately as a population with specific needs and requirements. Many
of these hospitals’ adolescent services have been working with these groups for decades; however, the recognition, support, and funding from the Ministry of Health has been much slower to formalize. There has historically been a lack of adolescent health programs for economic reasons (lack of resources result in health directors prioritizing maternal-child health to meet with government targets), and generally little importance given to adolescent health in public policy development.\(^{83}\)

The National Plan for Comprehensive Adolescent Health was established in 1993. Over a decade later, the municipal government established their own Program for Comprehensive Adolescent Health in 2008. This program brings together all actors working towards adolescent health care in the city of Buenos Aires, who meet monthly. The national program from the Ministry of Health then brings together all the programs around the country. (The overlap and different roles of these two programs remains unclear.)

Since the national program, there is an interest in adolescent health and in creating public policies surrounding adolescence that was previously nonexistent.\(^{84}\) One doctor attributed this to changes in leadership for “those who manage these issues” (presumably within the municipal Ministry of Health), as occurred with reproductive health in 2003. There are laws and programs now (previously nonexistent) that have facilitated things for all adolescent services. Within the past decade, adolescence has also become part of the rotation cycle for medical students, and a specialization offered within medical school (at the public Universidad de Buenos Aires).

In CABA, the hospitals, health centers (CeSAC), and working groups also have the aforementioned “Red de Adolescencia,” a network connecting medical professionals across Buenos Aires working with adolescents. There is also the “Sociedad Argentina de Ginocologia Infanta-Juvenil,” an Argentine professional association focused child and youth gynecology. One

\(^{83}\) Gogna, Monica “Programas de Salud Reproductiva para Adolescentes,” 28
\(^{84}\) Interviews, 5
of its founders was Dr. Enrique Bañiati, previously the chief of the adolescent service at the Hospital Rivadavia.  

The medical professionals interviewed felt there were many determinants that can play a role in adolescent pregnancy and repeat pregnancy. Despite improvements however, “the system does not support as it should” to allow medical professionals to be aware of all these and act accordingly.

**Measuring Impact**

To begin with, results and impact assessment are very difficult to measure. This makes it difficult to decisively state if efforts and initiatives from different adolescent services are effective or not. Most doctors speculated and spoke from personal observation.

The ideal would be to move to a standardized and systematized medical history record across CABA, the provincia of Buenos Aires, and even the rest of Argentina. As it stands currently, some hospitals do not even have a standard patient record template across different areas of the hospital. At the Argerich, this was only recently accomplished.

As it stands, there is very little systematized data. Individual hospitals will have records of the number of patients attended, but the potential for further analysis becomes difficult.

**Deeply Rooted Factors: Cultural and Socio-economic**

As detailed in a publication from Jorge Naranjo, there are primary, secondary, and tertiary levels of subsequent pregnancy prevention. Conversations with these doctors indicated that primary prevention was strongly present (availability of birth control, dissemination of information) but the second (use of a contraceptive method) and third levels (educational and employment reintegration) needed further work.

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85 Interviews, 2  
86 Interviews, 11
These problems only worsen in Gran Buenos Aires. Patients should attend their local primary health care centers. However, these in the provincia are “overburdened,” and patients travel hours to Capital Federal instead for medical attention.

Most of the hospitals interviewed were located in poorer areas of the city. For those in more middle income neighborhoods, the patient population was not necessarily local. At one Palermo hospital, a doctor explained that the majority of patients she attended were domestic workers at the homes in the area, rather than the actual residents.

A “Proyecto de Vida?”

Repeatedly, the medical professionals discussed how, whether by choice or default, motherhood became the ‘proyecto de vida’ (life plan) for many of these adolescent girls. For some, it might have begun as a general indifference, or lack of understanding as to how to use birth control effectively. Once pregnant however, views on motherhood range for normal and expected to appealing or even desirable. Many of these girls come from adolescent mothers themselves. Motherhood additionally confers a higher ‘status’ on these girls, and can protect them in certain ways from some of their troubles.

For others, the choice for pregnancy and motherhood seems even more autonomous and sought after. One doctor interviewed recalled girls who had previously come to the hospital and asked for their IUD to be removed. Even here though, further research would need to determine if the adolescent independently or at the request of her new partner. The new partner (especially if he is an older male) will often want a child of their own as a “tribute” for supporting the girl and her previous child. Indeed, further evaluation is needed to determine the degree of autonomous decision-making for these adolescents. Namely, are these girls indifferent to pregnancy, or actively seeking it?

87 Interviews, 42
88 Interviews, 70
89 Interviews, 58
Not a Cause for Concern?

Some doctors (with many years’ experience working with adolescents) countered that perhaps pregnancy in adolescence is not the issue we make it out to be. In terms of biological and psychical risk factors, a couple of doctors had determined that medical outcomes and health of the newborn and mother were the same (if not superior) to those of adult mothers, if the proper care and checkups were given throughout the pregnancy. Beyond medical outcomes, other doctors stressed the human rights perspective of adolescent health. Namely, the young adult in question has the right to autonomous decision making. If they opt for motherhood, the medical sector can only respect this choice.

Other doctors however fundamentally disagreed with this idea that these adolescents were making informed and autonomous choices. Although repeat pregnancies may not intrinsically be an issue, in “vulnerable high-risk populations such as our own, options for raising children are extremely complex, and as such repeat pregnancies are an issue.” In any event, these disparate viewpoints present an important reminder to incorporate a human rights and individual autonomy perspective into working with adolescents.

Raising Awareness - Patient

As one doctor explained, although there is a law on sexual and reproductive health and although many services are doing important work in this area, the issue is also having this information reach the adolescent. Many are easily unaware that there is a law in place and that they have a right to a contraceptive method. Today, the supplies are available at all hospitals and medical centers; it is a matter of increasing demand, both by promotion from the health team and patient request.

Furthermore, for those doctors that held that the information was available and communication was not an issue, others countered that “information is not the same as comprehension;” one can

90 Interviews, 3
91 Interviews 5
give information and place posters around the waiting room, but if the patient is unable to act on this information then something is failing.\footnote{Interviews, 10}

At the Argerich Hospital, a doctor stated that there was comprehension to some extent, but not for everything. He felt they were unable to achieve clear and precise communication such that the adolescent could truly internalize, and thus something was failing and further work was needed. While the Argerich has many years’ experience in adapting information for adolescent audiences, it gets to a point where information is not enough, and one would need to determine for each individual patient if they are able in that instance to both understand the information and sustain that in the future. For example, some girls are patients of the adolescent service and have been on birth control, but later become pregnant because they stopped taking the pill “because their aunt told them it would make them sterile.” Other studies show that a large percentage of prescriptions end up in hospital bins, not because the patient didn’t care but because they could not read the writing and did not ask what it was for. Culture and human nature play a role, and it is up to the public health system to work with the patient and ensure content and delivery of information is adequate.

**Raising Awareness: Adolescent Services and a ‘Servicio Integral’**

The doctors interviewed were asked about subsequent pregnancies, and if their services had any specific protocols or initiatives surrounding this. Here, conversations often turned to a discussion about their overall adolescent service.

Comprehensive adolescent services had interdisciplinary teams which included some combination of gynecologists, obstetricians, nutritionists, psychologists, and social workers. Most hospitals felt their adolescent services were aware of subsequent pregnancies and worked with pregnant, postpartum, and post abortion adolescents to provide counseling on the adoption of a contraceptive method. This varied slightly depending on the service.
In terms of specific initiatives, only the Argerich Hospital discussed having formal training on the topic, and the PROAMA program at the Sardá Maternity Hospital included reducing subsequent pregnancies as an objective.

Attitudes included pride in their hard work (and rightfully so), but admission that more needed to be done if time and resources would permit. As it is, doctors feel they work “a pulmon” (are worked ‘to the bone’) and lack the time or resources to dedicate more time to these issues.

Raising Awareness: Across the Hospital

The ‘missed opportunities’ concept surrounding subsequent pregnancy holds that the health sector has ideal opportunities to provide pregnant adolescents with information (and ultimately a contraceptive method) during their regular doctor visits throughout the pregnancy, while they are hospitalized for the birth, and during the regular check-ups attended for the baby’s health. Good medical practice would dictate that adolescents attending the service or interned post birth or abortion should leave the hospital that day with a contraceptive method in hand; however, some medics ensure this and others do not.93

Efforts are made across services at these hospitals, but there is not a formal or standard policy regulating that when an adolescent is discharged after giving birth, she is given counseling regarding a contraceptive method. “There should be, but there isn’t, and if there is it isn’t applied everywhere94” explains an Argerich doctor.

Throughout the hospitals visited in CABA, efforts have been facilitated with varying degrees of success, and results ultimately have proved difficult. The split between different services within the hospital, and lack of awareness (or implementation) across all medical professionals has proved an obstacle for avoiding missed opportunities.

For the hospitals with adolescent services (as was the case with all the hospitals interviewed), the medical professionals here sought to increase referrals from other sections of the hospital, 

93 Interviews, 3
94 Interviews, 9
namely pediatrics. In theory if an adolescent mother is bringing in her newborn for check-ups, the pediatrician should refer her to the adolescent service so that her health needs can be met (from sexual and reproductive health, mental health, nutrition, etc.). However, these referrals seemed mostly dependent on personal relationships and varied across hospitals. The Hospital Rivadavia for example, as explained by a doctor from the adolescent service, had well-established working relationships across the hospital and frequent referrals. This was not the case across the board however, as most other doctors cited lack of awareness and thus referrals from other areas of their hospital.

Some doctors interviewed were of the opinion that pediatricians should be able to do avoid these missed opportunities and provide the necessary information themselves. However, they do not seem equipped or trained to effectively do so. The obstetrician or gynecologist attending during the pregnancy and birth, and the pediatrician completing the check-ups for the newborn, are not necessarily (if rarely) trained in working with adolescents and addressing their health needs. An Argerich doctor feels “there is not enough capacity among professionals and colleagues to be able to work and take advantage of the missed opportunities while adolescents are at the hospital so that they understand the importance of leaving with a contraceptive method.95” In any case, neither this nor referrals are currently happening in most cases.

**Promoting Adolescent Attendance**

What steps would increase attendance to these adolescent services? Doctors’ responses centered around facilitating patient attendance and health team training. In terms of facilitating attendance, the adolescent service could (and must) increase opening hours and not require appointments where possible. The ideal would be to schedule both the adolescent and newborn for same day appointments. If the pediatrician refers the adolescent mother to the adolescent service, but the appointment is for a different day, it is exceedingly unlikely they will attend this appointment. As explained by a doctor at the Argerich, if the adolescent mother is given an

95 Interviews, 9
appointment for requesting and picking up a contraceptive method but lives 30 kilometers away, has to pay 12 pesos for the bus and bring the baby in tow, “she’ll never come.” The system “needs to enable the health team to efficiently respond to demand, and the team needs to view these as urgent cases.”

In terms of training, different services across a hospital should coordinate such that other services within the hospital refer adolescent mothers to the adolescent service. Currently, this is done on an ad hoc basis and is entirely dependent on personal relationships across the hospital and personal initiative.

Of the hospitals included here, the Argerich Hospital was the only to have held an official training. The Argerich Hospital created a training program funded by a research grant from the Ministry of Health in 2006. Even so however, there is not definitive data showing that referrals increased.

For those without adolescent services, a solution is presumably general training instructing health professionals on how to provide adolescent-friendly services and avoid missed opportunities. The guides and manuals published in 2011 from the city government’s Ministry of Health presumably help fill this gap. Nonetheless, there is no available information or studies to indicate successful implementation or subsequent positive indicators resulting from the use of these guides.

Pending Questions

Several interesting questions surfaced from these discussions. Given that subsequent pregnancies are a repeated and significant issue, one doctor from the Argerich Hospital felt it would be particularly interesting to determine whether further work was needed within the health team, or instead on adolescents’ comprehension of the importance of a contraceptive method, or

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96 Interviews, 15
any other obstacle in particular that was preventing adolescents from using some contraceptive method to prevent subsequent pregnancies.\(^{97}\)

Ultimately greater efforts are needed to further prioritize adolescent health, so established adolescent services can grow and receive the appropriate hospital and municipal support. Within hospitals, creating awareness and training programs across hospitals would increase referrals between different clinics and services. With all this, would the number of subsequent pregnancies then decrease?

As the conversations unfolded and discussion centered on wider adolescent health issues, these doctors were asked what they felt the best solution was. Essentially, given the wider issues in addressing adolescent health, is it preferable to continue developing a comprehensive approach to adolescent health across all hospitals, or instead develop a specific program or protocol directed towards subsequent pregnancies?

Those interviewed had differing opinions regarding solutions going forward. Some felt that stronger public policies and directives needed to come from the state. Others promoted greater emphasis on work within individual hospitals. A couple (as mentioned earlier) reminded all to bear in mind autonomous choices and that motherhood in adolescence is not an evil in and of itself. Following on from this however, just how autonomous are these decisions? Do these adolescents have repeat pregnancies due to indifference or a lack of alternatives, or is this a conscientious decision? Even for those who seemingly make the choice (such as the adolescent requesting her IUD to be removed), what is motivating this desire for motherhood? Is it the corresponding status, the desire of a new partner for her to “pay tribute” to his supporting her and her previous child from another father? Conducting a study on adolescent motivation regarding pregnancy would provide telling answers to these questions.

Whether a focus on overall comprehensive adolescent services or instead a specific initiative on subsequent pregnancy would be more effective remained unanswered. Those interviewed

\(^{97}\) Interviews, 10
likely preferred to focus on the achievements of their service given available resources, and indeed a comprehensive adolescent-friendly service is a necessary long-term aim. Nonetheless, replicating trainings and programs such as those at the Argerich and Sarda would be needed to ‘jump-start’ collaboration across a hospital.

B. The Adolescent Service at the Argerich General Hospital

The hospitals interviewed had long-standing adolescent services doing important work for the patient populations. The Adolescent Service at the Argerich General Hospital provides a particularly interesting case study, and perhaps potential lessons learned for other hospitals and services in the city of Buenos Aires.

Argerich at the Forefront

Located in the southeastern part of the City of Buenos Aires, the “Hospital General de Agudos ‘Dr. Cosme Argerich’” is at the forefront of adolescent health care services; specifically, the well-reputed “Servicio de Adolescencia,” or Adolescent Service within the hospital.

The programmatic area of the Argerich Hospital includes the southeastern zone of Capital Federal, and includes the neighborhoods of San Telmo, La Boca, and Barracas. Many are internal or external immigrants, and a high percentage of families have unmet basic needs and are not integrated into the health or education system. Indeed, in 1995 this area had the highest index of unmet basic needs in Capital Federal.98 Separated only by the “Riachuelo” from the southern metropolitan area, the hospital also serves these surrounding “villas” of Gran Buenos Aires, where these needs are reproduced and multiplied.

History of the “Servicio de Adolescencia”

In 1962, the Rawson Hospital opened an Adolescent Service, followed by the Children’s Hospital “Ricardo Gutierrez.” In 1978, the Rawson-Gutierrez hospitals were brought together, and

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98 FUSA 2000, “Proyecto Adolescencia Buenos Aires,” II
an Adolescent Section was opened in CeSAC\textsuperscript{99} No 2, dependent on the Hospital “Cosme Argerich.” In 1983, this service was moved to the main floor of the Argerich Hospital, where it included its own hallway, waiting area, and consultation rooms. It has since expanded to 8 consultation rooms, a meeting room and a small library.

The Adolescent Service adapted itself to increasingly meet the needs of its target population. The number of patients seen increased dramatically with time as the service adapted; first from an outpatient unit, to physical integration within the hospital (open 8 to 15 hrs), to extended hours (8 to 20 hrs), to finally developing the “Proyecto Adolescencia Buenos Aires.”

**Proyecto Adolescencia Buenos Aires**

From 1992 to 1995, the “Proyecto Adolescencia Buenos Aires” was established with funding from the W.K. Kellogg Foundation, in order to support and expand the Service’s work. In response to limited development achieved by national programs, the working team of the Service thought to develop a philosophy and method of care that could then apply to a broader spectrum of the Argentine adolescent population.

An interdisciplinary team put together a comprehensive project, detailing strategies and actions and proposing an administrative operating model with the necessary physical and human resources for the project’s aims to succeed and solidify themselves within the Hospital’s Adolescent service. Funding this project allowed innovative interdisciplinary professional cooperation between sectors to generate actions and build structures that ideally are replicable in other environments. The team eventually grew from one head of the section and three doctors to an interdisciplinary team including doctors, psychologists, and social workers.

