POPULATION ASSOCIATION OF AMERICA

2009 ANNUAL MEETING, DETROIT MI, APRIL 30 – MAY 2, 2009

99 MEXICAN YOUTH IN MEXICO AND THE U.S.

YOUNG PEOPLE'S BARRIERS TO REPRODUCTIVE HEALTH IN MEXICO CITY

Carlos Javier Echarri Cánovas
Centro de Estudios Demográficos, Urbanos y Ambientales

El Colegio de México, Mexico City

INTRODUCTION

Within the framework of the recent demographic dynamics of Mexico, the teenagers and their sexual behaviors became the object of increasing attention. One effect of the demographic transition is that the young cohorts are very numerous: the population between ten and nineteen years represents a fifth of the total population and will only reach 15% at the year 2022. In addition, and even with the problems of under recording and late recording, according to the data of Civil registration a little more than one on ten births corresponds to a teenager mother (of less than twenty years). The various sociodemographic surveys led recently in Mexico show also a younger age schedule of the fertility rates: those of the 15-19 age group passed from twelve to 15%, while the ${}_5f_{20}$ increased its participation by twenty-six to 30% (figure 1).

The population policy implemented by the Mexican government for thirty years, based on the diffusion of the family planning and the free distribution of the contraceptive methods in all the units of the Health sector, even for those not covered of the social security, has had a great success in the reduction of the final descent of the Mexican

women (Zavala de Cosío, 2001; Mier y Terán and Partida, 2001). Nevertheless it was not very effective concerning the increase in the intervals between births and especially the adjournment of the beginning of the reproduction. We observed the greatest reductions in the oldest groups, and if we make the comparison with the fertility levels of the Seventies, when we could describe it as natural, one can see in figure 2 how teen fertility started to go down only in 1984, when ${}_5f_{30}$ was only 60% of its value in 1970 or the rates ${}_5f_{35}$ and ${}_5f4_0$ had been reduced to half. In the recent years the fertility rates over the age of thirty showed a slight rise, in relative and also absolute terms, which is most significant in the youngest group of age. This evolution is similar to the one observed in Chile (Guzmán *et al*., 2001) and, ten years before, also in the United States and in the United Kingdom (Selman, 2002).

Teen pregnancies are regarded as risk events, as well for the mother, the product and the society. In the literature, they constitute factors that increase maternal and infant mortality (Atkin *et al*., 1998; Bobadilla, Schlaepfer and Alagón, 1990; Echarri, 2003; Hobcraft, Mac Donald and Rutstein, 1985; Schlaepfer and Infante, 1996), which promote school dropout and limit the possibilities of women of obtaining a favorable economic and social position (Stern, 1997; Stern and García, 1999; Welti, 2000) and represents threats for the social security, by imposing heavy financial expenses (Hakkert, 2001; Selman, 2002). Nevertheless, unlike the context of fewer developed countries, where the families take the place of the often nonexisting social protection systems, in the industrialized countries the majority of the teen pregnancies take place out of the marriage and in women of specific groups, they undergo social sanctions and are related to unfavorable psycho social characteristics (Geronimus, 1987).

However, certain studies question the social construction of the problem of the adolescent pregnancy, by specifying that the reproductive health of the teenagers can only be understood by referring to the social and cultural context in which they live (Stern, 1997); in this direction, accepting the universality of the problem would be difficult, since there are contexts where the pregnancies are not perceived as a problem, but as the basis of the only project of life perceived as available, in absence of other alternatives, in terms of continuing a school career and then a work and family ones. In addition, many negative consequences seem to be related to prior social disadvantages of the young mothers (Hakkert, 2001).

In this paper, I want to analyze the most recent data to contrast, in the Mexican context, some of the questions advanced in the literature like problems: first, the framework in which first pregnancies occur, then, the relationship between the early childbearing and the perinatal health care. More specifically,

The research project: "Identification of barriers to bridging the gap between health needs and reproductive health services", sought to document the economic, social and institutional reforms that make up a gap between the reproductive health needs of women, men, teens and offering health services (public and private) contexts in marginal and poor of Mexico City, with the intention of contributing to a better design of policies, programs and interventions.

The reproductive health needs as well as economic, social and institutional obstacles to their full satisfaction on the part of the population have received little attention in Mexico. The major socio-demographic and health surveys suffer from conceptual and methodological shortcomings. Hence, the proposed project seeks to combine a survey to identify the "needs in reproductive health and its determinants with a qualitative approach to deepen the knowledge of the obstacles to meeting them by the population and way that health services meet the care demands of the population.

1. SOCIAL INEQUALITIES

A way of taking into account the great heterogeneity of the Mexican society and its principal problem, poverty, is to take as axis of analysis the social differentiation. To do it, we built an indicator of the socioeconomic strata, SES. This indicator is built at the household level, and combines the characteristics of housing, the average relative schooling of the members and the best-remunerated occupation of the household. The average relative schooling is built as the relationship between the number of years of schooling of each person and those he/she should have, according to his/her age and sex, according to a national schedule. That makes it possible to separate the effects of the girl's school attendance from their socioeconomic status, and thus to check if indeed the teen pregnancies are much more related to the most impoverished population, even with the rise of the school offer and in consequence of the levels of schooling of the girls.