The project sought to structure a comprehensive health care system for the adolescent population served by the Argerich Hospital’s practice area. The three subprojects were as follows:

\textsuperscript{99} CeSAC, or Centros de Salud y Accion Communitaria, are local health centers which are regulated by Health Law 153 (1999), programs from family doctors, and neighborhood clinics. They implement municipal and national programs and provide primary health care services.
• Internal Hospital care: Reformulate and strengthen the control and ambulatory care of the Adolescent Service (for patients arriving through spontaneous demand, prompted, or derivation)

• External extension of care: Systematize outpatient care outside the Hospital within the program area, and extend influence

• Human resource training and education for health: Structure an overall training system for the Health Team, pre and postgraduate students, adults responsible for adolescents, and the general community that attends the hospital

The target population included the 15,200 patients aged 10 to 20 years that annually needed services from the Adolescent Section; this included the adolescent population attending school within the programmatic area, and the adolescent population that wasn’t (through homes and community, religious, and sports groups).

Some of the final achievements of the program include the definitive establishment of the Adolescent Service in the Argerich Hospital; a leading role for La Boca, Barracas, and San Telmo (Argerich’s programmatic area); implementation of the research proposal on overall adolescent health within and outside the hospital; establishing an adolescent health care network in municipal hospitals with “Proyecto Adolescencia Buenos Aires” as coordinator; training of human resource on all levels; cooperation with scientific entities; and projection to national entities. Specifically on this last point, the project was projected to the National Health Secretariat, and provided advice for the implementation of the National Plan on Adolescents.

Adolescent Pregnancy within the “Proyecto”

The first subproject was divided into several workings areas, including fertility. This area was further split into adolescent pregnancy and adolescent motherhood. The first details causes and establishes standards of care for adolescents to prepare them for childbirth and motherhood. The second area sought to promote adolescent consultations to further health education and responsible sexuality.

This second area was implemented by coordinating between the Adolescent Service, Pediatrics Division, and Obstetrics and Gynecology Division. The Project knew that internment
during the puerperium and attending monthly check-ups for the newborn were both opportunities for increasing an adolescent's understanding of newborn and maternal health topics. These opportunities were leveraged by coordinating so that consultation periods were made available for when the adolescent mother went to the hospital for check-ups for her newborn. The team also sought the adolescent’s gradual social reinsertion through support programs, efforts to continue studies or find work, child care, and involving the male counterpart. The team also provided advice for “managing fertility” and avoiding a second pregnancy.100

Stemming from this initial project, the Argerich hospital has had several initiatives since to promote adolescent health. For example, starting with this initial project and continuing since then, the Argerich has developed workshops held in the waiting area of the adolescent service. These are interactive discussions on various topics relevant to adolescent health, for education and health promotion. The topics include pregnancy and STI prevention, contraceptive methods, emergency contraception, condom use, abortion, discrimination, rights, etc.

A Grant Focusing on Subsequent Adolescent Pregnancy

In 2006 the Argerich hospital received a research grant for work in subsequent pregnancy. The grant covered four areas: interviews with other health personnel across the hospital; two semi-structured interviews with patients age 10-21 (spaced 11 months apart); training for other hospital services; and workshops in the waiting area of the adolescent service.

The interviews with other medical professionals helped establish current resources and processes across the hospital. The patient interviews established whether adolescent patients at the hospital had received counseling on a contraceptive method (and/or actually received one), or had been referred to the adolescent service. The training for the other hospital staff was on adolescent sexual and reproductive health, and working with adolescent patients. Finally, the waiting room workshops continued and expanded the service’s work of communicating content to adolescent patients on sexuality, gender and their ASRH patient rights.

100 FUSA 2000, “Proyecto Adolescencia Buenos Aires,” II
The surveys showed that comprehension levels went up after the grant period and implementation. However, an Argerich doctor noted that one creates indicators after identifying a problem, but it remains to be seen if they are effective over time. In this case, it is necessary to see if the number of repeat pregnancies has gone down.\textsuperscript{101}

In retrospect, it seems the grant did identify a problem, bring awareness to an issue, work in groups, and provide a tool to address the issue. The next step would be to create an established process and feedback mechanism, where on being discharged from the hospital, the adolescent patient is first sent to pediatrics and the adolescent service. According to a doctor at the Argerich Hospital, they should leave the building with a contraceptive method, because in waiting three months for the infant’s first checkup, she could already be pregnant again. When the adolescent leaves the hospital, follow-up appointments should be set with the pediatrician, obstetrician, and the adolescent service.

Indeed, one important drawback from this training is the lack of a feedback or evaluation mechanism to see if and how it’s being implemented and if there are issues. Previously, patients that were referred from pediatrics came with a yellow paper, so "visually it seemed like [the adolescent service] had more referrals, but now it is not possible to measure. Pediatrics might tell us they have referred the adolescents to us, but many patients come in without us knowing where they came from."\textsuperscript{102} One Argerich doctor indicated that effective implementation was not up to the adolescent service but rather the obstetrics, pediatricians, etc.\textsuperscript{103} However, this seems quite critical and an area where ownership can and should have been taken promptly. Referrals may have increased, but the process and feedback mechanisms need to be further formalized.

\textsuperscript{101} Interviews, 11
\textsuperscript{102} Interviews, 38
\textsuperscript{103} Interviews, 12
VI. Wider Adolescent Health Issues in Argentina

The conversations with health professionals at various municipal hospitals gave an overview of the issues surrounding adolescent health in Buenos Aires. Attempts to isolate the health sector intervention variable when researching subsequent adolescent pregnancy often turned into wider discussions surrounding socioeconomic contexts, or slow action at the municipal level.

Stepping back and looking at the wider context, similar issues can be found throughout Argentina. There are the same “missed opportunities” for addressing subsequent pregnancies. Looking more broadly, adolescent health is still only slowly being prioritized and differentiated, with sparse and slow implementation of best practices in adolescent health across the country. One publication from various authors and coordinated by Lic. Monica Gogna gives a thorough portrayal of adolescent pregnancy and motherhood in Argentina.

Adolescent Motivation and Background

It is interesting to note that from the adolescent population included in Gogna’s research, a third were neither studying nor working when they became pregnant. This could suggest that motherhood acquires a meaning and importance that maybe would not be present in different, more favorable circumstances.104

Subsequent Pregnancy in Argentina

With regards to subsequent pregnancy, all provinces face similar issues as those encountered in the city of Buenos Aires. With regards to patient referrals, Gogna discovered similar difficulties in ensuring that adolescent patients are referred somewhere and given family planning advice when discharged post-childbirth or post-abortion care. Whether it is in the same hospital, a maternity hospital, or a local health center, the follow-up mechanisms regarding contraception are

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104 Gogna 2005, 696
not in place. These breaks in the system are highly risky for the prevention of subsequent pregnancies.\textsuperscript{105}

In Gran Buenos Aires, strategies for prevention of subsequent adolescent pregnancies are the same as those for adult women; prevention is dependent on the woman or adolescent attending a puerperium appointment, where family planning information is provided. According to one interviewee, “Once the adolescent or non-adolescent has given birth, we give them a piece of paper saying “Go to the puerperium appointment, family planning.”\textsuperscript{106} There is no follow-up with the patient, nor communication with the health centers, after the patient is discharged from the hospital.

\textbf{Adolescent Health in Argentina}

Indeed, it is not solely a lack of specific initiatives addressing subsequent adolescent pregnancies, but rather obstacles to identifying and adequately addressing issues in overall adolescent health. Unfamiliarity with national programs, lack of provincial or hospital level initiatives, few health services available specifically for adolescents, disparate actions on contraception, and no standardized follow-up or referral system are just some of the remaining obstacles to providing comprehensive and suitable adolescent health care across Argentina. Actions improving adolescent care overall seem a necessary foundation for initiatives and policies surrounding subsequent adolescent pregnancy.

\textbf{Programs and Initiatives}

Official initiatives on adolescent health are not standard across all provinces. Gogna also found a link between professional unfamiliarity with national programs and initiatives and a lack of proposals on prevention of unplanned adolescent pregnancy (at the health institution level). Generally, it is also these professionals that promote strategies focused exclusively on education or dissemination of information.

\textsuperscript{105} Gogna 2005, 190
\textsuperscript{106} Gogna 2005, 190
It is noteworthy that in all provinces, the National Program for Sexual Health and Responsible Procreation has played a fundamental role in legitimizing the extension of contraception coverage and promoting guaranteed access to health care services and supplies. However, not all provincial programs on reproductive health have incorporated adolescents specifically as a target population (as they are in the national program).

Comparatively, health professionals in Gran Buenos Aires had the greatest knowledge of local initiatives directed towards the adolescent population. They mentioned specifically the Subprogram for Comprehensive Adolescent Health, incorporated into the Maternal-Infant Program. However in most jurisdictions, health professionals either did not know of or confirmed the nonexistence of policies or local action specifically directed at adolescent populations. The closest approximation would be the provincial health programs on reproductive health, but these generally do not include a specific programmatic area focused on adolescents.

Most interventions aimed at adolescents are hidden within a larger target population. While in some places there are health programs or services targeted specifically at adolescents, most interventions generally include larger social groups, including youth (defined as up until 25 years old), women of reproductive age, people with unmet basic needs, etc. In addition to this, several provinces have provincial programs on sexual and reproductive health that do not include adolescents as a target population (with the exception of youth that are already mothers).

**Adolescent Care**

Comparatively, Greater Buenos Aires has much more experience in providing specialized care to adolescents, and has taken the most definitive steps with regards to adolescent pregnancy and sexual and reproductive health. There are several hospitals with adolescent units that work according to the programmatic orientations at the national or provincial levels. Nonetheless, coordination between sectors remains a work in progress. At the time of publication, only one of

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several hospitals interviewed by Gogna had an adolescent committee working in conjunction with the education system. The rest did not have specific working ties, and many faced serious difficulties in communicating with the primary health care centers.

Similar issues to varying (worse) degrees are found throughout Argentina. At the time of publication, none of the health centers studied had a designated line of work for adolescent populations, showing a serious deficiency in the levels of adolescent primary care. Other health institutions (municipal and provincial hospitals, maternity hospitals) also did not have specific programs for adolescents. These public health services had serious difficulties in maintaining adolescent programs or services over time due to lack of resources or infrastructure.

Hospitals in other provinces might have previous experiences with differentiated adolescent care, but many of these were discontinued due to lack of resources or difficulties in institutionalizing them. These services were eventually discontinued due to “organizational issues, time, and lack of personnel.” Medical professionals are aware of the problems, and admit there is not “what there should be: educators, training, social workers…”

Similar to the experiences described in the capital, the efforts and personal affinity of health professionals to adolescent care (specifically pregnancy) stood out in most of the provinces, over the (lacking or nonexistent) formal mechanisms or programs. Further training of health professionals in adolescent health, gender perspectives and issues, and social and reproductive rights is required to strengthen current adolescent services.

Few of these actors had an adolescent unit within their obstetrics/gynecology services, and many that did have stopped functioning due to lack of resources or the need to redirect infrastructure to the general population. Furthermore, many of the adolescent units are within pediatric hospitals. In these hospitals as a general norm, contraception is not offered. These services then are then limited to providing solely consultations and not providing supplies.

108 Gogna 2005, 184
109 Gogna 2005, 184
Different provinces had varied experiences, processes and opinions on providing a contraceptive method. (This of course can also be attributed to personal conviction, though directives are presumably taken from provincial programs.) Some regions expressed that they were unable to provide adolescents with a contraceptive method simply because they did not have them (including condoms). Supplies had not been sent by either the provincial or federal government. Where supplies were available, differing opinions and methods of working came through. Some regions presented greater social resistance to increased contraception coverage among adolescents, preferring to promote “natural methods.” Particularly with regards to IUDs, some felt this was the best option for adolescents, while others refused to use these on adolescents in any situation.

To review the current and historical context, these evaluations across Argentina were completed in 2005. The National Program on Comprehensive Adolescent Health is from 1993, and the National Program on Sexual Health and Responsible Procreation from 2003. It would be interesting to see what progress has been made nearly 10 years after Gogna’s publication, and 3 years since the publication of the guides from the National Program on Comprehensive Adolescent Health.

Comparatively, at the time of publication Gran Buenos Aires actually had the best indicators with regards to school dropouts, use of contraceptive methods, and lack of or delayed attendance to prenatal controls. It would again be interesting to see if and how much these have changed given steady growth in immigration to the Gran Buenos Aires area. It is reasonable to assume however that comparatively this province still has better conditions to the rest of the country. Nonetheless, as explained here, there is strong overlap in many of the issues faced in both Buenos Aires and the rest of the country.
Adolescent Actions

Across Argentina, prenatal check-ups are much more common for first pregnancies than subsequent pregnancies, and less common for poorer adolescents and those not in school.\textsuperscript{110}

There is a lack of adequate information presented during prenatal check-ups and hospital internment following childbirth. In a survey across various hospitals in different provinces, only 29.9% received information on contraceptive methods, and 30% did not receive any counseling on breastfeeding, childcare or family planning. The data on these “missed opportunities” shows that across the country, the health system is not maximizing opportunities to promote preventative behaviors and incentive appropriate childbirth spacing (as recommended by the WHO).\textsuperscript{111} Furthermore, this is particularly worrying as in this same survey, 94.7% of adolescents stated their intention to use contraceptive methods in the future.

Delving further into options and preferred methods, adolescents preferred to use (in order) birth control pills, IUD, the birth control shot, and condoms. It is an interesting switch given that the preferred method for adolescents when they first begin to have sex is condom use; this might suggest that adolescent girls now prefer to use more effective methods that they are in control of. Interestingly, primiparous\textsuperscript{112} adolescents tend to choose highly effective methods (pills 49.3% and IUD 30%), while an important portion of multiparous adolescents use less effective methods (33% condom, 21% withdrawal, 5% natural methods). Furthermore, 35.5% reported being on the pill. These are worrisome statistics that show the difficulties of using this method, and the reported high level of intention to use oral birth control suggests that health centers must both guarantee access to this method and raise awareness for users on proper use for good results. Finally, it is worrisome that an IUD, the second-most preferred option, is not normally part of what is offered in the public sector.

\textsuperscript{110} Gogna 2005, 271
\textsuperscript{111} Gogna 2005, 276
\textsuperscript{112} Given or having given birth for the first time
Reproductive History, Schooling, and Pregnancy

Table 6: Medical practices completed during a pregnant youth’s doctor’s appointments

<table>
<thead>
<tr>
<th>Practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure taken</td>
<td>99.3</td>
</tr>
<tr>
<td>Weight taken</td>
<td>99.0</td>
</tr>
<tr>
<td>Stomach measured</td>
<td>97.9</td>
</tr>
<tr>
<td>Listen to baby's heartbeat</td>
<td>96.4</td>
</tr>
<tr>
<td>Ecography</td>
<td>96.3</td>
</tr>
<tr>
<td>Vaccination given</td>
<td>89.6</td>
</tr>
<tr>
<td>Iron prescribed</td>
<td>69.7</td>
</tr>
<tr>
<td>HIV/AIDS test administered</td>
<td>69.2</td>
</tr>
<tr>
<td>Breast examination</td>
<td>44.8</td>
</tr>
<tr>
<td>Taught how to prepare for breastfeeding</td>
<td>38.5</td>
</tr>
<tr>
<td>PAP smear</td>
<td>36.1</td>
</tr>
<tr>
<td>Discussed family planning</td>
<td>32.1</td>
</tr>
</tbody>
</table>

Table: During pregnancy check-ups, only 32.1% of doctors spoke to adolescent patients about family planning

With regards to subsequent pregnancies, research shows similarities across the country regarding contributing factors for subsequent pregnancy. Social conditions (such as poverty level and access to education) are the most determinant factors when establishing if adolescents will both use a contraceptive method (thus decreasing subsequent pregnancies) and attend prenatal checkups. These are largely outside of the health sector’s control and thus difficult to tackle. Nonetheless, it is still possible to identify efforts the health sector (and others) can take to improve an adolescent’s situation, and that of her children.

Firstly, the health and education sectors must promote adequate contraceptive counseling. Education level is positively associated with the use of a contraceptive method for their first sexual experience. Research also shows that the older the adolescent, the more likely they are to use a contraceptive method.

Prior to motherhood few adolescents have defined life plans in terms of studies, work, or personal fulfillment, and their actions are focused on the present. In this context, motherhood/fatherhood can be a defining factor in their lives. While pregnancy is normally
accidental and can incite fear or humiliation, it can also reaffirm their identity, provide increased social recognition, and bring them closer to the adult world.

**Motivations**

Gogna’s research studies adolescent motivation following the birth of their first born. The majority of girls (76%) did not return to school after the birth of their first-born. The principle motivators were that they wanted/needed to take care of their family (42.6%) and they no longer wanted to study (28.4%). Another 19.8% stated they did not return to school for financial reasons. Some research suggests that the lack of motivation or desire to return to school is due to ‘cultural obstacles’ and inaccessibility as factors for dropping out of school.

**Conclusion and Recommendations**

As shown by other research and publications, the issues faced by health professionals in the city of Buenos Aires are pervasive throughout the country. Providing some differences and province-specific background, the problems and proposed solutions are seen throughout. These include proposals for improved overall adolescent care, with some of particular relevance to subsequent pregnancy.

Changes for improved adolescent care should include: expanding provincial sexual and reproductive health programs to include adolescents; promoting the institutionalization of adolescent health services with interdisciplinary teams within general and maternity hospitals; include groups to work with abuse and violence victims; guarantee provision of contraception by ensuring supplies are available; articulate actions promoting adolescent sexual and reproductive health between health, education, and civil society organizations.\(^\text{113}\) Furthermore, two important pending changes are particularly relevant for subsequent pregnancy: strengthening networks between local health centers and hospitals to refer patients and provide appropriate pregnancy care and follow-up, specifically providing family planning information for adolescent postpartum or

\(^{113}\) Gogna 2005, 210
post-abortion; ongoing training for health teams on adolescent and gender perspectives, sexual violence, and humane and proper post-abortion complications.

Health professionals across Argentina felt that one important area for improvement was bringing the health centers closer to the community, guaranteeing an effective network between hospitals and health centers and establishing cross-sector ties.

One important suggestion discussed how groups (not necessarily medical professionals, but rather health promoters engaged with the topic area) to create actions and dialogue where the formal education sector does not reach (for either schools with lacking sexual education, or for youth that are not enrolled in school). They would create awareness of national programs on sexual and reproductive health (and the rights these confer) and where to go to receive the necessary medical attention and contraception information and method.
VII. Subsequent Adolescent Pregnancy in Latin America

Evaluating subsequent adolescent pregnancy in Buenos Aires and Argentina shows a strong need for programs in this area, but an overarching need for improved adolescent care generally. A regional panorama would further contextualize this issue, and help show overlaps in the issues at hand as well as insight for health sector interventions that adequately address subsequent pregnancies. Relevant research includes regional authors and their corresponding studies, as well as recent publications from international organizations such as the Pan American Health Organization (PAHO) and United Nations Population Fund (UNFPA).

Literature on Subsequent Pregnancy from Latin America

Is there literature specific to Latin America regarding subsequent pregnancies, is this being addressed regionally, and if so, how?

Research shows limited literature specific to Latin America regarding subsequent pregnancies. Most mention of this is included within reports on adolescent pregnancy in general. One other publication on improving adolescent clinical care post-abortion also includes a discussion on subsequent pregnancies and the provision of adequate contraceptive information and method.

A publication from Dr. Jose Luis Escobar presents the most thorough assessment of subsequent pregnancies coming from a Latin American context, describing primary, secondary, and tertiary pregnancy prevention as detailed previously. In addition to this, two presentations from Ecuadorian doctors provide perspective on subsequent pregnancies from their patient groups.

Dr. Jorge Naranjo Pinto from Ecuador also has several documents pertaining to subsequent adolescent pregnancy, highlighting the high rates within his clinical area and indicating some potential actions from the health sector. He breaks down the principle causes for repeat pregnancies into those relating to: risk factors of the individual and couple; poor quality of health center attention; and dysfunctional family issues.
While the first two coincide with items previously discussed in the Argentine context, Naranjo Pinto highlights dysfunctional families as a cause and distinguishes them where they previously might have been included as a general ‘risk factor.’ Some of the sociofamilial risk factors include: poor mother-daughter relationship; lack of a father figure in the household; living with one or no parents; lacking family support for contraception; lacking family support or cohesion; low education levels of the mother; lacking any adult support outside the family.

The causes (and thus recommendations) relevant to the health sector are similar. Causes related to the health sector include unfriendly prejudiced staff not dedicated or engaged with the patient; merely ‘informative’ attitudes to contraception; insufficient evaluation of their level of understanding, maturity, and decision-making; missed opportunities in the postpartum and pediatric appointments; and lack of internal and external promotion of family planning services. Similar to Argentina, future programs and initiatives need to promote comprehensive health services with trained and engaged health sector staff to provide friendly and adequate adolescent services. Other causes however (individual, couple, or family risk factors) remain out of reach of the health sector, and increased intersectoral options should be evaluated where possible (engaging community groups or the education sector, for example).

Another publication from Dr. Susana Guijarro evaluates the impact of family planning counseling on subsequent pregnancy prevention. After reviewing rates of adolescent pregnancy and the impact of family planning counseling on subsequent pregnancy outcomes, Dr. Guijarro details some important aspects of adolescent development, and what makes for effective counseling for this population group.

She describes counseling in sexual and reproductive health as the psychosocial personalized help that is established between someone from the health team and the adolescent, with the intention of strengthening their ability to make free, informed, responsible choices coherent with their convictions with regards to their sexuality and within their human rights. She describes how this is a lengthy process, because it does not solely depend on the action taken but on maintaining
this action, or risk falling back. She includes strategies and methodologies designed to guide the health sector; for example, tools for guiding an adolescent through difficult decision-making.

These presentations provide additional insight into issues surrounding adolescent pregnancy. Other literature specifically on this topic is limited, and instead folded into research on adolescent pregnancy. Given the fairly substantial amount of literature on repeat pregnancies from western countries, it remains to be analyzed how to best combine the Latin American context and specifics with existing research on subsequent pregnancies, in order to determine the most appropriate program responses.

**Subsequent Pregnancy within International Organizations**

A joint publication from the WHO/PAHO, “Adolescent and Youth Regional Strategy and Plan of Action: 2010-2018” provides a comprehensive plan for the region over the next few years. The document details strategic areas and their corresponding objectives, targets, indicators, and activities at both the interagency and regional level. While pregnancy is mentioned throughout as an important area requiring particular attention, there is no specific mention of subsequent pregnancies.

This could indicate both a lack of regional awareness and a call to each national government to work with their respective ministries of health and health sector entities.

Reports on all health topics have been put together in advance of the 68th World Health Assembly in May 2015, including a report on adolescent health in November 2014. While this does not detail specific health aspects or initiatives, it describes the “growing interest in adolescent health and recognition of its importance for public health throughout the life course.” Listing recent efforts:

*The need to give adequate attention to the health and development of adolescents is being acknowledged in discussions on the post-2015 development agenda. Major international development agencies (UNESCO, World Bank, UNICEF and UNFPA) have recently published substantive reports on adolescents and have given specific attention to adolescents in their operational plans. A commission on adolescent health has recently been established.*
regional committees for the Americas and for Europe have approved strategies on adolescent health, the South-East Asia Region has established strategic directions, and the regional offices for Africa and the Western Pacific plan to develop regional strategies on adolescent health\textsuperscript{114}.

In light of all this, the WHO is looking to provide increased support for the development of national policies and programs and develop a comprehensive plan on adolescent health. This proposed framework includes ‘accessible health services’ and ‘safe sexual debut’ as two of five important domains. It also will seek to focus on common determinants that underlie health problems and are necessary for positive development, which include: personal characteristics such as age, gender, knowledge and skills; peers; parents; providers such as health workers, teachers and youth workers; protective and supportive environments including families, schools and communities, and social values and norms; and political decisions and frameworks that affect legislation, policies and the allocation of resources.

Subsequent Pregnancy within National Governments

Developed in support with PAHO, the following countries have National Plans regarding adolescent health (including pregnancy):

- **Peru**: Strategic National Plan for Adolescent Health 2012-2021 (Ministry of Health)
- **Paraguay**: National Plan for the Promotion of Quality of Life and Health with Equality in Adolescence 2010-2015 (Ministry of Public Health and Social Welfare)
- **Panama**: National Plan for Child and Adolescent Health 2008-2012 (Ministry of Health)
- **Guatemala**: Policy for Adolescent and Youth Health 2033-2012 (Ministry of Public Health)
- **Central America and the Dominican Republic**: Current State of the National Plans and Programs for Adolescent and Youth Health in Central America and the Dominican Republic 2010 (PAHO)
- **Chile**: National Policy on Adolescent and Youth Health 2008-2015 (Ministry of Health)
- **Bolivia**: National Plan for Comprehensive Health for Bolivian Adolescents and Youth 2009-2013 (Ministry of Health and Sport)

All mention adolescent pregnancy as an important area for attention.

\textsuperscript{114} WHO, “Adolescent health: Report by the Secretariat,” Executive Board 136\textsuperscript{th} Session, 21 November 2014
There is also an important document at the subregional level, the Andean Plan for the Prevention of Adolescent Pregnancy from November 2009. This assesses the current situation and describes the sociodemographic context; socio-economic implications; access to information, education and health services; and recommendations and challenges in this area. The comprehensive and multi-sectoral recommendations for action include actions from the health sector, public policies, networks and social participation, education, access to information, and job opportunities for adolescents.

Ecuador subsequently established its own plan in accordance with this, a National Plan for the Prevention of Adolescent Pregnancy (PNPA). This was responding to the fact that within the Andean region, it had the highest adolescent fertility rate. It attributed the principle causes of this with limitations to access to the health sector (specifically sexual and reproductive health) and a lack of information and education. It also considers socioeconomic, generational, ethnic, and gender inequalities as a cause and effect.
VIII. Western Approaches to Subsequent Pregnancy

For reasons aforementioned, subsequent adolescent pregnancies present an important issue within adolescent health, and the “missed opportunities” concept would suggest that the health sector could do more to change these outcomes. Though this area is less researched as compared to adolescent pregnancy overall, subsequent pregnancies require different approaches and programmatic responses. Despite the scarcity of formal studies and publications from the developing world and/or Latin America, a review of these from the western ‘developed’ world could provide important insight into the situation in Argentina. This includes those determining potential predictors and motivators, reviewing the importance of adolescent-friendly services, and evaluating specific programs.

Predictors and Motivators

It is important to note relevant predictors and motivators within a given adolescent population group prior to making comparisons. Several publications and studies from the United States and Canada focused solely on this aspect, presumably to later use this information to create policies and programs to adequately address the needs of the population.

Some research explores social ecological predictors of repeat adolescent pregnancy, others focusing on interpersonal or psychological motivators. Several U.S. publications particularly focused research on economically disadvantaged teens, presumably because a higher percentage of adolescent pregnancies occur in the U.S. among this population. A significant number of factors have been studied repeatedly, with varying conclusions as to their relevance and predictive ability. These include race/ethnicity of the mother, age, schooling, living with parents, marital status, and multiple vs. stable partners. Frequently, studies concluded “low schooling, multiple partners, and non-stable bonds” as risk factors for pregnancy recurrence. Nonetheless, there are individual, dyad, and peer/community level predictors to bear in mind, and the specific factors studied and the conclusions reached varied.
Some studies found the reasons teen mothers give for not consistently using contraceptives consistently before their first pregnancies then predict the occurrence of subsequent adolescent pregnancies (or conceptions). Specifically, those who attributed their previous failure to consistently use contraceptives due to side-effect concerns and their own lack of motivation to postpone childbearing are least likely to use hormonal contraceptives after delivery and most likely to conceive again.

Another study found low-parental monitoring was associated with repeat pregnancies among minority adolescent females, suggesting that interventions designed to increase parental monitoring or adolescents’ perceptions of parental monitoring could be effective components of pregnancy prevention programs. Building off of this, another study found that low-income adolescent girls’ attitude toward contraception did not predict contraceptive use. Rather, regular contraceptive use was associated with a positive mother-adolescent daughter relationship and the presence of the girls’ father in the home. This led the authors to conclude that parental support of contraception, rather than attitude toward contraception, played a more important role in preventing repeat pregnancies. (Both these studies correlate well with programs reporting success with home visiting programs, showing the positive impact of supportive personal relationships, explored in greater detail below.)

Interestingly, one study on a “Teen Mother & Child” Program found that the 10.6% of adolescents that had a repeat pregnancy were more likely to be Hispanic (or have a Hispanic partner) than those that did not repeat. (Alongside this, the adolescents that repeated were more likely to be in a stable relationship; with the baby’s father.) Speculative correlations between the Hispanic population in the U.S. and the context in Buenos Aires could include the socio-economic status of the adolescents from the U.S. study, or Roman Catholic views against abortion or contraceptive use.

Among all this, it is often difficult to separate cause from effect. Research suggests that “many negative outcomes previously ascribed to mothers’ age are as much causes or correlates of
teenage pregnancy as effects of it.\textsuperscript{115}n This line of thought feasibly extends into subsequent adolescent pregnancies, although certainly motherhood or alternate outcomes of the first pregnancy add another set of factors.

Indeed, perhaps comparing intended versus unintended rapid repeat pregnancies provides the most relevant dimension when assessing predictors and motivators. One study found that racial/ethnic characteristics, educational status, and age of the mother at first birth were not associated with either intended or unintended rapid repeat pregnancies. Instead, other factors such as intended first pregnancy or prior poor obstetrical outcome were associated with intended repeat pregnancies.

As explored previously, in the view of the adolescent motherhood might have various positive effects (for example, conferring an increased ‘status’ in the family), and as such subsequent pregnancies might be either desired or at least not unwelcome once an adolescent learns she is pregnant. One longitudinal examination concluded that “female adolescents with inconsistent reports of pregnancy intentions” might benefit from further information and education. Indeed, one study found participants “expressed a sense of optimism and confidence in their abilities to manage single parenthood, achieve educational goals, and maintain supportive relationships with the fathers of their babies.”\textsuperscript{116}n Nonetheless, pregnancy intentions are complex conversations, understandably in particular among adolescents. Considering the intendedness of repeat pregnancies (as opposed to solely ‘risk factors’) could create more effective and appropriate family planning interventions.

This calls to mind the previously discussed argument that reminds policy makers that adolescent pregnancy by definition is not necessarily negative. As such (perhaps obvious but often overlooked), it is important to involve adolescents in the conversation. An intended subsequent pregnancy should be viewed within the overall context for that particular mother. Indeed, one study found that self-reported reasons for pregnancy can reveal important

\textsuperscript{115} Coley, Rebekah Levine. “Adolescent pregnancy and parenthood: Recent evidence and future directions.”
\textsuperscript{116} Spear, Hila. “Teenage Pregnancy: ‘Having a Baby Won't Affect Me that Much.’” 2001
characteristics of pregnant adolescent. This particular study found that young women who reported intentional pregnancy “seemed to fare better with regard to their financial status and their relationship with the father of the baby.”⁶¹¹⁷ Although this is easily different in the context of Argentina and the developing world overall, an intended subsequent pregnancy may or may not have positive or negative subsequent outcomes for the health and wellness of the mother and child(ren), and each mother’s case should be viewed individually.

An Adolescent Focus: Methods of Communication

Without a doubt, the depth and complexity of potentially relevant predictors and factors leading to rapid repeat pregnancies confirm the need for multifaceted, multidisciplinary approaches. Given the particular characteristics of the population group, efforts must be tailored accordingly and be “adolescent-friendly” in order for them to be successful. Drawing conclusions from the literature seem to indicate two particular areas of focus. Firstly, health services must ensure access to contraception and other health services, tailoring these specifically to the adolescent population. Following on from this, communication and interactions should be adolescent-friendly, to both ensure comprehension and development positive supportive relationships.

On the first area, as the primary level of response and prevention, ensuring access to services is essential. This currently easily varies between countries, states, cities, providers, etc. Nonetheless, it is fairly obvious that if an adolescent can neither have a doctor’s appointment without a parent or guardian present, nor afford or even access contraceptive options, they are a greater risk to not receive the appropriate care and information they need to make informed choices regarding their sexual and reproductive health. Access furthermore goes beyond a legal right to services, and also incorporates ensuring and facilitating patient visits. Efforts in this realm are seen both in the western world and in Argentina; several doctors interviewed in Buenos Aires

⁶¹¹⁷ Rubin, Valerie and Patricia East. “Adolescents’ pregnancy intentions: Relations to life situations and caretaking behaviors prenatally and 2 years postpartum”
detailed how their adolescent service had increased their opening hours and allowed for walk-in appointments at any time to facilitate adolescent attendance.

Secondly, establishing adolescent-friendly services is the follow-on from ensuring primary access. Communication should be adapted and comprehension ensured. While opening hours and walk-in appointments facilitate access, the interactions and conversations once inside the health and social service should be adapted for this patient group. Written communication and information given to adolescents should be adapted, as well as in-person conversation to ensure comprehension. Pediatricians and gynecologists may likely need to have specific training in order to work effectively with this population group.

An ideal way to bring together both of these area of work would be to have adolescent specific services, providing a specific space for them with staff presumably trained to work specifically with this patient group. If this is not possible however, at the very least staff awareness and training would allow medical professionals to most effectively interact and form positive relationships with the adolescents attending their services. Adolescent-friendly services goes beyond simply ensuring a legal right to services and methods, although this is a necessary first step and still lacking in certain contexts. Building on this, ensuring comprehension and encouraging conversation and dialogue through tailored communication is also critical for this population group. The doctors interviewed in Argentina repeatedly stressed the importance of these factors, discussing their efforts to establish comprehensive adolescent services within their hospital, as well as raise awareness among the other hospital sectors to refer adolescent patients to the their service.