It is all the more significant to take into account this socioeconomic differentiation given the great differences in the reproductive behaviors of the different contexts. Figure 3 shows that there is even an increase in the ${}_5f_{15}$ rate at Very Low SES. The Total fertility Rate of this stratum is 4.3 for the year 2002, while it is 2.4 for Low and is of one child per woman at the least poor sectors, comparable with the levels of Spain or Italy. The mean age at the first pregnancy, calculated by means of a table of life to avoid truncations, is 19.2 years for Very Low stratum, 20.4 for Low and 21.6 in the Middle sector. There is a 4-year gap between the poorest and the High sectors. However, on the other hand, there is hardly difference in the proportion of premarital first pregnancies: it is a little more than

one third. It is the age that introduces variations into this proportion and we find a negative relationship: 48% of first pregnancies that occurred among women of less than 17 years are premarital, against only 30% when it happened among women aged of more than 20 years.

Once the active sexual life started, the pregnancies occur very quickly: the use of contraception at the time of the first sexual intercourse only happens in 12% of the cases; there is nevertheless a very great variation by socioeconomic level: only 6% of the girls of the poorest households are protected from a non desired pregnancy, against one on four in the easiest sectors. Even if we take into account other variables, as the age group, the relative schooling of the girls, living at the parental home, the size of the current locality and where the woman lived when she was a child, and the age at the first sexual intercourse, the results of the multiple classification analysis presented in figure 4 first of all show a significant change between generations, since the contraceptive prevalence of the youngest girls -who already had sexual intercourse- is three times the average and it appears a cut in the neighborhood of the age thirty. It is important to underline how low schooling becomes a handicap for the girls, since even by controlling all the other variables they have a lower use of contraceptive methods.

The span of the non-reproductive sexual life is very short: it does not reach two years and there is a direct relationship to the age at the first pregnancy (figure 5). Similarly, the mean protogenesic interval hardly exceeds 13 months, but it does not seem to have a very strong relationship with the socioeconomic level. It would seem that the sexual revolution that a number of industrialized countries knew in the Sixties and seventies has not yet been experienced in Mexico, or that the girls are achieving their childbearing desires, since the most frequently quoted reason not to have used contraceptives at the time of the first sexual intercourse is precisely the desire of a pregnancy, in 36.1% of the cases, followed by the lack of knowledge of methods, 34.2%. The third reason in importance -13.8%- is that the girl had not envisaged having intercourse. When the socioeconomic sectors are considered, the desire of pregnancy reaches 41% in the highest group, while in the poorest the ignorance of methods is the first reason, with 43%. Even if it the answers can be a re elaboration of its experience, three women out of four declare that they wanted to have children before getting pregnant, but the proportion falls to a little more of half if it is asked whether they wanted to have a child in this moment or later. This desire to have a child is in direct relationship to the age at which the first pregnancy arrived (figure 6).

THEORETICAL AND CONCEPTUAL BACKGROUND.

THE STUDY OF HEALTH NEEDS FROM A QUALITATIVE POINT OF VIEW

Health needs are understood as health status perceived by individuals and / or diagnosed by health professionals. Health needs have been conceptualized and operationalized in different ways depending on the type of theoretical approach and the model of analysis used (Lara Flores et al. 2000:98). According to Donabedian there are two perspectives in the study of needs, professional or technical standards dictated by doctors and so-called "standard needs " and the patient's perspective, the perceived need for the individual, called "felt need" (Lara Flores et al. ibid.). Both perspectives are different when it comes to identifying the needs resulting in "... unrecognized latent needs and unmet needs ... and expressed by patients but considered inappropriate by practitioners" (Lara Flores et al. 2000:103).

The anthropological point of view, used in our work, takes as central the concept of culture, including "language, ideas, beliefs, customs, taboos, codes, tools, techniques, values, ideals" and accounts for "a symbolic and interpretive process that constructs the subjectivity of individuals and directs their actions "(Lara Flores et al., op.cit: 106). Thus, both the health personnel and population perceive health needs from their particular "world view" and constructs them both socially and culturally.

"From this perspective, the needs are the result of the way that individuals belonging to different social groups interpret the health-disease process in different ways, being necessary to understand that this interpretation is not only the expression of individual desires, but the projection of the how a sector of the population socially constructs their own meanings and expresses them through language "(Lara Flores et al*., op.cit*: 107).

The anthropological perspective has shown that health needs can be addressed in a more integrated through the use of interpretive methods that seek understanding rather than causal explanation and is supported by technical data that not only recognized, but the produce, retrieve and interpret (Lara Flores et al., op.cit: 107). In a manner consistent with this perspective, we recover a qualitative approach to research and use of tools such as observation, interviews and focus groups to get closer to the viewpoint of health care providers, users of these services and the general population.

REPRODUCTIVE HEALTH NEEDS.

Before talking about what we mean by "reproductive health needs" we should go back to the concept of unmet need for family planning, which finds various assumptions, limitations and meanings depending on the approach in which it is embedded. According to the points made by Camarena and Lerner (sf), there are two approaches or paradigms that differ on the definition of the concept of needs in

reproductive health. Within the population approach (1970's and 1980's) behind the antinatalist position and primarily oriented towards the expansion of contraceptive coverage to regulate and reduce fertility, the population's needs are defined primarily in relation to these goals and accordance with the interests and concerns of the government authorities responsible for family planning programs, service providers and researchers and academics.

Thus, the concept of unmet need for contraception responded to political concerns that prioritize actions aimed at increasing the use and effectiveness of methods to monitor, control, and reduce fertility and thus obtain a higher welfare in the population.
The second approach, known as reproductive health, is just like the previous criticism that the movement of women conducted the orientation, justification and legitimacy of population policies, family planning programs and their negative consequences on women, the apparent tension between the needs and interests of industry or public versus private, individual concerning the use of contraceptive methods.