**Program Evaluations and Recommendations**

Given these general guidelines, have any programs specific to subsequent pregnancy been particularly successful? Adding on from and bringing together the varied (if not conflicting) information regarding predictors and motivators, what programs have proved effective? Although mostly based in the western world, assessing these may hopefully provide insight into the
Argentine context. Researching programs in the U.S. and Canada, some successful programs here may potentially have relevant insight, particularly those with other similarities such as urban contexts or similar socio-economic characteristics.

**Adolescent Pregnancy Programs**

There is an extensive amount of literature on adolescent pregnancy, and a wealth of publications describing the results and effectiveness of a particular program or study. Thankfully, there are several useful publications and articles that bring these together, and summarize the most effective evidence-based programs and the population groups they target.

As discussed, there are numerous risk and protective factors (individual, environmental, peer, partner, and culture) that influence adolescent behavior. Knowing the relevant factors for a particular community leads to more effective interventions. Because some factors can be more easily modified through programmatic interventions that others, quality interventions would focus on these that are more amenable to change.

According to a publication from the Minnesota Department of Health, programs to prevent adolescent pregnancy can be categorized into three groups: those focusing on sexual risk and protective factors, and those focusing on nonsexual factors, and those focusing on both. Programs focused on sexual factors would focus on aspects such as:

“an adolescent’s knowledge, attitude, or beliefs about sex, perceived norms, confidence in communication and refusal skills to avoid sex, confidence in their ability to accurately use contraceptives, and their intentions regarding sexual behavior and the use of contraceptives.”

Programs focusing on nonsexual factors focus on all aspects that might influence sexual behavior, not solely those related to sexuality. Some examples would include family connectedness, school enrollment and performance, substance abuse, interpersonal violence, and others relationships to school, community and peers. These are often youth development programs, and can be service learning programs.

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Within these categories, programs can have a variety of structures. The major categories are school-based, clinic-based, parent-child communication, service-learning programs, and multi-component programs. School-based programs often designate curriculum-based programs with STI/HIV education components. Clinic-based programs are particularly effective when they are structured around one-to-one counseling with an adolescent to give counseling and information about abstinence and contraception. Parent-child communication programs increase communication about sexuality between parents and children, and may involve both or just the parents. Service-learning programs are the youth outreach programs which focus primarily on nonsexual factors. Within these general structures programs would then be further tailored to best suit the needs of a particular population group (urban, minority, low-income, enrolled or not enrolled in school, etc.).

**Subsequent Pregnancy Programs**

The different programs structures can generally also be applied to programs working specifically with adolescent mothers. However, important differences apply. For example, while community or school-based programs may be effective in reducing rates of teen pregnancy, adolescent mothers face a unique set of circumstances that could affect their interest in or ability to attend community or school–based programs. New mothers may have difficulties in attending community-based programs, and these chronically face high rates of absenteeism, particularly among disadvantaged participants. School-based programs geared towards adolescent mothers might have positive success rates, but those in this intervention group likely represent a self-selected sample of adolescents motivated to achieve the program outcomes.

What then is effective? The U.S. national organization Advocates for Youth compiled a list of programs that have proven effective in preventing or reducing the incidence of second (or other higher order) pregnancies or births among adolescent mothers. The programs included had strict criteria for inclusion to ensure scientific validity, and the program content for all those included provided specialized services which encouraged the adolescent mother to: use contraception correctly and consistently to prevent rapid repeat pregnancy; envision a brighter future for herself.
and her child; and complete her education and/or learn useful job skills. Six programs met all these criteria, five of which were based in the United States and one in Jamaica.

In addition to these criteria, the programs included all measured different additional outcomes. These included: improvements in contraceptive use; improvement in maternal health; improvement in health outcomes and/or reductions in abuse and neglect among infants of adolescent mothers; improvements in completion of high school or earning a general equivalency diploma (GED); and improvements in employment outcomes and/or reliance on public assistance.

The program structures are varied and include hospital-based, home-visiting based, community-based, and school-based programs. They are generally multidisciplinary programs, with frequent interactions with the adolescent mother (and often her partner and family as well). These might be facilitated through the health center (such as one offering free round-trip transportation to and from follow-up appointments) or involve nurse practitioners visiting the home. The staff are generally trained to work specifically with adolescents or given curriculums to follow, and/or there is a multidisciplinary staff of both health and social workers.

Of the programs included here, the programs based in urban low-income contexts (such as the Queens Hospital Center’s Comprehensive Adolescent Program for Teenage Mothers and their Children) and the program based in Jamaica (the Women’s Centre of Jamaica Foundation Programme for Adolescent Mothers) might be most relevant. Nonetheless, all demonstrate the importance of comprehensive multidisciplinary programs that address the complex needs of adolescent mothers and additionally structure programs for that particular context.

**Home Visiting Programs**

One particularly exciting area for continued research and development is home visiting programs. These programs are based on the premise that a developing a close relationship with a vulnerable adolescent mother over time through regular visits and communication will have subsequent positive effects on pregnancy outcomes, as well as maternal life course outcomes and child health and development. These relationships begin during or soon after the first pregnancy,
and visits are either in the teen’s home or mutually agreed location. Visits include educational aspects such as child development, baby care, and reproductive health. Visitors ideally also establish a connection with partners and/or family members.

Where other programs have been unsuccessful in delaying subsequent births, the continuous findings of the Nurse Home Visitation Program for example (targeting young and not just teen mothers) are “highly encouraging.” This is just one of several programs reporting success with home-visiting programs. Nonetheless, success is not guaranteed across the board, with some programs showing no difference in subsequent pregnancies to the control group, or even a slightly higher percentage in one study. Nonetheless, there were often other positive effects on rates of school continuation or parenting attitudes. Some studies have tried computer-assisted or cell phone-based counseling, but these “may not be the most ideal for addressing complex, socially-mediated behaviors such as [repeat teen pregnancy,] except for selective subgroups.”

One debated area within home visiting is the use of paraprofessionals or professional nurses. Paraprofessionals are normally drawn from the community and trained in the delivery of intervention, often sharing cultural, racial or socioeconomic backgrounds with adolescent participants. These are often seen more as mentors or peers instead of service providers. Some studies cite the positive effects of this, while others question whether there might be a perceived lack of authority. Finally, paraprofessionals tend to focus on social support and environmental factors instead of health related issues. There is no definitive research concluding the effectiveness of one group of home visitors over the other. In either case, positive findings of home-visiting programs correlate with studies indicating parental monitoring (perceived or real) and parental support of contraception as important factors in preventing repeat pregnancies. To an adolescent mother facing the difficulties of first-time motherhood as a teen, supportive relationships from a trusted adult seems to make a great difference.

119 Center for Law and Social Policy. “More than one: Teen mothers and subsequent childbearing.”
120 Katz, Kathy et al., “Efficacy of a randomized cell phone-based counseling intervention in postponing subsequent pregnancy among teen mothers.” 2011
Conclusions

Indeed, different programs have shown varied results regarding the best approach to delay subsequent pregnancies. The above mentioned programs among others, have reached positive conclusions and results. However, another holds that only a long-active hormonal contraceptive during the puerperium was associated with pregnancy prevention during the first 2 postpartum years, while “frequent clinic visits, contact with supportive healthcare and social service providers, and return to school were not.” This study reached this conclusion from assessing a multidisciplinary, comprehensive, adolescent-oriented maternity program.

The other programs detailed earlier reporting success would seem to contradict this finding; nonetheless, all programs would need to run and be compared for the same 2 year amount of time in order to compare. Indeed, another meta-analysis seeking to establish the effectiveness of secondary pregnancy prevention programs found that the programs produced a 50% reduction in the odds of pregnancy at the first follow-up period (average 19 months). But, by the second follow-up (average 31 months) the effect had dissipated.

Conversely to the study emphasizing long-acting contraceptive use as the primary if not sole factor, various studies and articles do hold that the most important aspect of an adolescent motherhood program looking to delay subsequent pregnancies is the personal relationships developed with that adolescent and either a healthcare or social service provider.

These various conclusions suggest that multidisciplinary comprehensive approaches will allow service providers to determine the best program, policy, or course of action. Indeed, bringing together some of the previous conclusions, it seems intuitive that a service provider (whether health or social worker) developing a personal relationship with an adolescent might increase the likelihood of their continued use of a long-acting contraceptive.

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121 Stevens-Simon, Catherine, Lisa Kelly, and Rachael Kulick. “A village would be nice but …: It takes a long-acting contraceptive to prevent repeat adolescent pregnancies.”

122 FSU Center for Prevention and Early Intervention Policy, “Subsequent Pregnancies and Births Among Adolescent Mothers.” 2005
In sum, home-visiting programs are often very effective, generally more so than community or school-based. Nonetheless, community and school-based provide important access health services, education, and peer support. Repeated characteristics of effective programs as compiled from Best Start (Canada) are outlined below:

**Summary of Characteristics of Effective Programs:**

Programs that appear to lead to a reduction or delay of subsequent teen pregnancy, as well as to other positive outcomes, share some common characteristics.

The following program components are acknowledged as being key to successful programming for pregnant and parenting teens:

- An individualized and sustained relationship with a primary staff person
- Program personnel that are knowledgeable about contraception, sexual and reproductive health issues, and are comfortable discussing these issues with teens and their parents
- Program implementation during pregnancy and continuation for up to 3 years after the birth
- Counseling to facilitate continuation of education and planning for future employment
- Support for parenting and childcare responsibilities
- Access to health and mental health services
- Involvement of partners and family members

All these programs can improve school continuation and/or employment, improve parenting skills and knowledge, and positively impact infant and child development. Some of the programs indicate effectiveness in reducing subsequent pregnancy rates or at least increasing time between pregnancies. It can be argued that subsequent pregnancy prevention should be the secondary of these programs, while the primary outcomes should focus on improved maternal and child health and alleviating socioeconomic disadvantage for teen mothers and their children. However, these would seem to go hand in hand.

All of this compiled information and ongoing research can provide important insight for Buenos Aires. There is information available on adolescent pregnancy in Latin America, but less empirical research on the effectiveness of particular programs, and even less on programs specific to subsequent adolescent pregnancies. Certainly, the overall context varies between the western
world and Latin America, in addition to particulars specific to Argentina and the city of Buenos Aires. Nonetheless, these examples provide insight that could help focus limited resources on effective programs; namely, what are aspects of successful programs that the health sector and policymakers should consider, and the importance of tailoring programs specific to each situation and adolescent population group.
IX. Recommendations for the City of Buenos Aires

Given the existing research on effective programs and health sector responses to subsequent adolescent pregnancy, what might be best suited for Capital Federal? The program evaluations and methodologies examined in the previous chapter hold important lessons for general insight in working with adolescents, both young mothers and their partners. However, the overall context surrounding adolescents in the city of Buenos Aires will also bring its own unique and important implications. As such, in order to further evaluate this question, it is necessary to contextualize potential policy recommendations within first a ‘developing’ context, and more specifically then to a Latin America context. Taking this information along with the information specific to Argentina could then provide insight as to which programs, policies, and approaches might be best suited for the city of Buenos Aires.

In terms of evaluating the development context, one can first examine what studies and information on ASRH in the developing world are currently available. Subsequently, one can assess western studies, taking lessons learned and placing them in a development context. The same can then be done for Latin America specifically. Keeping these contexts in mind, one can ascertain potential policy recommendations surrounding subsequent adolescent pregnancy for the city of Buenos Aires.

Development Context

Working within a development context brings certain implications in terms of resources, as well as a wide spectrum of political contexts from a policy perspective. However, few studies have looked at these contextual factors exclusively in detail. The WHO publication from Blum cited earlier states that

“very few studies explore the contextual factors associated with ASRH – whether it is government policy, the economic climate, family functioning, school climate and
relationships, peer or community; rather most research focuses on adolescent knowledge, attitudes, and beliefs with little attention as to how these are derived.\textsuperscript{123}

In short, there is a need to “more clearly [define] the contextual factors that influence behavior.\textsuperscript{124}

Nonetheless, while there is surely a limited number of robust studies and evaluations of interventions in developing countries that meet strong inclusion criteria, current evidence and anecdotes can still help illustrate issues and factors specific to developing contexts. Below are some areas of insight within different areas relevant to adolescent health issues in developing countries.

**Existing Research: Access to Services, Risk and Protective Factors, and Effective Interventions**

Resources and access to services is an essential and basic starting point for adolescent health services. For example, many adolescents in developing countries have an unmet need for contraception, contributing to poor reproductive health outcomes.

Overall though, “few rigorous studies have been conducted” in low and middle-income countries (LMICs) that measure contraceptive behaviors, and few interventions reach vulnerable groups of adolescents such as the young and out of school populations. Despite the lack of extensive research or strong evidence base, there are some common elements of programs that measured an impact on contraceptive behavior. For example, these normally “[combine] numerous program approaches and [address] both user and service provision issues.”\textsuperscript{125} Some element specific program characteristics include adolescent-friendly services, fostering connectedness between a close adult and adolescent(s), community engagement, educational interventions, multimedia, and peer education. Filling in gaps in the evidence base will allow for stronger conclusions and programmatic recommendations.

\textsuperscript{123}Blum, 3
\textsuperscript{124}Blum, 8
\textsuperscript{125}Gottschalk, Lindsey B. and Nuriye Ortayli. “Interventions to improve adolescents’ contraceptive behaviors in low-and middle-income countries: a review of the evidence base,” 2014. Page 1
In terms of risk and protective factors, Blum’s publication researches those affecting adolescent reproductive health in developing countries. However, the publication concluded that while existing research established what were important factors in industrialized countries, “current research in developing countries is too scanty to say.” From the limited studies included in Blum’s study, the following factors were established as risk or protective factors in developing countries relevant to adolescent pregnancy:

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<tr>
<th>Reference Codes</th>
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<tr>
<td>R</td>
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<td>P</td>
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### Table 2: Factors Related to Pregnancy Occurrence

<table>
<thead>
<tr>
<th>Individual-level Factors</th>
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<tbody>
<tr>
<td>Employed (2/2)</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Higher education level (2/2)</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>Knowledge about contraception (2/3)</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>Low future aspiration (2/2)</td>
<td>R</td>
<td></td>
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<tr>
<th>Peer-level Factors</th>
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<tbody>
<tr>
<td>Has a pregnant friend (2/2)</td>
<td>R</td>
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<tr>
<th>Family-level Factors</th>
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<tbody>
<tr>
<td>Lives with both parents - females (4/4)</td>
<td>P</td>
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</table>

### Table 6: Factors Related to Early Childbearing

<table>
<thead>
<tr>
<th>Individual-level Factors</th>
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</thead>
<tbody>
<tr>
<td>Older age (2/3)</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Early onset of puberty (2/2)</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Older age at first marriage (2/2)</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Higher education level* (2/4)</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>Cigarette smoking (2/3)</td>
<td>R</td>
<td></td>
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<tr>
<td>Alcohol use (2/3)</td>
<td>R</td>
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<table>
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<tr>
<th>Family-level Factors</th>
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<tr>
<td>Lives with both parents (2/2)</td>
<td>P</td>
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*As education level increase, the risk of early childbearing decline.

While there are limited studies that could be included in Blum’s evaluation, there is still important insight from the information available.

For example, according to Blum’s research higher educational level/school enrollment is a protective factor for pregnancy and early childbearing. Increasingly, evidence shows that the most effective interventions “enhance protective factors of young people” instead of solely attempting to reduce risk.

Understanding this link, policymakers in developing countries could then make

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126 Blum, 3
127 Blum, 1
more explicit efforts to link education and health, and look to increase educational enrollment while linking schools with local health services and public health programming. Programs focused on school enrollment, retention, and performance should “be given high priority and evaluated for improving ASRH outcomes.” These and other non-individual risk and protective factors (including family, peers, and school) are areas where governments and policy makers could have a positive influence.

Finally, another WHO review assessed the effectiveness of adolescent reproductive health interventions in developing countries. The review assessed interventions that fell into the following settings or types: school-based programs, mass media programs, community-based programs (youth development, peer educators and educational programs), workplace programs, and health facility based-programs (youth-friendly services and youth center). The publication concluded that though each study reviewed varied in set-up and methods of evaluation, most seemed to have a positive effect on adolescents’ attitudes and knowledge. However, the effect on behavior was less consistent. Once again, the authors concluded that there remained a need for further rigorous assessment of ASRH interventions.

Western Studies and Development Applications

Having reviewed some existing research on ASRH and interventions in the developing world, what then in terms of research, specific programmatic responses, and policy recommendations from western interventions could be applied to a developing context? Blum’s research on risk and protective factors, although citing the scarcity of data specific to the developing world, does show several correlations with research on predictors and motivators from western industrialized countries. Nonetheless, different studies showed the same components to be more or less statistically significant, depending on their specific population group. It would be interesting to use

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128 Blum, 7
western studies as a reference, but further explore the relevance of these factors in the developing world through additional interventions and research.