This approach was consolidated with The Cairo Conference (1994) emphasized that the unmet needs as a concern of personal and private attention on reproductive rights and conditions of social inequality and gender. Their rationality, unlike the first approach outlined, based on individual needs, especially those of women, which do not necessarily coincide with those derived from the public interest.
Adopting the theoretical perspective of this second approach, when we speak of needs in reproductive health we refer to those related to contraception, pregnancy, childbirth and postpartum, the interruption of pregnancy, the method fails, the side effects of contraceptives, sterility, prevention of cancers of the reproductive male and female, the prevention and treatment of reproductive tract diseases, including STIs and HIV / AIDS care and prevention of violence. These needs change according to the specifications given by the socioeconomic, gender, sexual orientation, age, marital status, expectations and life plan and timing of the reproductive cycle.

Although it would be desirable or expected that the needs of women, men and adolescents are the starting point for the organization and delivery of reproductive health services, guidance hegemony that has prevailed in the health institutions has led to the exclusion of the perceptions, needs and demands of the population. In our environment, some research has documented how often assume the needs of people from what the medical system means that they require service providers to be the only authorized "morally" to determine (at first) and meet (second) through technical procedures and by detecting only those for which they were trained (Jasis, 2000:133). Jasis investigated about the needs that women had during the whole process of pregnancy, childbirth and postpartum in a hospital in Baja California, concluded that in most cases, doctors do not meet the needs "sense" of users, but rather needs to assume that the suppliers themselves or pose, because it involves finding the route to ask women directly if their needs were met by the health care received (Jasis, op.cit.: 106 and 134).

If, as indicated by Dixon-Mueller and Germain (1993), the challenge is to meet the reproductive needs of women and men, requires, first, expand the scope of unmet needs by taking into consideration the demands and specific conditions of different population groups (Quoted by a waitress and Lerner, op.cit.). Hence, the challenge and goal of our research is the comparison between met and unmet needs as defined by the women and men of different age groups living in areas where poverty prevails and marginality, and those identified by programs and providers of health services.

THE HEALTH PROVIDERS AS AN OBJECT OF STUDY.

Institutionalizing the practice of fertility control both the allocation meant for the public health function of birth control such as transfer to the health of the decisions about family planning in the population, which has led a process of increasing public input in a private sphere is linked to the exercise of sexuality and reproduction. Thus, the health institutions have to be in areas from where they spread and form certain values, norms and practices associated with different aspects of reproductive health to be health workers who have been awarded legal and regulatory authority on technical and moral this area of people's lives. "By act or omission are the mediators as the decisions of their patients on issues and policies for reproductive health, population and family of the State. His influence is expressed through: a) their practices via the implementation of preventive procedures, diagnostic and therapeutic and b) their messages "(Ramos et al., 2001:27).

"Their individual visions of the world and the people who come to them with great strength ... make your professional practice, offering guidance and how they interact among themselves and with users and patients" (Leal and Martinez, 2002:58).

It is a complex and conflictive interaction, as "... is influenced by the providers' perception on their responsibility to the processes of health and reproductive decisions as well as certain elements of class, gender and institutional characteristics that come to change priorities in their daily relationship with people ... "(Figueroa Perea, 1997:35). To study how service providers perceive health needs presented by the users and through which actions are trying to meet them necessarily implies to recognize, first, that they are constructed from intersubjective link established between the health personnel and users and in the medical consultation. Secondly, the possibilities of health personnel to meet patient expectations are constrained by the material resources at its disposal but the source is essentially his #professional me#; (Leal and Martinez, op. cit. 60). Following these authors to understand the logic or rationality of the representations and medical practices to meet reproductive health needs would be essential to look in two directions: first, to the conditions in which providers do their work (characteristics organization of the institution, degree of freedom granted to it, relations with staff and managers who organize and supervise their work, relationships between the different components of the health team, the type of people it serves, psychological closeness or distance cultural and keeping her

opinion or prejudice that they have formed), the second to his professional identity, how it conceives its own professional identity, what is your work, how they conceive, how they live and what their user's perspective andalusia serving (Leal and Martinez, op.cit.. :62-3).

The access to reproductive health services and service quality are two critical aspects in the provision of services, service providers playing a central role in both dimensions. For nearly a decade, several researchers began to get interested in studying how to minimize or eliminate obstacles to the public when attending or want to go to family planning services, particularly interested in the barriers associated with the policies and medical practices. Bertrand et al. (1995) suggest a number of restrictions on access grouped into: obstacles and barriers in accessing medical services. According to these authors, although a user or may have drawn the geographical, economic, administrative, cognitive and psychosocial aspects of access cannot access the method due to barriers that include medical eligibility criteria, contraindications outdated, that the method is not available , medical attitudes against the use of certain methods or inappropriate management of side effects.

Shelton *et al.* (1992) defined barriers as medical practices, derived in part from the medical rationality but are scientifically unjustified, impeding or denying contraception. These barriers, according to the authors, on two levels: a) the level of macro policies, protocols and regulations, and b) at the micro level through the medical attitudes and behaviors (Cited in Miller *et al.* 1998:161 -- 179). One study examined the medical restrictions on access to family planning methods in five countries in Africa (Miller *et al.,* Op.cit.) Reached the following conclusions:

a) Although the protocols outlined a national set of eligibility criteria for the provision of contraceptives, are the providers who perform these protocols, reporting that they impose greater barriers to customers as required by policy, thus protocols, although based on medical evidence are not applied in a medical manner.
b) the restrictions found are possibly motivated by social rather than medical needs, the pattern followed by medical providers is debatable though perhaps appropriate from a social or cultural,
c) providers impose certain restrictions "with the best intentions and believe that doing so" protects "both the user and her society,
d) the cultural attitudes of the providers have a huge impact on how services are offered and the motivation for providers to impose restrictions to protect its society, culture and values is a serious matter and usually untreated.