In terms of programmatic implications and overlaps, these too will vary. Some western-based studies located in certain contexts with specific population groups might have especially relevant insight, such as those interventions which were based in urban contexts and worked with minority adolescents, or those from lower socioeconomic contexts.

Programmatic responses would need to be adapted and understand the development context in several important ways. Most youth receive some education, particularly with the importance of schooling in the Millennium Development Goals. However, solely-school based interventions have had mixed results, and perhaps more importantly, these interventions miss adolescents who are not in school. At the same time, providing comprehensive sexual and reproductive health education has been impeded in many countries due to ideologically driven restrictions (such as opposition from conservative religious traditions). Furthermore, community-based programs have often had to focus solely on HIV prevention instead of comprehensive SRH due to funding restrictions (particularly in Sub-Saharan Africa, given the AIDS epidemic).  

**Conclusion**

The above publications present summary reviews of current interventions, providing summary documents of existing interventions that meet certain inclusion criteria, and giving some general insight into effective development specific interventions. These publications however, also cite the need for further research and the lack of interventions that can provide thorough insight and transferable recommendations. Additionally, Blum cites a lack of studies that specifically assess the influence of an adolescent’s external context and background. Thus, there is a lack of research both on ASRH interventions within the development context, and on the effects of the development context itself on ASRH.

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130 Hindin, Michelle and Adesegun O. Fatusi. “Adolescent Sexual and Reproductive Health in Developing Countries: An Overview of Trends and Interventions,” 2009.
To clarify the second point, extensive literature exists on the state of ASRH, with facts, figures and statistics on different countries and regions. However, the scarcity according to Blum is in the lack of analysis surrounding this; what factors (such as socioeconomic context, institutions, or social norms) within a certain context impact ASRH, and how.

This of course leaves ample room for future scientific research. Some factors to study might include the political situation and policy limitations, infrastructure, levels of institutional development, and the influence of civil society groups, to name a few. It is true however, that broadly categorizing and researching the ‘developing world’ would give equally broad (and therefore only moderately relevant) insight. Specifics would of course vary for each region and even country. In this case then, more specific recommendations and insight could be gathered from both placing western recommendations within the Latin American context (bringing out and applying factors specific to this region to western experiences), and in particular learning from existing successful interventions in Latin America where possible.

**Latin American Context**

The region of Latin America and the Caribbean has its own regional specifics in terms of socio-cultural, economic, and infrastructure and institutional development. Policy and program efforts should take the following various aspects of the situational context into account, and adapt accordingly.

As mentioned above, access to services is the basic starting point for ASRH. In Latin America, most youth “face significant obstacles to sexual and reproductive health services.” Research has identified the major barriers, which include characteristics of the facilities, design of services, how providers treat youth, and legal barriers. Delving further into this, facilities might not be accessible to young people, either because they are seeking care outside of their neighborhoods in order to avoid family or acquaintances, or because they lack privacy and are not spaces devoted specifically to youth. To illustrate this, another interesting insight (though only gathered from pilot

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131 Moya, Cecilia. “Improving Youth’s Access to Contraception in Latin America,” 2001
studies and formative research) suggests that many adolescents in Central America prefer to get their contraceptives from pharmacies. This could indicate a need to apply adolescent-friendly service friendly principles to this region and others with similar preferences.\textsuperscript{132}

In terms of program design, youth might be deterred by high cost, crowded waiting rooms, lack of walk-in clinics, and inadequate supplies of contraceptive methods. This is if they are even aware of both the importance of accessing these services, and where to do so. Provider's attitudes interestingly is considered “the most important barrier to care,” when they “fail to take seriously youth’s need for services” and may try to dissuade young people from having sexual relations. In the end, a hostile attitude “may result in young people’s giving up—not on having sexual intercourse—but on using contraception."\textsuperscript{133} Finally, laws and policies can also prohibit or limit confidential services for youth.

Gottschalk’s aforementioned literature review of studies designed to improve adolescents’ contraceptive behaviors included only four studies from the LAC region that fit the inclusion criteria, of which only two demonstrated positive effects on contraceptive behaviors. This ‘suggests’ that different approaches are worth exploring in the region,\textsuperscript{134} and further research is pending to determine the most effective ways to improve adolescent contraceptive behavior.

Premarital sex remains taboo in many areas of the world, including Latin America where there are strong conservative and conservative social elements. As such, one particularly critical element of future programmatic and policy efforts in Latin America is the ‘buy-in’ from the rest of the community. This should start at home with parents and family members (given the great importance family life and connections has in Latin America), and then extend into the rest of the community. Mobilizing community leaders, particularly religious figures, would be critical to success. Undoubtedly, strong opposition from the Catholic Church and other conservative elements would present a barrier. However, perhaps bringing together education, health, religious

\textsuperscript{132} Gottschalk, 221
\textsuperscript{133} Moya, 2
\textsuperscript{134} Gottschalk, 213
and other community elements on a local level could find common group and mutually desired outcomes. Informing and educating these sectors would be critical; there remains a persistent belief that sexual education will encourage promiscuity (and thus premarital sex), and demonstrating that this is incorrect would allow policymakers and the health sector to make greater and more effective efforts to achieve gains in ASRH.

To help achieve this, groups such as Advocates for Youth both provide specific tools and resources, as well as listing national and regional organizations that promote programs to improve ASRH. “Advocacy kits” providing tools and information for those wanting to advocate for adolescent sexual and reproductive health focus on certain critical areas. These include education and media campaigns, the role of coalition building in community education, and involving religious communities in advocacy campaigns. These tools are especially important in regions such as Latin America. Guides such as this one discuss the importance of organizing at the local level to affect policy changes, and detail how to go about conducting a needs assessment, coordinating public awareness campaigns, evaluating a coalition’s effectiveness, and responding to opposition and critics.

Although important in any ASRH program, greater involvement of male partners would also make significant impact in Latin America. With ‘machismo’ alive and well and patriarchy present to varying degrees depending on specific contexts, sexually active men and adolescent males need to be targeted and included in ASRH programming to understand the importance and relevance of issues, and the role they can and should play. Research shows that while over 50% of sexually active men from LAC are protected from unplanned pregnancy, most of this protection depends on methods that women use (female sterilization and modern reversible contraceptive). At last intercourse, 39-68% of men aged 15-25 and 65-85% of men aged 25-54 did not use a condom at last intercourse. Finally, between 15-39% of men 25-54 want no more children or to delay their

137 Stillman, Amy “Machismo persists in Latin America despite rise of female presidents,” 2014
next child, but are not protected by contraceptive use (their own or their partners).\textsuperscript{138} Greater efforts should be made to “meet men’s needs for medical and counseling services relevant for their sexual and reproductive health,”\textsuperscript{139} and provide relevant information to engage them in this wider conversation and have them play a leading role in improved overall ASRH.

Regarding sex education, many countries in Latin America have laws stating that this must be made available in schools (in Argentina since 2011). However, given that these are implemented haphazardly (if at all), another area of work could focus on stronger implementation and follow-up on already existing legislation. In Cuba, where sex education is complemented by extracurricular activities and family education, there have been significant decreases in school dropout due to pregnancy and marriage. Similarly, one public official in Brazil cites the “major impact” that national curriculum standards have had on the prevention of HIV/AIDS and teen pregnancy, and that “there has been a significant increase in the interval between first and second pregnancies.”\textsuperscript{140}

Indeed, another study based in northeast Brazil points to evidence that “the promotion of education may be the most effective means of encouraging delayed childbearing among adolescents.”\textsuperscript{141}

These success stories in the region show the potential and continued work needed in other Latin American countries, including Argentina.

In terms of economics and purchasing power, Latin America is considered middle-income, but with a large percentage of the population living in poverty. Given the limited resources despite recent and ongoing regional economic growth, “pro-poor” policies must ensure that they are reaching their targeted populations, and consider the long and short-term outcomes before implementation. Peru’s experience with family planning policies in the early 2000’s provides a perfect example. Given the limited resources of developing countries, “providing universal coverage[ of contraception] through the public sector, although conceptualized as a strategy to

\textsuperscript{138} Alan Guttmacher Institute, “Sex, Marriage and Fathering: A Profile of Latin American and Caribbean Men,” 1.

\textsuperscript{139} Alan Guttmacher Institute, “In Their Own Right: Addressing the Sexual and Reproductive Health needs of Men Worldwide,” 3.

\textsuperscript{140} Cevallos, 2006

reach the poor, often ends up serving a considerable proportion of people who can afford to pay for care and restricts access among those people who can least afford it.\textsuperscript{142} This is exactly what occurred in Peru, in combination with other resource pressures and restructuring of the health sector. In response, the Peruvian government is now trying to increase modern contraceptive use and access to accurate information among the poor through conditional cash transfers and social insurance programs. Peru’s experience provides an important lesson for the region to monitor and evaluate policy implementation and be willing to make adjustments as needed to achieve the desired outcome.

Finally, Latin American collaboration with other regions in the form of south-to-south collaboration is another potential area for further work. Sharing experiences between developing countries (between individuals, NGOs, governments, and their agencies) can allow organizations in developing countries to “improve programs, pool scarce resources, and advance mutually beneficial goals.” These gains could be achieved with little reliance on developed countries, and the solutions and strategies developed may be more easily adapted between developing countries (as compared to programs from developed countries) in terms of social, cultural, and economic conditions. In particular with ASRH, south-to-south collaboration can “facilitate the sharing of evaluated, culturally appropriate, highly effective strategies and programs.”\textsuperscript{143}

**Conclusion**

In terms of applying western studies to the Latin American context, these could have relevant lessons for others in Latin America. Examples could include any studies or programs which mobilized local community leaders or religious groups (particularly any which previously directly clashed with public health efforts), or studies based in health centers trying to promote adolescent access to youth-friendly services.


\textsuperscript{143} West, Sydney “South-to-South Collaboration to Improve Programs for Youth,” 2005
In conclusion however, there is much to the regional context found in Latin America and the Caribbean, and understanding these will lead to more effective programming and interventions. As with any region, ensuring access to adequate services is the essential first step, and Latin America has its share of barriers to ensuring this in the first instance. In addition to this, the Latin American context includes strong influence of conservative religious sectors which can keep certain topics taboo and create barriers to essential and effective programming. A ‘machismo’ culture, inadequately implemented sex education laws, and a middle-income economic status with a high percentage of the population still living in poverty also all add to the regional context. This illustrates and emphasizes the need for a strong understanding of the region, and tailored approaches mobilizing multiple sectors of the population.

**Effective Interventions**

Having established aspects of working with ASRH in developing contexts, and further regional particulars of Latin America, what methodologies or broader lessons learned would bring all these experiences together? Research and WHO publications have brought together global lessons learned that would have important implications for the city of Buenos Aires. The following discusses approaches that are important for ASRH interventions in any context, but particularly in the developing world.

**Integrated Approaches**

Increasingly, both research and program experiences show that it “neither feasible nor productive” to focus on an isolated behavior without addressing broader ASRH concerns. Research is increasingly citing “the failure of narrow problem-specific education programs.”

Various case studies in the developing world instead show approaches that present integrated efforts to prevent HIV, other STIs, and pregnancy among teens in developing countries. Indeed,

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144 Blum, I  
in order to effectively address subsequent pregnancy, general adolescent sexual and reproductive health (ASRH) needs must be met. Focusing on developing and improving these integrated approaches will ultimately best address the complex sexual and reproductive health needs of today’s youth, and provide comprehensive long-term solutions. This requires both supply and demand side actions, from a broad spread of actors and sectors.

Considering a potential barrier and area for further research, it can be difficult to disentangle the influences of interventions with multi-component approaches. Furthermore, studies often do not look at the long-term impact of interventions, or at the sustainability of changes. However, critically reviewing these various interventions and evidence of their effectiveness still provides important insight for health care workers, policy makers, and their future programs.

**Generating Demand: Adolescents and their Communities**

As aforementioned, there is a need for both supply-side and demand-side interventions. Of course, improving supply side interventions such as the friendliness of adolescent services and reducing barriers to access are a critical first step. In order to go beyond this and generate demand however, adolescents need to be informed about the availability of services through a variety of channels, which includes schools, media, parents, and youth groups. Furthermore, information should not be limited to information on the when and where (information about the availability of services), but also the why. Adolescents need to understand why they should use them and be able to have any questions answered and anxieties resolved.

In addition to generating demand from adolescents themselves, more demand-side activities need to create a more supportive environment for adolescents seeking care and uptake of services. Families and communities can obviously play a central role in an adolescent’s health and

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146 Tombros, Allison, “Integrating Efforts to Prevent HIV, Other STIs, and Pregnancy among Teens in Developing Countries,” 2005.
development. Despite recognition of this, efforts to foster this participation in adolescent programs have been weak, and even when implemented have little or no links with health services.¹⁴⁷

Given the sensitivity of sexual and reproductive health issues in many communities, it is not enough to only equip adolescents with knowledge and information. Gate-keepers such as parents, religious leaders, and other community leaders must also informed and involved in increasing the use of services by young people. Community acceptance and a supportive social environment result in higher uptake and utilization of services, indicating a need for broader social mobilization and community education interventions. These demand-side interventions would seemingly be particularly important in the Latin American cultural context, given the importance of family life and familial connections, and the strong influence of conservative religious elements.

Despite widespread recognition of the importance of community support, it remains “one of the weakest elements in adolescent health programming,”¹⁴⁸ with little or no link to health services even when it included. Unfortunately, “the evidence base in...demand and community support for adolescent sexual and reproductive health services in relatively underdeveloped.”¹⁴⁹

Finally, evidence shows that it is not enough to provide youth-friendly services, but instead to link these with their wider development needs. As such, “it seems a comprehensive approach is most promising.”¹⁵⁰ Young people need relevant information, but also life skills and access to care when they need it. The specific best method will vary by gender, social setting, and developmental stage.¹⁵¹

One recent publication from the WHO reviews the available literature and interventions focused on generating demand and community support for sexual and reproductive health services for adolescents.

¹⁴⁷ WHO, “Generating demand and community support for sexual and reproductive health services for young people: a review of the literature.” 2009. Page 4
¹⁴⁹ WHO, “Generating demand and community support for sexual and reproductive health services for young people: a review of the literature.” 2009. Page 8
¹⁵¹ Spiezer, IS, RJ Magnani, CE Colvin, “The effectiveness of adolescent reproductive health interventions in developing countries: a review of the evidence.”
young people. This brings together findings from a variety of interventions (both in the developed and developing world) aimed at generating demand and their outcomes. The interventions fall into a variety of categories, and include in-school education, community based-facilitated education sessions, youth centers, IEC (information, education and communication) outreach from health facilities, peer education and counseling, life skills education or broader youth development approaches, the use of media, finance interventions, and community participation (including community education sessions or community wide IEC activities through festivals, celebrations, etc. and media use).

As concluded in recommendations from the WHO, “more large-scale, innovative, integrated, multifaceted research interventions in adolescent sexual and reproductive health are needed.” These should furthermore incorporate a focus on generating community support and increasing adolescent demand for services into the various components of interventions. A stronger evidence base would then lead to better recommendations and insight.

**Recommendations for Buenos Aires**

Evidently, numerous factors all intersect and influence efforts in ASRH and subsequent pregnancy reduction in the city of Buenos Aires. Having studied the Argentine context; evaluated existing ASRH efforts in the developed world, the developing world, and Latin America; and established elements that would be critical for successful interventions, one can begin to ascertain factors and components that could lead to effective programming, improved ASRH outcomes, and hopefully improvements in rapid repeat adolescent pregnancy in the city of Buenos Aires.

Additionally, drawing on existing research and the interviews with medical professionals in the city of Buenos Aires, two areas in particular stand out. One, the importance and influence of a “life plan” is both mentioned in relevant literature and was repeated throughout the interviews.

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152 WHO, “Generating demand and community support for sexual and reproductive health services for young people: a review of the literature.” 2009. Page 11
Secondly, subsequent pregnancy efforts should be better integrated and driven forward with overarching public health improvements and progress in ASRH.

**The City of Buenos Aires**

Revisiting some of the nuances of the Latin American context and assessing their application to Argentina and Buenos Aires specifically leads to interesting needs for future tailored approaches.

For example, a fair generalization of the Latin American context includes mentioning the influence of conservative religious sectors, often producing real and significant barriers to efforts in ASRG (indeed, SRH in general). However, Argentina in many respects is quite progressive, particularly in comparison to other countries in the region. Argentina has led the way in other social issues such as gay marriage (legal since 2010), and many Argentines identify as Catholic but are non-practicing. This would likely be especially true for larger cities, especially large and cosmopolitan Buenos Aires. Nonetheless, the influence of the Catholic Church and other religious groups or conservative sectors is still significant. Abortion is still illegal, and adolescents still face cultural barriers and community resistance to appropriate and friendly ASRH services. As such, interventions focused on mobilizing and educating families and the wider community are of particular relevance in the Buenos Aires context.