In this sense, the constraints imposed by the providers and access to quality reproductive health services from the motivation of professional staff, their

experience, technical capabilities, among others, is regarded as a serious impediment to providing quality services. Hence, our aim to identify and analyze what a group of providers recognized as reproductive health needs of the population, constitute the object of its intervention and the resources used to respond to them.

OTHER KEY PLAYERS: THE POPULATION.

In the last decades of XX century interest in recovering the point of view of users, subjects and patients in the general population regarding the care and health care strengthened (Mercado F., et al. 1999). The development of this research has led to a gradual weakening of the doctor-centrist stance, has led to a strengthening of the qualitative methodological frameworks, and has expanded the scope of understanding of the social conditions that influence the search, access and assessment health services (Mercado F., et al. 1999, 2007).
In the field of reproductive health raises the interest to understand the obstacles faced by people accessing family planning services or care for ailments related to the exercise of sexuality and reproduction, but is still limited information gives a systematic proposals from different groups of people who want to come or go to the services available in a particular context.
Hence our goal to recover and analyze the perspectives of different groups of people living in areas reporting high rates of medium and marginalization of Mexico City. The generation of this information will find an approximation to the problems, needs and obstacles to reproductive health care present between men and women belonging to different age groups.

PART TWO: METHODOLOGY

Adopting a qualitative methodology involves assigning centrality to the subjective dimension of social action, adopting techniques and tools for data collection and analysis that focus on the views of stakeholders to access their own interpretations, intentions and attributes of meaning (Castro and Bronfman, 1995:58).
The qualitative research component that seeks to understand how different groups of people identified the main problems, needs and obstacles to reproductive health care was done by integrating focus groups, as is a methodology which enables approach and interpretation of rules, representations and practices group through a discourse that is created collectively and simultaneously identifies individual disagreements and lack of consensus within the group. Likewise, in-depth interviews were used because this technique allows us to recover the speech of subjects reinterpreted to go to certain dimensions of subjectivity.
The dynamic and engaging speech in each of the focus groups, as well as information from the interviews was recorded with the support of audio and video equipment. In

turn, were prepared daily reports from the field and ethnographic observation. The information obtained in the focus groups was transcribed for subsequent analysis.

SERVICE PROVIDERS

The study of service providers included visits to various public services are located in the Ajusco Medio (Tlalpan) area, which employed the techniques of systematic observation and interviews with doctors, nurses and social workers. Subsequently, two focus groups were integrated with different categories of providers who work in health facilities under the medical services of the Federal District. Focus groups were conducted at the health center II T-Mayan Culture and counted with the assistance of three doctors, two nurses and two social workers.

In another phase of the research process, the approach to the viewpoint of healthcare providers in the private sector, was accomplished through the integration of a focus group, in which seven doctors and as a nurse working in medical units located in the northeast of the Delegación Tlalpan.

Focus groups with service providers from the public and private sector had the following objectives:

- Get an initial overview of the main concerns and reproductive health needs presented by women, men, and adolescents.
- Knowing which sectors of the population believe that they are more concerned with issues of reproductive health.
- Learn about the social obstacles they consider each of the different groups to identify their main needs in making informed decisions, and the expression of demands to satisfy them.
- Learn the major difficulties faced in meeting the reproductive health needs of the population they attend.
- Knowing the views of providers as to how they could better meet the reproductive health needs of the population.

POPULATION

Since meeting the reproductive needs requires taking into consideration the demands and specific conditions of different population groups, it was considered most important to explore the views of users and potential users of services related to the promotion and care of health.

In an area with a high marginality located in Iztapalapa Delegation, three focus groups were included consisting of thirty-three women belonging to different age groups (15-

19, 20-24, 25-49 years) and who reported having a life sexually active. It became a focus group composed of ten men whose age ranges between 25 and 49 years.

The objectives that guided the focus groups of women and men were

• Identify the most important reproductive health needs experienced by women and men of different age groups.
• Identify how women and men express the barriers and access to health services.
• Establish the conditions and types of interactions that prevent or encourage women and men express their needs, are able to translate into a demand for health services and through this to meet their reproductive health needs.

PART THREE: RESULTS.

REPRODUCTIVE HEALTH SERVICES IN THE PUBLIC SECTOR

In this section we describe the information obtained from visits to health services in the public sector in the area of the Middle Ajusco, Delegación Tlalpan, which was an exercise in systematic observation, two focus groups and interviews were applied to medical / as nurses and social workers. In addition, information was supplemented by the document review.

CHARACTERIZATION OF PUBLIC HEALTH SERVICES IN AN AREA OF MEDIUM MARGINALITY

Tlalpan delegation is considered a medium poverty one (Boltvinik, 2006:34). It comprises 25% of the 44 third-level units available to the Federal District, however 46% of the inhabitants of this demarcation does not have access to health care institutions (Quintero and Balthazar, 2000:8).
Since 2002, health services in Mexico City (ruled by a left-wing party, the PRD) to provide the Medical Services and Free Medication Program for the uninsured population of the City. The program was designed from the perspective of a right to health, aims to reduce inequality in health conditions and resources, removing first the economic obstacle (GDF-Secretary of Health, 2002).
Under the jurisdiction Sanitary Tlalpan are ten health T-I health centers, three T-II health centers, five T-III health centers and the Hospital Materno Infantil Topilejo. It also offers primary care nursing homes in eleven and twenty-two peripheral. It is worth mentioning that the Houses of health came under the administration of Mayor Martínez della Roca and its main aim is to provide primary and preventive care to the poor. The nursing homes were opened in May 1998 in the colonies of more modest means. Staff working in them is composed of one or more physicians, a nurse and a

social worker. The program began as a coordinated effort between the authorities of the delegation, the Secretariat of Health of Mexico City and private initiative. Prior to the design and implementation of services carried out an investigation that led to the needs and requirements of communities and the problems that most affect as malnutrition, poor hygiene, lack of potable water and drainage pipes and overcrowding (Quintero and Balthazar, ibid).
Within this area (delegation), we chose *Ajusco medio*, considered medium marginality to take a first approximation to the point of view of the services rendered.

Within the Public sector, we visited the Mirador II, Spring-Summer People and Santa Teresa health houses, Lomas Padierna T-I health center of and a peripherical consulting . All these services belong to the Health Delegation Tlalpan. We also visited a private clinic, located a few blocks from the health center Lomas de Padierna. In each of these services, we describe the physical characteristics, hours of operation, the cost of consulting, human resources that comprise the health team, the main health problems affecting the community they serve, the services they provide, with a particular interest in learning about reproductive health activities carried out and those which for various reasons are not done.

THE VIEWS OF ADOLESCENTS (15-19 YEARS)

This focus group consisted of nine young women, with an average age of 17.4 and an average of 0.6 children. Seven were single, one was married and the remainder lived in free union. As for occupation, two teenagers were engaged in housekeeping, three were students, two stated that they worked as seamstresses and the other two as laborers. With regard to schooling, a teenager was illiterate, two had not completed primary school, one ah completed primary, one had incomplete secondary school, and four had started high school but not completed.

In the focus group of women aged 15-19, were welcomed as contraception allows delaying or spacing pregnancies by providing "to give children the attention and everything they need so they can grow and be recognized the need to prevent sexually transmitted infections.
Adolescent girls are sexually active. Therefore expressed the need to "take care", referring to the use of any contraceptive method when you have a partner, and sex on a regular basis, whereas when it is not stable there is no need to "carry" a

method. Subject to this observation, adolescents do not use contraceptive pills and injections of daily, and is even more difficult to access the IUD.

In the focus group of women aged 15-19, contraception was given a positive valuation, as it allows delaying or spacing pregnancies by providing "to give children the attention and everything they need so they can grow"; the need to prevent sexually transmitted infections was recognized.

Adolescent girls are sexually active. Therefore, they expressed the need to "take care", referring to the use of any contraceptive method when you have a partner, and sex on a regular basis, whereas when it is not stable there is no need to "carry" a method. Subject to this observation, adolescents do not use daily contraceptive pills and injections, and is even more difficult to access the IUD. They mentioned Emergency Contraception (EC) as one of the main options when they have unprotected sex. EC is considered the strategy most suitable for their needs, since "the contraceptive pills must be taken daily, these are forgotten, so it's better the next day." Peer groups are the primary source of information on the use of AE. By this way of socializing, participants got references on how to use the emergency pill, "think that you have intercourse today, tomorrow you take one and the day after another one at the same time."

Another strategy to avoid an unplanned pregnancy is the practice of anal sex. The teens suggested different opinions as to the possibility of pregnancy through this practice, some participants mentioned that "pregnancy sometimes happens without penetration" or "when you have anal sex you can also get pregnant, I think so."

The condom is also mentioned as one of the main options teenagers dispose to avoid transmission of STIs. Participants identified gonorrhea, urogenital herpes and AIDS, as main STIs. Also mentioned the difference between HIV and AIDS, and confirmed that the greatest challenge posed by the identification of this disease due to the latency period of the virus. They distinguished the main routes of transmission of STIs, the fact of "having been with men" (having sex), "tight clothing" and "use of scented soap". They perceive that some practices without penetration, as oral sex, are not exempt from the risk of contracting an infection, and that anal sex enlarges the scope for the transmission of these diseases, so that "mandatorily you have to use a condom. "

Beyond these references, the group dialogue indicates a condom use as that prioritizes their contraceptive quality at the expense of barrier to STIs. Often, they indicated that the characteristics of situations where they have sex influence their planning and condom use. Reportedly, among the adolescents and sex is often unplanned, and it can be can distinguished between "faje" (excitation without penetration), or "rapidín" a quick sexual encounter). These are

conducted in public places that require the urgency of sex, such as inside a closet, in cybercafés, on sidewalks or subway cars, at the movie theaters, in soccer fields, among others. In this situation, the difficulty in using condoms often increases. "At that moment you are not thinking, the condom, nooo, and later you have the consequences".
When asking about these consequences, they mentioned mainly the fact of getting pregnant and there was a reduced emphasis on the transmission of some STDs.
In the hypothetical case of having any STD, adolescents said that, in the presence of symptoms, they would go to a "trusted doctor", which should be read as a private physician, while others said they would turn first to the mother and other resort first to close friends. In turn, a recurring theme in the group was the fact that men do not worry about avoiding a sexually transmitted infection and almost never go to a doctor, which creates significant health risks for women.
For its part, pregnancy is also an experience that is told first to the closest friends, after the partner, and finally to the parents of the teenager. According to these young people, "having much sleep, starting to eat more", and "the absence of menstruation" are some signs that lead to the suspicion of a pregnancy. However, a reproductive health problem mentioned by the participants was irregularities of menstruation, because this situation makes it difficult to identify more precisely the event of pregnancy.
For them, a teen pregnancy would be the main consequence of the non-use of contraception or its failure, which means that "nothing will be equal again ", because it creates a process of adopting new responsibilities, where there is always the uncertainty of "being able to support the child and give him everything he needs".
Faced with an unexpected pregnancy, some young people expressed the non-acceptance of pregnancy interruption as an "animal act", while others do think that induced abortion is a viable resource, but none declared having practiced one. Other young people mentioned their partner or parents suggestion to abort when they told them that they were pregnant, believing that "the baby is a burden for them".
Furthermore, sexual abuse emerged as a very important issue within the group. It was said that cases of rape committed by stepfathers were known. One participant commented on their experience of abuse, the support she got from its mother, the birth of his son a few months ago and the great sadness she felt at the moment. Another recounted the attempt by her uncle to abuse her, and another, the one which she suffered by a cousin.
Regarding the reproductive health services access, some participants felt that attendance with the general practitioner and / or a gynecologist on a regular