Another particularity for the context of Buenos Aires is the large (and growing) number of immigrant workers. Many immigrants move to Buenos Aires from neighboring countries in the region, primarily from Paraguay, Bolivia, and Peru. In terms of resources and planning, the immigrant population is likely to increase over the years, contributing to the expected population growth in Greater Buenos Aires to 13.6 million by 2025\textsuperscript{153}. Better understanding the cultural background of these populations, and their belief systems as they relate to ASRH, would allow for more effective interventions. Given the variety of attitudes, beliefs, and communication patterns about health, sexuality, contraception and childbearing across cultural and ethnic groups, "tailoring

\textsuperscript{153} World Population Review, 2014
programs to the cultural background(s) of participating youth can increase [a] program’s effectiveness,” particularly when working with immigrant youth.

The CESAC Network and Home-visiting

In terms of specific program recommendations, these will depend on the specific context and population group of each hospital. Broadly speaking however, home-visiting programs could especially hold great potential for the city of Buenos Aires. Specifically, these could be built into and formalized through the CESAC network that already exists. CeSACs (Centros de Salud y Accion Communitaria) provide primary health care and help fill a public health need in densely populated areas of the city. Generally, these health centers already general have a greater connection with the patient populations they work with. As explained by one doctor (obstetrician/gynecologist) working at a CeSAC, the patient receives more personalized care at the CeSAC, “there is greater concern, we are more engaged.”

Currently, hospitals will often refer adolescents to CeSACs for follow up care. These can generally be easier to access and often more readily provide a contraceptive (due to opening hours and wait times). While there is not currently a formal program for home visiting, this doctor explained that even currently, if there is a patient with a complex case who suddenly stops attending their appointments, they will follow up with a phone call and even go visit her home. The doctor explained they were “on top of the situation” but would be unable to have such a program due to lack of human resources.

It seems in terms of general relationship building and accessibility for adolescents, CeSACs have a distinct advantage. In order to address subsequent pregnancy prevention, a home-visiting program could be formalized using this existing health center network. This would involve communication and referrals from the hospital where the adolescent first gave birth to the local

155 Interviews,
CeSAC, and a more formalized home-visiting program for high-risk adolescents through the first six months (if not a year) of motherhood.

‘Adolescentes en Buenos Aires’: “Life Plans” and Integrated Approaches

Specific recommendations of course vary depending on the context. Adolescents have a variety of external influences, including their families, school, other individuals, their community, and other societal factors. As such, multi-component strategies which tackle some of these areas would be necessary to generate and (most importantly) sustain changes in behavior.

As previously identified, two areas of particular importance and relevance for Buenos Aires are an adolescents “life plan” and greater advances in integrated health system approaches to adolescent health.

Un “Proyecto de Vida”

Throughout the interviews held with medical professionals working in adolescent health across the city of Buenos Aires, the lack of a “proyecto de vida” (life plan, life program) was an oft repeated concern about their adolescent patients, particularly females. Recommendations and future programming should delve further into this, establishing the causes and proposing ways to address this.

Interestingly, this same concern is found even in western publications. Ethnographic studies in the United States attempting to determine the cause of persistently high teen pregnancy rates show…

“…a real sense of desperation and hopelessness, where it seems like there’s a large component of population that just think it doesn’t really matter whether they get pregnant or not. They’re not looking forward to great outcomes anyways….If women are in a situation that they’re going to do what they’re going to do because their aspirations have been sufficiently
diminished, it’s going to be really hard to move them off of that by providing different forms of sex education, better access to contraceptive, or things like that.\textsuperscript{156}

Remarkably, this U.S. economist considers high-school drop-out as part of the trajectory they were on anyways, and not caused directly by teen childbearing. Instead of focusing on the decisions that lead to birth at a young age or having sex without protection, he encourages a focus on a more holistic approach viewing teen pregnancy as “part of a bigger issue of poverty and, maybe, disaffection.” For him, if a teen is going down a life path with high expectations and aspirations, they will make those decisions (to use contraception or not engage in sexual activity) anyways. As such, public policy should find “ways to put people on better life paths so...they make better decisions on their own.”\textsuperscript{157} Indeed, this was the main take away from extensive interviews in Buenos Aires, and it is interesting to note similar conversations outside of Latin America.

Educational attainment then could subsequently seem like the appropriate aim of future programming. One could reason that if students are better educated and complete secondary school, they can then go on to university (with free university options in Argentina), graduate with a degree, and pursue better jobs and career aspirations. And indeed, education certainly plays a critical role in helping children and adolescents reach their potential. For girls, early schooling and education has “long lasting-implications for women’s lives because education serves as a source of knowledge and cognitive skills; as a resource that enhances economic opportunities and social mobility; and as a socialization process that shapes attitudes, values and aspirations.”

In terms of Buenos Aires, certainly continued and increased emphasis on educational attainment for girls can lead to positive outcomes in multiple areas. However, lack of access to education does not seem to be the leading issue in this urban context. Instead, one could argue that the perceived lack of social mobility and the perceived ‘futility’ of education to significantly change one’s life path is a (perhaps subconscious) driving factor for some “ni-ni” in Buenos Aires.

\textsuperscript{156} Levine, Phillip and Melissa Kearney, “Q&A: Putting Teens on Better Life Paths May Keep Them From Having Children Too Soon.” 2014
\textsuperscript{157} Levine, Phillip and Melissa Kearney, “Q&A: Putting Teens on Better Life Paths May Keep Them From Having Children Too Soon.” 2014
If this is the case, programming should focus less on education and increased enrollment as an end in itself, and instead provide broader life skills, technical training options, and mentorship opportunities through youth development programs.

Indeed, programming and training of individual adolescents cannot account for slumps in the national economy, high inflation and unemployment, and other national or regional economic factors. National economic hardship will have corresponding effects on the population, and adolescents or young adults with minimal schooling and training can be especially adversely affected. Nonetheless, these are challenges faced by countries throughout the region and the developing world. Schools, health centers and communities need to determine how to best potentially engage their youth and provide them with the tools and aspirations to develop “life plans” outside of the “ni-ni” population and (for girls) early motherhood. The aforementioned CEPAL publication details how girls, lacking other opportunities and restricted by socio-cultural patterns, view motherhood as a way to overcome poverty. This only further highlights the intersectoral nature of the issue, and specifically “the need for education policy and insertion into the labor market to increase girls’ development options.” Examples of successful programs in developing countries often have life planning skills as “a cornerstone of the behavior change component... [with] demonstrated improvements in SRH knowledge, perceptions, attitudes and behaviors among students who received training in life planning skills.

Integrated Approaches to Adolescent Health

The second major repeated comment from the interviews was the need for overall greater emphasis and work on adolescent health. Directives, programs, and guides for health works on adolescent health issues are fairly new (both from the National and City Ministry of Health), and even these don’t seem to have the necessary impact to make them effective. Similar to the Ley 26.150 mandating sex education in Argentine schools, implementation is much at the discretion of

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158 CEPAL, “Casi 30 % de las jóvenes latinoamericanas ha sido madre adolescente,” 13 November 2014
159 WHO, “Generating demand and community support for sexual and reproductive health services for young people: a review of the literature.” 2009. Page 63
the institution (e.g. health center or school) in question. Hospitals with adolescent services that have been in existence for years continue to function as they did previously, and other hospitals have the official guides available but have not had specific training or established a feedback mechanism to ensure these are being implemented and followed.

In terms of recommendations in this area, greater prioritization of adolescent health, and ASRH in particular, should lead to greater integration of these into overall national and city health initiatives. Although many countries adopted the “Program of Action” drafted at the 1994 International Conferences on Population and Development (ICPD) in Cairo and initiated public policy reforms, implementing integrated reproductive health programs has been more of a challenge. Priority setting for integrated reproductive health interventions, increasing financing for services, and developing delivery strategies are all areas of ongoing work. Within all this, adolescents require distinct attention within SRH efforts.

Efforts in these areas should not work in isolation. For example, awareness and programming focused on subsequent adolescent pregnancy will not be as sustainable if they are not included within overall improvements in adolescent health. Improvements in adolescent health would include training doctors in establishing adolescent-friendly services (ideally creating specific physical spaces within the hospital for these services), running cross-departmental trainings such as those at the Argerich Hospital (and including feedback mechanisms to assess their impact and effectiveness), and working with education sectors and community organizations to develop both supply- and demand-side interventions to generate and increase demand for adolescent health (particularly contraceptive) services. Including adolescent services as part of a medical student’s residency rotation is a great first step in showing the importance of this age group and considering their health needs separate to pediatrics and adults.

Having observed some of the contextual specifics for Buenos Aires (within the wider country, region, and as compared to the other developing countries and western nations), these are some

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160 Hardee, Karen et al, “Reproductive Health Policies and Programs in Eight Countries: Progress since Cairo.” 1999
of the broad initial conclusions to begin the discussion over ongoing efforts in ASRH. Focusing on these wider systemic issues of youth development opportunities and better integrated efforts from the public health system seem to indicate areas for the greatest potential and sustainable livelihood improvements. With these, subsequent pregnancies (alongside overall adolescent pregnancy) will hopefully decline.
X. Conclusion

The research initially sought to examine the "missed opportunities" concept in the city of Buenos Aires, and determine potential gaps in health services working with adolescents. At first consideration, it would seem plausible that any number of complex factors contribute to an adolescent pregnancy. However, once the adolescent is interacting with the health sector for appointments during her pregnancy and throughout checkups for her infant, this would be the ideal time for the health sector to provide this adolescent mother with information and a contraceptive method. This research sought to provide insight into the persistently high rates of subsequent adolescent pregnancy, and where and how these ‘missed opportunities’ continued to reoccur. After researching the available literature, the factors behind subsequent adolescent pregnancy in Buenos Aires can be broadly categorized into two areas: institutional and socio-cultural.

Institutional

In terms of institutional factors, this applies both within hospitals, and across the wider city of Buenos Aires. For the city of Buenos Aires, and indeed in Argentina generally, adolescent health has only fairly recently been prioritized and considered separately, as a unique (and vulnerable) patient population with specific needs. Recent efforts are manifested through National Programs (such as the National Program for Comprehensive Adolescent Health) and the publication of guides to assist health care workers in working with this population. However, coordinating implementation, resourcing, and training are persistent issues. Much like the implementation of the law mandating sex education in schools, implementation is ad hoc and not enforced. Including adolescent services on medical students’ rotations is an important step to continue increasing training in and prioritization of this area of medicine and health policy.

Furthermore, there are institutional and organizational issues within hospitals as well. Having a separate adolescent service, ideally with its own physical space within a hospital, very much helps to serve these populations that often fall through the cracks. However, few hospitals in Buenos
Aires actually have these. The ones that do have been hard at work, some for decades, dedicated to these populations. However, the issue here often lies with coordination between these services and the rest of the hospital. Adolescent mothers attending appointments for their infant newborns are not given counseling and contraceptive advice for themselves, and adolescents attending obstetrics/gynecology are not necessarily subsequently referred to the adolescent service, or treated with adolescent-friendly services. The adolescent service of the Argerich Hospital took an important first step in holding a training workshop across hospital sectors on working with adolescents and encouraging pediatrics and obstetricians/gynecologists to refer adolescent patients to their adolescent service. Training of this nature should be repeated across Buenos Aires public hospitals, as it provides awareness and simple mechanisms for improving adolescent health. However, this training did not incorporate a feedback mechanism or way to officially gather evidence of effectiveness. Doctors at the Argerich felt that referrals from other hospital sectors had increased, but were unable to measure this, and certainly unable to measure reductions in subsequent adolescent pregnancy.

In response to institutional issues, there is a need for greater integration of comprehensive adolescent sexual and reproductive health to overall health services. Efforts to address adolescent pregnancy will be successful through improvements in overall comprehensive adolescent sexual and reproductive health. Health systems strengthening and capacity building could allow individual hospitals to lead on these issues, conducting trainings and increasing referrals between hospital services and CeSACs at the hospital level. The doctors interviewed repeatedly mentioned resourcing issues, and what would be possible and could be accomplished if there were time and resources to do so.

Socio-cultural

Secondly, there were repeated socio-cultural factors that both the literature and interviews indicated as barriers. For example, motivations and reasons behind adolescent pregnancy in Argentina shed some light on the socio-cultural framework for these adolescents. In Gogna’s
survey, the most frequently cited reason for not using a contraceptive method was “I did not expect to have sexual relations at that time” (36.6%). Analysis of this reason for not using a method divulges important cultural valuations of sexuality for men and women. Other LAC research shows a sexual culture establishing a strict gender division between male (active) and female (passive), and considering the ‘spontaneity’ of sex as a central value. As such, it is easy for girls to have an unprotected first sexual relation (whether it is through partner pressure or they consider it ‘what is meant to happen’). To do so otherwise would imply having planned ahead and taking an active approach, “which might imply they are ‘experienced’ and generate doubt as to their ‘morality.”

Certainly, unequal gender dynamics and even gender-based violence too often play a role in adolescent pregnancy. At the same time however, many doctors interviewed felt that a lack of motivation, social mobility, and a “life plan” also play a role in many adolescent pregnancies. This is feasible within the context of the increasing “ni-ni” population of Argentina, and is seen also in literature from developed countries. Adolescents might be indifferent towards motherhood and not actively preventing it, and once mothers they feel a benefit from the improved ‘status’ this can confer on them.

Tackling wider socio-cultural factors is of course complex and not easily addressed through programmatic efforts. Nonetheless however, as detailed previously, multi-component strategies are “necessary” to change behavior, and “more large-scale, innovative, integrated, multifaceted interventions in adolescent sexual and reproductive health are needed. Female empowerment and wider work in gender equity can teach and empower adolescent girls to take control of their own sexuality and reproductive health. Youth engagement and development work can focus on

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161 The next highest were “I thought I would not get pregnant” (17.7%), lack of knowledge about contraceptive methods (12%), not specific reason (10%), and the desire to have a child (9.5%). Though these are averages for Argentina and specifics vary by region (e.g. Catamarca with 27.3% citing lack of knowledge of a method, and 30.8% in Misiones stating the desire to have a child). Gogna, page 258
163 Gogna, Monica: “Embarazo y maternidad en la adolescencia: Estereotipos, edivencias y propuestas para politica poublicas,” page 258
broader youth engagement and helping them plan for the future, through education, training, and mentoring among others. As mentioned previously, many programs have experienced success in these areas, incorporating life planning skills with other activities such as drama, sports events, peer education, youth clubs, and parent-child communication sessions. Indeed, life skills and broader youth development approaches “[have grown] out of the failure of narrow problem-specific education programmes.” These approaches aim to address “wider determinants of behavior, placing ASRH behavior in the broader context of adolescents’ lives.

Finally, if socio-cultural frameworks present a barrier to ASRH services and contraception, generating demand for ASRH services and building sustainable results requires both supply and demand side interventions, with a particular focus on generating community support. Of course, improving supply side interventions such as the friendliness of adolescent services and reducing barriers to access are important; however, these must go hand-in-hand with broader community education and mobilization efforts. Broader community mobilization can gather increased support for ASRH programs, and help ease some of the barriers adolescents have in accessing services. Involving not only adolescents but the adults around them (teachers, parents, etc.) will ultimately lead to sustainable changes, as their involvement will ensure interventions meet the needs of the population as well as bring a sense of ownership to sustain these in the long run. In order to improve demand-side activities and create a more supportive environment for ASRH, governments, civil society, and community organizations need to all work in partnership to establish common goals and determine how to reach adolescents effectively.