basis is necessary regardless of whether or not you have a sexual partner while others said that one goes to the doctor when sick and takes this occasion to make a review.

The main obstacles to access to reproductive health services that young people mentioned were: the fact that the health professional is male and the shame that this causes, the strong bureaucratic system of services, lack of knowledge about available services, the lack of trust in the capacities of health personnel and the dependents, the lack of social security affiliation and the limited economic resources that limit the search for attention with a private physician and the abuse practiced by the health care providers in the public sector. For example, one couple told the inaccessibility to health services because of the administrative procedures:

- "Last week I went to the clinic, the one is nearest, because there in my dad dad's social security I am very well treated, they attend me well, but is very far and better to ... here, the "25" ... I went very early and got the first card, the lady comes and says, 'You do not have a student ID' ... and I said ... 'is the first card and everything and to be told that I’ve got no school ID... they did not attended me and I got out very angry, I shall not return. "

Some of the strategies proposed by the adolescents to improve access to health services and the relationship with providers were:

• that services are close to where they live - "sometimes they are far away, having to ride a car or having to get up very early in order to arrive on time ..."
• Having places without a lot of people
• That there were women physician those who treat them: "I would ask for a woman to take care of me, and a young one, ... a good person..."
• That male and female physicians gain the trust of the population,
• That male and female physicians pay attention to them - "Some are very bad ... they are sleeping ... then get to talk between doctors, nurses, or get out... or say come later or I do not have time and then they are with the cell ... I was telling the doctor : 'It hurts here' and he was laughing and punching the button.. they almost do not work ... then there are many people and it takes a lot of time.... "

THE VIEWS OF YOUNG WOMEN (20-24 YEARS)

The focus group consisted of twelve young women, with a mean age of 22 years and 1.25 children on average. Five were single, three were married and the other

four were cohabiting. Most are devoted exclusively to the household chores (ten) and only two had extra-domestic work (a secretary and the other was working on a print). As for schooling, five had completed primary education, four had started secondary but only one had completed this cycle, one had started high school but not finished it and two had conducted technical studies.
Young women aged 20-24 have information and expertise in the use of contraceptives, mentioning having used the IUD, the daily pill, and sometimes the condom. However, one of the major needs identified by participants in this group was at adolescence, given that before the first pregnancy (which took place in those years), they had limited access to contraceptive information and even more to the various methods.

- "All of us got pregnant at a very young age ... there is no such campaigns coming here and guiding you as to that, of course we already know right?, Yes there are pills, condoms, but they do not come and give you orientation ... that is what is needed, there are many girls and much younger and they have a son and another and another."

The group discourse indicates that some of the obstacles to access to contraceptives among young women are: the lack of planning of intercourse, the shame which carries going to the pharmacy to buy them, not to be entitled to social security, the lack of basic infrastructure in gynecological attention faced by public health services; difficulties in talking about contraception with men and negotiating condom use with their partners.

- "We had intercourse ... is not that one is ignorant ... I was ashamed to go to the pharmacy and say, 'Oh give me this! ... how I would be looked by the pharmacist and for not doing that for shame I got pregnant, it is not by ignorance but instead by shame".
- "I already had my daughter and went to the social security clinic 120 to have an IUD inserted, but they had not the device, you see, I had no insurance and there was no IUD for those uninsured, I did not got it, but they gave me condoms, but I did not use them".

Moreover, it was noted that the failure in the use of contraception is common in the community, whether for breach of the directions for use, or by the IUD failure.

- "Until I got married we both went to the health center to wait longer for getting pregnant but I got pregnant fast, I do not think we did as we were told there,

because in fact, they explained it to us and gave me pills and even so I got pregnant, I was controlling myself with pills, but I forgot to take one. "
- "I went to the health center and from there we were sent to a perinatal hospital and there were those who decided that I would remove the IUD and seeing that the baby is fine and if the baby stays we won ... And this ... I took it, nothing happened, no blood or anything and my pregnancy was very difficult as it was high risk ...."

Given the suspicion of a pregnancy based on non-use or inadequate contraception use, young women get a home test and then go to consultation with a health professional. Others alluded to the difficulties in identifying the presence of a pregnancy as, sometimes, lack of menstruation is not synonymous with pregnancy and the irregular menses or bleeding can occur even while pregnant.

Several of the young women reported feelings of concern and fear that arise when they suspect they may be pregnant or to confirm their status for what their parents will say, even more when there is no partner, "the only thing you feel is fear, how I'm going to do as a single mother. " The feeling of loneliness is also very present when you do not have the support of the couple.