Conclusion

Adolescent pregnancy, subsequent adolescent pregnancies, and their respective effects on adolescent and child development have been widely studied over the years. This research

165 WHO, “Generating demand and community support for sexual and reproductive health services for young people: a review of the literature.” 2009. Page 63
166 WHO, “Generating demand and community support for sexual and reproductive health services for young people: a review of the literature.” 2009. Page 9
provides an assessment of current adolescent health issues in Buenos Aires, focusing on subsequent pregnancies as a case study for overall issues and ongoing challenges within adolescent health in Buenos Aires. Many factors will parallel other urban Latin American contexts, hopefully providing relevant background and insight for the region.
# APPENDICES

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## Appendix 1 – Tables and Figures

### Table 1

**Live Births Registered According to the Mother’s Age, by Jurisdiction of Mother’s Residence**  
Republic of Argentina - 2013

<table>
<thead>
<tr>
<th>Jurisdiction of Mother’s Residence</th>
<th>Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;15</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Republica Argentina</td>
<td>754,603</td>
</tr>
<tr>
<td>Ciudad Autonómica de Buenos Aires</td>
<td>43,615</td>
</tr>
<tr>
<td>Buenos Aires</td>
<td>289,451</td>
</tr>
<tr>
<td>Partidos del Aglomer. GBA</td>
<td>205,610</td>
</tr>
<tr>
<td>Catamarca</td>
<td>6,570</td>
</tr>
<tr>
<td>Cordoba</td>
<td>55,965</td>
</tr>
<tr>
<td>Corrientes</td>
<td>19,899</td>
</tr>
<tr>
<td>Chaco</td>
<td>22,296</td>
</tr>
<tr>
<td>Chubut</td>
<td>10,076</td>
</tr>
<tr>
<td>Entre Rios</td>
<td>22,371</td>
</tr>
<tr>
<td>Formosa</td>
<td>11,957</td>
</tr>
<tr>
<td>Jujuy</td>
<td>13,165</td>
</tr>
<tr>
<td>La Pampa</td>
<td>5,590</td>
</tr>
<tr>
<td>La Rioja</td>
<td>6,257</td>
</tr>
<tr>
<td>Mendoza</td>
<td>34,525</td>
</tr>
<tr>
<td>Misiones</td>
<td>25,508</td>
</tr>
<tr>
<td>Neuquen</td>
<td>11,210</td>
</tr>
<tr>
<td>Rio Negro</td>
<td>12,144</td>
</tr>
<tr>
<td>Salta</td>
<td>27,313</td>
</tr>
<tr>
<td>San Juan</td>
<td>14,894</td>
</tr>
<tr>
<td>San Luis</td>
<td>17,717</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>5,969</td>
</tr>
<tr>
<td>Santa Fe</td>
<td>56,379</td>
</tr>
<tr>
<td>Santiago del Estero</td>
<td>17,092</td>
</tr>
<tr>
<td>Tucuman</td>
<td>29,399</td>
</tr>
<tr>
<td>Tierra del Fuego</td>
<td>2,849</td>
</tr>
<tr>
<td>Otros Paises</td>
<td>394</td>
</tr>
<tr>
<td>Lugar no especificido</td>
<td>1,938</td>
</tr>
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</table>

Source: Secretaria de Politicas, Regulacion e Institutos, “Estadisticas Vitales-Informacion Basica-Año 2013
Table 2  

<table>
<thead>
<tr>
<th>Province</th>
<th>Overall Fertility Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
</tr>
<tr>
<td>Country Total</td>
<td></td>
</tr>
<tr>
<td>Ciudad Autónoma de Buenos Aires (CABA)</td>
<td>1.84</td>
</tr>
<tr>
<td>Buenos Aires</td>
<td>2.31</td>
</tr>
<tr>
<td>Catamarca</td>
<td>3.18</td>
</tr>
<tr>
<td>Chaco</td>
<td>2.65</td>
</tr>
<tr>
<td>Chubut</td>
<td>2.53</td>
</tr>
<tr>
<td>Córdoba</td>
<td>2.12</td>
</tr>
<tr>
<td>Corrientes</td>
<td>2.91</td>
</tr>
<tr>
<td>Entre Ríos</td>
<td>2.70</td>
</tr>
<tr>
<td>Formosa</td>
<td>3.21</td>
</tr>
<tr>
<td>Jujuy</td>
<td>2.95</td>
</tr>
<tr>
<td>La Pampa</td>
<td>2.43</td>
</tr>
<tr>
<td>La Rioja</td>
<td>2.56</td>
</tr>
<tr>
<td>Mendoza</td>
<td>2.58</td>
</tr>
<tr>
<td>Misiones</td>
<td>3.42</td>
</tr>
<tr>
<td>Neuquén</td>
<td>2.48</td>
</tr>
<tr>
<td>Río Negro</td>
<td>2.57</td>
</tr>
<tr>
<td>Salta</td>
<td>3.21</td>
</tr>
<tr>
<td>San Juan</td>
<td>2.91</td>
</tr>
<tr>
<td>San Luis</td>
<td>2.98</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>2.76</td>
</tr>
<tr>
<td>Santa Fe</td>
<td>2.23</td>
</tr>
<tr>
<td>Santiago del Estero</td>
<td>2.62</td>
</tr>
<tr>
<td>Tierra del Fuego, Antártida e Islas del Atlántico Sur</td>
<td>2.75</td>
</tr>
<tr>
<td>Tucumán</td>
<td>2.64</td>
</tr>
</tbody>
</table>

Note: The overall fertility rate is the number of children that on average a woman would have from a hypothetical cohort of women during their reproductive life if they had children according to the fertility rates by age of the study period and that are not exposed to mortality risks from birth until the end of their fertile period.

Table 3
Cuadro P6-P. Autonomous City of Buenos Aires. Total population born abroad by place of birth, according to sex and age group. Year 2010

Population born abroad from America

<table>
<thead>
<tr>
<th>Place of Birth</th>
<th>Total Population Born Abroad</th>
<th>Sex and Age Group</th>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Sex and Age Group</td>
<td>Female</td>
<td></td>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total (all countries)</td>
<td>Male total</td>
<td>Female total</td>
<td>0 - 14</td>
<td>15 - 64</td>
<td>65 and over</td>
<td>0 - 14</td>
</tr>
<tr>
<td>Total (all countries)</td>
<td>381,778</td>
<td>168,914</td>
<td>13,218</td>
<td>131,004</td>
<td>24,692</td>
<td>212,864</td>
<td>13,482</td>
</tr>
<tr>
<td>AMERICA</td>
<td>297,325</td>
<td>131,203</td>
<td>11,888</td>
<td>112,492</td>
<td>6,823</td>
<td>166,122</td>
<td>12,159</td>
</tr>
<tr>
<td>Border Countries</td>
<td>207,889</td>
<td>91,108</td>
<td>8,289</td>
<td>77,179</td>
<td>5,640</td>
<td>116,781</td>
<td>8,468</td>
</tr>
<tr>
<td>Bolivia</td>
<td>76,609</td>
<td>36,818</td>
<td>4,128</td>
<td>31,600</td>
<td>1,090</td>
<td>39,791</td>
<td>4,137</td>
</tr>
<tr>
<td>Brasil</td>
<td>10,357</td>
<td>4,254</td>
<td>375</td>
<td>3,614</td>
<td>265</td>
<td>6,103</td>
<td>373</td>
</tr>
<tr>
<td>Chile</td>
<td>9,857</td>
<td>4,386</td>
<td>216</td>
<td>3,609</td>
<td>561</td>
<td>5,471</td>
<td>155</td>
</tr>
<tr>
<td>Paraguay</td>
<td>80,325</td>
<td>31,752</td>
<td>3,266</td>
<td>27,041</td>
<td>1,445</td>
<td>48,573</td>
<td>3,467</td>
</tr>
<tr>
<td>Uruguay</td>
<td>30,741</td>
<td>13,898</td>
<td>304</td>
<td>11,315</td>
<td>2,279</td>
<td>16,843</td>
<td>336</td>
</tr>
<tr>
<td>Non-border Countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(América)</td>
<td>89,436</td>
<td>40,095</td>
<td>3,599</td>
<td>35,313</td>
<td>1,183</td>
<td>49,341</td>
<td>3,691</td>
</tr>
<tr>
<td>Perú</td>
<td>60,478</td>
<td>26,360</td>
<td>2,267</td>
<td>23,444</td>
<td>649</td>
<td>34,118</td>
<td>2,341</td>
</tr>
<tr>
<td>Rest of América</td>
<td>28,958</td>
<td>13,735</td>
<td>1,332</td>
<td>11,869</td>
<td>534</td>
<td>15,223</td>
<td>1,350</td>
</tr>
</tbody>
</table>

Note: This includes the population living on the street

Source: INDEC. Censo Nacional de Población, Hogares y Viviendas 2010.
### Table 4

Cuadro P32-P. Autonomous City of Buenos Aires. Population in private homes born abroad by place of birth, according to year of arrival in Argentina, in percent. Year 2010

<p>| Place of Birth | Total | Year of arrival in Argentina |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Before 1991</th>
<th>Between 1991 and</th>
<th>Between 2002 and 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2001</td>
<td>2010</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>38.8</td>
<td>22.4</td>
<td>38.8</td>
</tr>
<tr>
<td>AMÉRICA</td>
<td>100.0</td>
<td>28.5</td>
<td>25.7</td>
<td>45.8</td>
</tr>
<tr>
<td>Países limítrofes</td>
<td>100.0</td>
<td>37.0</td>
<td>23.3</td>
<td>39.8</td>
</tr>
<tr>
<td>Bolivia</td>
<td>100.0</td>
<td>24.0</td>
<td>30.2</td>
<td>45.8</td>
</tr>
<tr>
<td>Brasil</td>
<td>100.0</td>
<td>28.0</td>
<td>17.0</td>
<td>55.1</td>
</tr>
<tr>
<td>Chile</td>
<td>100.0</td>
<td>68.0</td>
<td>8.9</td>
<td>23.2</td>
</tr>
<tr>
<td>Paraguay</td>
<td>100.0</td>
<td>30.2</td>
<td>24.1</td>
<td>45.7</td>
</tr>
<tr>
<td>Uruguay</td>
<td>100.0</td>
<td>79.8</td>
<td>9.6</td>
<td>10.6</td>
</tr>
<tr>
<td>Países no limítrofes (América)</td>
<td>100.0</td>
<td>9.1</td>
<td>31.3</td>
<td>59.6</td>
</tr>
<tr>
<td>Perú</td>
<td>100.0</td>
<td>6.4</td>
<td>40.3</td>
<td>53.3</td>
</tr>
<tr>
<td>Resto de América</td>
<td>100.0</td>
<td>15.6</td>
<td>9.5</td>
<td>74.9</td>
</tr>
</tbody>
</table>

**Note:** This includes the population living on the streets.

The data in this table comes from the expanded questionnaire. The results are presented in percentages and with grouping of the variable ‘place of birth’ differentiated by each jurisdiction, due to methodological considerations. For more details, consult the Methodological Annex.

**Source:** INDEC. Censo Nacional de Población, Hogares y Viviendas 2010.

### Source: INDEC, Censo 2010
### Table 5
Cuadro P32-P. Buenos Aires Province. Population in private homes born abroad by place of birth, according to year of arrival in Argentina, in percent. Year 2010

<table>
<thead>
<tr>
<th>Place of Birth</th>
<th>Total (all countries)</th>
<th>Before 1991</th>
<th>Between 1991 and 2001</th>
<th>Between 2002 and 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>51.9</td>
<td>18.8</td>
<td>29.3</td>
</tr>
<tr>
<td>AMÉRICA</td>
<td>100.0</td>
<td>42.8</td>
<td>22.2</td>
<td>35.0</td>
</tr>
<tr>
<td>Países limítrofes</td>
<td>100.0</td>
<td>46.0</td>
<td>20.6</td>
<td>33.4</td>
</tr>
<tr>
<td>Bolivia</td>
<td>100.0</td>
<td>34.1</td>
<td>28.0</td>
<td>37.9</td>
</tr>
<tr>
<td>Brasil</td>
<td>100.0</td>
<td>40.3</td>
<td>25.3</td>
<td>34.5</td>
</tr>
<tr>
<td>Chile</td>
<td>100.0</td>
<td>87.8</td>
<td>6.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Paraguay</td>
<td>100.0</td>
<td>39.4</td>
<td>21.4</td>
<td>39.3</td>
</tr>
<tr>
<td>Uruguay</td>
<td>100.0</td>
<td>80.9</td>
<td>9.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Países no limítrofes (América)</td>
<td>100.0</td>
<td>15.5</td>
<td>35.6</td>
<td>48.9</td>
</tr>
<tr>
<td>Perú</td>
<td>100.0</td>
<td>12.8</td>
<td>40.7</td>
<td>46.5</td>
</tr>
<tr>
<td>Resto de América</td>
<td>100.0</td>
<td>24.3</td>
<td>19.1</td>
<td>56.6</td>
</tr>
</tbody>
</table>

**Note:** This includes the population living on the streets.

The data in this table comes from the expanded questionnaire. The results are presented in percentages and with grouping of the variable ‘place of birth’ differentiated by each jurisdiction, due to methodological considerations. For more details, consult the Methodological Annex.

**Source:** INDEC. Censo Nacional de Población, Hogares y Viviendas 2010.

Source: INDEC, Censo 2010
### Table 6

<table>
<thead>
<tr>
<th>Place of Birth</th>
<th>Total Population Born Abroad</th>
<th>Sex and Age Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>0 - 14</td>
<td>15 - 64</td>
</tr>
<tr>
<td>Total (all countries)</td>
<td>941,941</td>
<td>431,495</td>
<td>38,662</td>
</tr>
<tr>
<td>AMÉRICA</td>
<td>756,560</td>
<td>350,097</td>
<td>36,244</td>
</tr>
<tr>
<td>Países limítrofes</td>
<td>667,663</td>
<td>309,684</td>
<td>30,623</td>
</tr>
<tr>
<td>Bolivia</td>
<td>147,781</td>
<td>74,274</td>
<td>8,446</td>
</tr>
<tr>
<td>Brasil</td>
<td>9,862</td>
<td>3,572</td>
<td>633</td>
</tr>
<tr>
<td>Chile</td>
<td>46,664</td>
<td>21,682</td>
<td>617</td>
</tr>
<tr>
<td>Paraguay</td>
<td>392,697</td>
<td>176,408</td>
<td>19,845</td>
</tr>
<tr>
<td>Uruguay</td>
<td>70,659</td>
<td>33,748</td>
<td>1,082</td>
</tr>
<tr>
<td>Países no limítrofes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(América)</td>
<td>88,897</td>
<td>40,413</td>
<td>5,621</td>
</tr>
<tr>
<td>Perú</td>
<td>69,395</td>
<td>31,333</td>
<td>3,315</td>
</tr>
<tr>
<td>Resto de América</td>
<td>19,502</td>
<td>9,080</td>
<td>2,306</td>
</tr>
</tbody>
</table>

**Note:** This includes the population living on the streets

**Fuente:** INDEC. Censo Nacional de Población, Hogares y Viviendas 2010.

Source: [INDEC, Censo 2010](#)
Table 7
City of Buenos Aires: Percentage of births by mother’s age

<table>
<thead>
<tr>
<th>Grupo de edad (años)</th>
<th>Años</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>100,0</td>
<td>100,0</td>
<td>100,0</td>
<td>100,0</td>
<td>100,0</td>
<td>100,0</td>
</tr>
<tr>
<td>15-19</td>
<td>5.5</td>
<td>7.0</td>
<td>7.1</td>
<td>8.3</td>
<td>8.9</td>
<td>8.1</td>
</tr>
<tr>
<td>20-24</td>
<td>19.8</td>
<td>18.9</td>
<td>17.5</td>
<td>17.1</td>
<td>18.8</td>
<td>17.3</td>
</tr>
<tr>
<td>25-29</td>
<td>31.9</td>
<td>28.8</td>
<td>28.2</td>
<td>23.4</td>
<td>21.1</td>
<td>19.9</td>
</tr>
<tr>
<td>30-34</td>
<td>27.1</td>
<td>27.7</td>
<td>28.0</td>
<td>28.8</td>
<td>26.6</td>
<td>27.4</td>
</tr>
<tr>
<td>35-39</td>
<td>12.6</td>
<td>13.9</td>
<td>15.3</td>
<td>17.6</td>
<td>18.9</td>
<td>20.7</td>
</tr>
<tr>
<td>40-44</td>
<td>2.9</td>
<td>3.4</td>
<td>3.7</td>
<td>4.6</td>
<td>5.2</td>
<td>6.0</td>
</tr>
<tr>
<td>45 y más</td>
<td>0.3</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td>0.4</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Source: La fecundidad en la Ciudad Autonoma de Buenos Aires: Situacion al año 2013

Graph from Table 7 Data
<table>
<thead>
<tr>
<th>Years</th>
<th>Under 15</th>
<th>15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45 and over</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>1.3</td>
<td>56.1</td>
<td>122.8</td>
<td>130.1</td>
<td>98.1</td>
<td>53.0</td>
<td>16.6</td>
<td>2.3</td>
<td>60.0</td>
</tr>
<tr>
<td>1997</td>
<td>1.4</td>
<td>56.9</td>
<td>119.3</td>
<td>126.5</td>
<td>95.4</td>
<td>51.7</td>
<td>15.7</td>
<td>2.1</td>
<td>58.6</td>
</tr>
<tr>
<td>1998</td>
<td>1.0</td>
<td>52.0</td>
<td>124.1</td>
<td>131.4</td>
<td>100.0</td>
<td>56.4</td>
<td>17.8</td>
<td>2.1</td>
<td>60.6</td>
</tr>
<tr>
<td>1999</td>
<td>1.1</td>
<td>49.7</td>
<td>122.1</td>
<td>126.0</td>
<td>96.9</td>
<td>54.6</td>
<td>17.3</td>
<td>2.0</td>
<td>58.7</td>
</tr>
<tr>
<td>2000</td>
<td>0.8</td>
<td>47.6</td>
<td>123.1</td>
<td>127.1</td>
<td>100.1</td>
<td>54.7</td>
<td>17.3</td>
<td>1.7</td>
<td>59.1</td>
</tr>
<tr>
<td>2001</td>
<td>0.7</td>
<td>45.8</td>
<td>119.2</td>
<td>121.0</td>
<td>98.9</td>
<td>53.1</td>
<td>17.1</td>
<td>1.6</td>
<td>57.2</td>
</tr>
<tr>
<td>2002</td>
<td>0.8</td>
<td>44.5</td>
<td>118.6</td>
<td>121.3</td>
<td>100.3</td>
<td>53.3</td>
<td>17.8</td>
<td>1.5</td>
<td>57.3</td>
</tr>
<tr>
<td>2003</td>
<td>0.8</td>
<td>47.3</td>
<td>105.3</td>
<td>109.5</td>
<td>103.0</td>
<td>60.7</td>
<td>19.7</td>
<td>1.6</td>
<td>56.0</td>
</tr>
<tr>
<td>2004</td>
<td>0.6</td>
<td>53.4</td>
<td>112.6</td>
<td>114.5</td>
<td>108.3</td>
<td>63.8</td>
<td>21.1</td>
<td>1.5</td>
<td>59.5</td>
</tr>
<tr>
<td>2005</td>
<td>0.7</td>
<td>53.6</td>
<td>108.9</td>
<td>109.8</td>
<td>102.8</td>
<td>62.3</td>
<td>20.0</td>
<td>1.6</td>
<td>57.5</td>
</tr>
<tr>
<td>2006</td>
<td>0.8</td>
<td>55.4</td>
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<td>106.8</td>
<td>97.8</td>
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<td>19.0</td>
<td>1.6</td>
<td>56.7</td>
</tr>
<tr>
<td>2007</td>
<td>0.7</td>
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<td>110.7</td>
<td>107.1</td>
<td>92.9</td>
<td>60.2</td>
<td>18.5</td>
<td>1.6</td>
<td>56.3</td>
</tr>
<tr>
<td>2008</td>
<td>1.0</td>
<td>60.7</td>
<td>117.0</td>
<td>113.1</td>
<td>98.0</td>
<td>63.7</td>
<td>19.0</td>
<td>1.8</td>
<td>59.3</td>
</tr>
<tr>
<td>2009</td>
<td>1.1</td>
<td>62.3</td>
<td>116.0</td>
<td>110.9</td>
<td>95.5</td>
<td>62.5</td>
<td>19.0</td>
<td>1.6</td>
<td>58.6</td>
</tr>
<tr>
<td>2010</td>
<td>1.0</td>
<td>58.1</td>
<td>112.7</td>
<td>109.6</td>
<td>101.7</td>
<td>63.3</td>
<td>19.4</td>
<td>1.7</td>
<td>58.4</td>
</tr>
</tbody>
</table>


Elaboración: Dirección Provincial de Estadística.
Graph from Table 8 Data
Appendix 2 – Adolescent Health Programs in Argentina

Below is an extended list and additional detail on the directorates, programs and plans that deal with adolescent health and adolescent pregnancy, at the national, municipal, and hospital level.

List 1 – National Entities and Programs

List of relevant National Directorates, Programs, and Plans

- Dirección Nacional de Maternidad e Infancia: Salud Integral de la Mujer, la Niñez, y la Adolescencia
- Plan Nacional de Salud Integral en la Adolescencia (1993)
- Plan para la Reducción de la Mortalidad Infantil, de la Mujer y Adolescentes (2009)
- Programa Nacional Sumar (2012)

Details of relevant National Directorates, Programs, and Plans

- Dirección Nacional de Maternidad e Infancia: Salud Integral de la Mujer, la Niñez, y la Adolescencia
  - National Directorate for Maternity and Infancy: Comprehensive health for Women, Children, and Adolescence
  - The Directorate sits within the National Ministry of Health, Secretariat for Health Promotion and Programs, Subsecretariat of Community Health. It formulates and implements the nation’s maternal and child policies.
  - In order to implement public policies that address maternal and infant health, this Directorate set three strategic priorities: perinatal health, comprehensive child health, and comprehensive adolescent health.
- Plan Nacional de Salud Integral en la Adolescencia (1993)
  - National Plan for Comprehensive Adolescent Health
  - “The National Program addresses health as a human and social right. It frames its actions within the International Convention on the Rights of the Child (1989) with Constitutional status, as well as Law 26.061 (2005) on Protection of the Rights of Children and Adolescents which guarantees the right to their comprehensive health (Art. 14), Law 25.673 on Sexual Health and Responsible Procreation, and Law 26.529 on Patient rights, medical history and informed consent. From this framework, it promotes and disseminates adolescents’ rights
to autonomously access the health system, without requiring adult accompaniment and respecting confidentiality.”¹

- Its purpose is “promote and protect comprehensive adolescent health by increasing coverage in quality and quantity of services”²

- It was driven from the PAHO resolutions (approved by the XXXVI Meeting of the PAHO Executive Committee in 1992) urging governments to develop or strengthen initiatives to promote comprehensive adolescent health.

- The Program’s website also stresses the important influence of the social determinants of comprehensive adolescent health, and considers health as a medical, social, and cultural construct. It holds that health sector efforts alone are not enough, and that comprehensive adolescent care instead requires intersectoral efforts from education, justice, social welfare, labor, environment, and all sectors of society.

- Initially, it was not considered “relevant” to develop a national reproductive health plan, as each province was meant to formulate its own program following the guidelines of the National Plan. However, the National Plan does have a section dedicated to reproductive health and reflects the need to promote responsible sexuality and procreation as well as information, as this is “an aspect that is particularly neglected in the care of adolescents.”³

- In 2012 the leadership had placed strong emphasis over the past 3-4 years on SRH; focusing on lowering adolescent pregnancy rates and increased contraceptive production.

- In terms of shortfalls, the Plan includes no mention of the need to encourage male responsibility in sexuality and contraception, or of adolescent girls' autonomy in reproductive decision-making. There is a lack of a ‘rights-based’ approach, and only vague references to gender equity.⁴

- **GUIAS**: The National Program has recently (2011) published **a series of guides** for health professionals working with adolescents.
  - Below is a list of all current publications:
    - Guía de Recomendaciones para la Atención integral de adolescentes en espacios de salud amigables y de calidad (2011)

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² Gogna, Monica, “Programas de Salud Reproductiva Para Adolescentes,” 29

³ Gogna, 32

⁴ Gogna., 33
• Recomendaciones para la Atencion Clinica para Adolescentes (2011)
• Evaluacion de Calidad
• Herramientas para el Monitoreo de Programas de Salud para Adolescentes
• Lineamientos para la atencion del Consumo episodico excesivo de alcohol en adolescentes (2011)
• Lineamientos para la atencion del Intento de suicidio en adolescentes (2011)
• Guia de Trabajo sobre Estrategias de Prevencion y Promocion de la Salud destinada a Equipos de salud que trabajan con adolescentes (2011)
• Guia para el uso de Metodos Anticonceptivos (2002)

o Of the above publications, the following are most relevant to subsequent adolescent pregnancy:
  • Guia de Recomendaciones para la Atencion integral de adolescentes en espacios de salud amigables y de calidad (2011)
    • “This guide was developed through a collaboration between the Ministry of Health, UNICEF and the Argentine Society for Pediatrics. Its objective is to contribute to improved adolescent access to quality health services. It provides tools to install new spaces for care as well as the adjustment of contact points that already exist in the health system.”
    • General recommendations on adolescent-friendly spaces, resources, and the consultation process
      o Includes contraceptive recommendations
  • Recomendaciones para la Atencion Clinica para Adolescentes (2011)
    • “This guide looks to contribute to improving adolescent access to quality health care services. It provides tools for comprehensive medical attention to pathologies and/or common situations in adolescence"
• The guide gives procedural standards for various medical situations, including follow-up and prenatal checks for pregnant adolescents
  o It includes two brief mentions of subsequent pregnancy:
    ▪ Childbirth: “Before discharge a contraceptive method should be given that does not interfere with breastfeeding and the relationship with the adolescent clinic will resume through a follow-up appointment
    ▪ Pueperium should include: “the prevention of a second unplanned pregnancy”
  o There is also a mention of reenrollment in school

  o National Program for Sexual Health and Responsible Procreation
  o The Program aims to promote equal rights, equity and social justice; and help improve the structure of opportunities for access to comprehensive care for sexual and reproductive health.
  o Program objectives\(^{5}\) are:
    ▪ Reach the highest level of sexual health and responsible procreation in the population so allow decision-making free from discrimination, coercion, and violence
    ▪ Reduce maternal and child morbidity and mortality
    ▪ Prevent unwanted pregnancies
    ▪ Promote adolescent sexual health
    ▪ Contribute to the prevention and early detection of STIs, HIV/AIDS, and genital and breast diseases
    ▪ Guarantee access to information, guidance, methods and services related to sexual health and responsible parenthood
    ▪ Enhance women’s participation in decision-making regarding sexual health and responsible parenthood
  o The Program includes some of the following initiatives: universal and free access to contraceptive methods in public hospitals; the right of adolescents over 14 years of age to access these services without being accompanied by an adult;

and the mandate for the Ministry of Education to design and implement sex education programs.

- **Plan para la Reduccion de la Mortalidad Infantil, de la Mujer y Adolescentes (2009)**
  - *Plan for the Reduction of Infant Mortality, for Women and Adolescents*
  - The plan looks to reduce infant mortality (neonatal and postnatal), maternal mortality, *unplanned adolescent pregnancy*, incidence of and mortality from cervical and uterine cancer, and *adolescent mortality* from external factors, and improve access to quality sexual and reproductive health.⁶
  - It focuses on management, human resource, inputs, and infrastructure issues that produce obstacles to adequate health care access, and is implemented via individual agreements and objective-setting between the National Ministry of Health and the Governor of each province.

- **Programa Nacional Sumar (2012)**
  - *National Plan ‘Sumar’*
  - The “Sumar” Program is an expansion of Plan Nacer (2004), which provided public health insurance to uninsured pregnant women and children under the age of six.
  - Programa Sumar *extended coverage to 5.7 million children and adolescents* 6 to 19 years, and 3.8 million women 20-64 years old. As with Plan Nacer, it uses results-based financing mechanisms to improve the quality of health services.
  - The Program builds on Plan Nacer’s national network, and aims to strengthen access to public health in different population groups and provide new benefits packages for perinatal, children, adolescents, and women.

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List 2 – Municipal Entities and Programs

List of relevant City Programs and Plans

- Programa de Salud Reproductiva y Procreacion Responsable (2000)
- Programa de Salud Integral de Adolescentes y Jovenes (2008)
- Red de Adolescencia (1993)

Details of relevant City Programs and Plans

- **Programa de Salud Reproductiva y Procreacion Responsable** (2000)
  - *Program for Reproductive Health and Responsible Procreation*
  - Established in 2000 by Ley No. 418 in order to **guarantee sexual and reproductive rights** for “all people of childbearing age,” which include: access for men and women to information and contraceptive method of their choice; comprehensive health care during pregnancy, childbirth, and puerperium; **information, counseling, and appropriate care for adolescents**.
  - Previous to this, since 1988 there was a “Programa de Procreacion Responsable” (Program for Responsible Procreation) focused solely on family planning. This Program included women age 15-19 in the target population.
  - Previous to this, the lack of a standard norm meant each hospital had to develop their own plans without specific resources or legal frameworks.

- **Programa de Salud Integral del Adolescente** (2008)
  - This Program was established through Resolution 1.751. This document states the Program will be implemented through designated appointees for each of the four Sanitary Regions of CABA, and incorporates all health actors from General Hospitals to primary health care centers (CeSACs).
  - The website does not have extensive information but includes a flyer stating adolescent health rights and listing hospitals and CeSACs with adolescent clinics. *(see figure below)*
  - For many years, the city of Buenos Aires did not have a specific adolescent health program. Prior to this program, a 1996 proposal for a “Programa para la Atencion Medica integral y adolescentes en el Gobierno de la Cuidad de Buenos Aires” failed due to “cultural and religious barriers.” Critics place the blame on
the Catholic Church’s influence, blocking sexual education and programs seeking to provide information and contraceptive methods to adolescents.\(^7\)

- **Red de Adolescencia (1993)**
  - *Network for Adolescence*
  - From 1993 to 1997, groups that attend to adolescents form part of this ‘Red de Adolescencia’ in order to exchange experiences, successes, and challenges, and to consolidate complementing services within hospitals, organize trainings, research, etc. The network discontinued in 1997 due to administrative and political changes, and competition for patients between adolescent and pediatric specialists. From then, the ‘Red de Adolescencia’ was included in the ‘Red de Pediatria’ (pediatrics).\(^8\)
  - Interviews with medical professionals at Buenos Aires public hospitals (detailed later) discuss monthly meetings of a ‘red de adolescentia’ where every hospital and CeSAC is represented (that wants to attend).
  - It is unclear whether this ‘red’ remains part of the ‘Red de Pediatria,’ though the adolescence network is not listed online as a “Red Conformada”

\(^7\) Indeed, for this reason in 1995 a Reproductive Health Law, which would have provided adolescent reproductive health and provided IUDs as a contraceptive option in public hospitals) did not receive Senate approval despite approval in the Camara de Diputados. (Gogna 278)

\(^8\) Gogna 2001, 30
List 3 – Hospitals in the City of Buenos Aires

Hospitals in the City of Buenos Aires

Different hospitals have different types of adolescent services. Some services within general hospitals have their own separate clinic with a division head, whereas others have a working group or team within pediatrics. Others are maternity hospitals with an adolescent section.

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Programs at Buenos Aires Hospitals

From the research and hospitals interviewed, two hospitals had specifics programs to address subsequent adolescent pregnancy. These are a training held at the Argerich General Hospital, and the PROAMA program at the Sardá Maternity hospital.

The Argerich training (to be later described in further detail) essentially brought together other services within the hospital (such as obstetrics/gynecology and pediatrics) and trained them on adolescent–friendly services. It also raised awareness and encouraged other hospital services to refer their adolescent patients to the adolescent service.

Since 1988, the Sardá Maternity hospital created PROAMA: Programa de Apoyo a Adolescents Embarazadas, a support program for pregnant adolescents. The program brings together an interdisciplinary team to prevent STI transmission and subsequent unplanned adolescent pregnancies by providing support for adolescent mothers and their children. Their experience reflects the importance of interdisciplinary teams working together. For them, the principle factor to keep in mind with adolescent pregnancy is the “organization of the family structure.”

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9 Hospital Materno-Infantil Ramon Sardá: PROAMA
Appendix 3 – Interviews

Schedule of Questions
The interviews were semi-structured conversations with various medical professionals at several hospitals with established adolescent services in the City of Buenos Aires.

Similar general topics were covered, although conversations slightly varied between each hospital depending on the flow of the conversation and topics of interest to the doctor. Relevant topics were introduced by the researcher, and the doctors in turn discussed the situation at their particular hospital, and their personal opinions on subsequent adolescent pregnancy and adolescent health in the City of Buenos Aires.

Questions and conversation topics included:

- Discussion around a general introduction to the adolescent service at that particular hospital, the services offered, and the different professionals (medical and other) working there
- What is the hospital patient population? Demographics?
- Of the 33 public hospitals in the city, very few have adolescent services. How and when was this particular service started?
- The National Program on Adolescent Health was initiated in 1993:
  - Since when has this hospital had an adolescent service/section?
  - If prior to 1993, discuss the protocols and norms used by the hospital prior to existing legislation or programs from the National government.
  - The guides published from this Program: relevance? Are these referenced?
- Have there been any specific initiatives regarding adolescent pregnancy or subsequent adolescent pregnancy at this hospital? Are you able to measure results?
  - What happens before, during, and after an adolescent’s pregnancy and childbirth when she visits this particular hospital?
  - Do other areas of the hospital know to refer adolescent patients to this service?
- Discussion of initiatives and efforts in subsequent pregnancy and adolescent health in general at that particular hospital and at the city level
  - Is the work you do standardized across the other hospitals in the city?
- Discussion around levels of (adolescent) patient comprehension regarding sexual and reproductive health topics
  - Where is the disconnect?
  - Do you feel that the adolescent patients are making informed decisions?
  - Discussion around primary, secondary, and tertiary levels of prevention
- Discussion around the need for established protocols instead of having actions rely on the individual efforts of medical professionals
  - Possibilities for and effectiveness of community-based, school-based, and health center-based initiatives
  - Importance of establishing comprehensive adolescent-friendly services
- Adolescent health issues have only recently been prioritized and differentiated at the municipal and federal level. Why now, and what has changed?
  - Discussion on adolescent health services available in CABA and where further work is needed
• Should the focus be on improving comprehensive and adolescent-friendly services, or instead a specific program or initiative surrounding subsequent adolescent pregnancy?

**Interviewees**

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**Interview Data**

- 16 interviews
- 12 doctors
- 6 hospitals
  - 3 general hospitals
  - 1 maternity hospital
  - 1 children's hospital
  - 1 infectious disease hospital
- 1 primary health center
- 1 international organization
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