Other concerns expressed during pregnancy by the young people have to do with how mother's emotions affect the health of her son, in which institution birth will take place, how labor will develop and how the expenses will be addressed, the latter expressed most by those young people without a partner, as if you got a husband, there is an agreement that the man who should take over this responsibility:
- "The doctor said that the baby feels what you feel and that I get sad or depressed I would only have problems during the pregnancy ... that after the babies are born yellow or depressed as well ... I am insured and I'm also with the concern of where I'm going to give birth and all that ... but more than anything the financial aspect... I have the support of my parents, well my mom more than anything.... "

Faced with an unexpected pregnancy the abortion option appears as a possibility, sometimes under pressure from the couple, but apparently the idea is abandoned by the family interaction and pressure that discourage it and the pregnancy is carried on. None of the youths said to have had this experience but have felt ambivalence about proceeding with the pregnancy:
- "At some point I thought about and even I researched on the phone, because I was afraid of my parents and me as a daughter ... and that everyone said no, then I thought about all the things I had to do, and the truth is I said no, no. "

- "He told me he did not want it ... that he was not to blame, that I aborted, and I told him no, that is something that is within me, and feeling nice ... my cousins told me that 'that if I had that perversion, for God's sake no' and I sort of said, no, it is right, I got this for something ".

Young women also know that abortions are performed in "normal" clinics, which have a high cost, so it is impossible to attend them; nevertheless but cases are known of young people who can collect enough money to access this practice: Once the pregnancy confirmed and having taken the decision of having the child, they expressed the need to seek medical advice "to get checked, given vitamins ... having an ultrasound". Sometimes birth control starts late as in the case of a girl who became pregnant at age 18 and said that she went to the doctor just at six months, so far none of her relatives had noticed.

Attendance with different providers seems to be a common practice. Sometimes prenatal care is performed by a private physician and childbirth in a public institution or attending a health center for pregnancy control and delivery takes place in a public hospital. During pregnancy, other models of care are also used, for example, "sobadores", or the advice of relatives such as the mother-in-law or aunts.

Another important aspect of antenatal care, were frequent complaints about the treatment received by the health care providers. Several young people indicated that they did not pay enough attention to their concerns, complaints and discomforts, and had no access to routine clinical prenatal care procedures, received inadequate treatment in gynecological care or faced physicians' incompetence and negligence.

- "I never did blood tests, gave me no vitamins, no nothing, never weighed me, I was never measured, never, I mean nothing, just told me your baby is fine ...."
- "At the Social Security clinic where I'm going... the doctor attending me in fact I do not like his way of being, I don't like him because he do not even weighs you and says: 'You are exaggerating, it is normal ...".

However, the experience of other young people indicated satisfaction with care received in health services in the public sector, indicating a proper antenatal monitoring and providing information and counseling by health staff.

- "Since the start of your pregnancy, they begin to chat about how you should massage your breasts, do exercises to get out the milk ... like when I was discharged from the hospital they gave me a leaflet with instructions on how to

care for your son, you had to sunbathing, 30 minutes a day, bathe daily, so many things .... "

Some of the health problems that emerged during the pregnancy were the threats of abortion, spontaneous abortions and glycemia. Sometimes these problems are related to incompetence and medical errors, for example, one of the girls recounted their traumatic experience of aborting at six months of pregnancy due to a urinary infection never detected and treated.

Fears concerning delivery are focused on economic difficulties in accessing health services, which increases among single mothers. In addition, other concerns are addressed to the pains of childbirth, the fact that they were going to "steal or change your baby" in health services, or "who will take care of the baby if something happens to them".

The problems that arise at the time of delivery were also discussed, given that frequently they are not received by various health services, which, in the best case involve a long journey looking for services until they are accepted at some institution:

"Me in my first pregnancy I had a bad time because at 6 months I broke waters, then no hospital received me and as I was seeing a private doctor, They told me "you know that your child is fine, if you want to go to a hospital go, the doctor is not here"... and we went up to Ticomán" ....".

Once in the health services, women opt for the use of accommodation in order to receive a good treatment by health professionals. For example, it was mentioned not to express the pain felt in an attempt to avoid a bad mood and to have better medical care. Apparently, the abuse carried out by health professionals during the birth, increases among adolescents and young women, and even more among single mothers.

When speaking about the needs in the postpartum, the first answers alluded to the care needs required by babies and only when the interviewer asked about the needs of women during this period the participants mentioned the possibility of infections in cases of childbirth by natural or by cesarean section. Therefore, the group indicated that a need is the follow up of the recommendations on care and hygiene and issued by physicians and close relatives, with the intention of being and feeling good, to care properly for their children rather than for themselves. From this perspective, the main concerns revolve around the care of children rather than their health.

On knowledge about STDs, young participants mentioned AIDS, followed by gonorrhea and syphilis. The symptoms that would make one suspicious of having

an STD were: the presence, color and odor of vaginal discharge. In the presence of any of these symptoms they say that the right thing to do would be visiting the doctor, but it was mentioned that the search for attention is not immediate, because of shame or lack of confidence to discussing it with a family member like the mother or sister, omitting the possibility of sharing this experience with one's partner.

The young women identified their male partners as the central actor in the transmission of STIs, either by their lack of hygiene when they go to public baths as well as due to the multiple relationships they may have not taken steps to protection.

As the participants tell, the central role that men occupy in the transmission of STIs, increasing the risks to the health of women, as they are often asymptomatic carriers of infections. In this situation, it is common for men not know or accept their responsibility in transmitting the infection, which is another obstacle for them to seek medical attention and continue to contribute to its spread.

In addition, a recurring theme in the group was the limitations young women have to negotiate the conditions under which they carry out intercourse. Men often refuse to use condoms, because the non-use is symbolized as a test of "couple's fidelity". Under these conditions, women relegate the preventive strategies and opt for curative care, attending the physician to detect and provide treatment for STIs.

Inquiring on references about human papilloma virus, some participants reported having heard of this infection and expressed their close relationship with the development of cervical cancer. "As things stand right now with cancer and infections, they can remove your uterus and all that, I think I now think I no longer let him".

Regarding the prevention of cervical cancer, some participants mentioned that the Papanicolaou (Pap) is a study used to detect “infection or virus”. Some young people commented that they attend health services with some frequency to having a Pap; others however, said they had never practiced that cytological study. Referred to the need for the Pap for all women, regardless of sex and dating, or motherhood, and mentioned the discomfort involved in this invasive process. The group also noted that the Pap does not know if you have infections, indicating that colposcopy is more effective as a screening method. However, access to colposcopy is not derived from personal experience, as none of the attendees had been subjected to this test, but she knew from the experience of women nearby. “To tell the truth, doing a Papanicolau never called my attention, even if I know that can give you cancer, but it not called my attention”.

Usually they say that it is not in the smear, you have to do colposcopy, where infections do better.... Some factors affecting girls attendance at the services to have the Pap were lack of social security entitlement and the long queues required to achieve a turn. The latter aspect is particularly important given the perception of danger in the context in which they live and therefore should not leave in the morning, “here is ugly at this time”.
Other major health problems were mentioned by the young women: the violence experienced by women during courtship or during pregnancy and the need for better access to information on reproductive health care because they are the ones who care about this area as opposed to the little interest shown by males. Women are aware that they are the ones that deal with one’s health and family, unlike their peers, so that this creates concerns about how to address family needs in family health:
“I worry about things, we as women are concerned ... more like that of men living the spending and spending and spending and by a no, because your savings because you say when someone gets sick walk running from here, there, we are not sure where to look for and grab money, where to get it more than anything for the child or for yourself …”
With regard to access to all reproductive health services, the group dialogue suggests that although young women identify certain health services to those who can turn presents a problem when there are several obstacles to access them as: difficult to get attention in the schedules, because you do not have to leave the children at the restriction of working hours, for not having the required gratuity titles.
In addition, several women complained about the care they receive from medical providers that they consider them of little interest to their concerns, cold treatment and so “they treat you as stupid as they say, this message does not know”. They believe that, good or bad treatment, the power is not exclusive to doctors, stating that the social workers or receptionists, sometimes also verbally assaulted. For example, one couple reported that at its last review before the birth:
“I felt bad because I was working and my job is to go walking and I tell the doctor: ‘Can I get my disability [leave] now?’, and I said, ‘That you had you’d think and not pregnant!, If you had studied would have ended your career and not pregnant and you’d not be experiencing any of this and I ... I felt bad because it gave me much anger and sadness. Yes they are ugly...”
In the group, there was no consensus on the choice of being treated by a male or female physicist, but it was mentioned that one issue that causes mistrust doctors (males) is knowledge through relatives or friends of cases sexual abuse (handling) by professionals. Similarly, the younger they are uncomfortable

answering questions on his private life for the development of the medical record, such as, having gone through the experience of an abortion, the status of partner, or if you are alone.
Although the majority believes that government services do not provide good care, many participants felt they received very good attention at the IMSS [social security]. They also felt that going at a particular time is no guarantee of receiving better care.
The strategies proposed by the group of young women to improve access and quality of health services were:
• The outpatient services to reach the neighbourhood and provide their services there, as once did the DIF,
• When your doctor may need to spend more time with a patient,
• Let them know exactly what you have,
• Friendly reception staff and
• That in general the personnel address the population with respect, to be more sensitive, more accessible one.

DISCUSSION

To conclude, it should be said that the more recent developments of fertility in Mexico, even if they seem surprising at first sight, have already been experienced in other societies, industrialized as well as less developed. One should expect that the perception of teen pregnancies as a problem increase, only for its magnitude. Moreover, we will find more and more young mothers in the poorest groups. The initiation of the active sexual life remains a field of opportunity for research, public policy and NGO's. The absence of contraceptive use represents a risk factor, as well for the reproductive health of the Mexican young people, as for their life in a couple, which they often entered because precisely of an unprotected sexual intercourse, sometimes the first one. It is very alarming that a third of the girls states not to have used contraception by ignorance.
The results that emerged from the research project, "Identification of barriers to bridging the gap between health needs and reproductive health services", provide many starting point for building policies, programs and interventions that will facilitate women's access to services for sexual and reproductive health.

The beliefs about sexual and reproductive health that women shared in this research show the importance of working from the psychosocial level with the population for further progress towards the full enjoyment of sexual and reproductive rights. The beliefs

expressed in relation to open sexual expression, infidelity in the couple, the role of reproduction in women’s life and the appropriate age to start it, show that even if Mexican society has changed, there are still stereotypes and practices that limit women’s development.

The experiences of women with pregnancy show that the terms have been used to describe pregnancies, including "unplanned" and "unwanted", are limited in reflecting a reproductive reality both subjective and complex. The results of this investigation call the health sector to take greater steps to ensure that every child born is a desired child, as stated in the Program of Action of the Fourth International Conference on Population and Development (UNFPA, 1996, para 6.6). These measures include: informing the population about preventive care before pregnancy and address the public health problem that unsafe abortion represents. Care during pregnancy, including childbirth and puerperium should also be strengthened within a framework of respect for gender equity and human rights.

The results of this study confirm the impact of family planning programs in Mexico, however, also warn about the barriers, both cultural and material found along the road. It also confirms that both methods and human beings are fallible and that there will always be unintended pregnancies. Despite this, the health sector has an obligation to inform the public about the different contraceptive methods available and ensuring their availability, making use of innovative strategies for this purpose.

Uncertainties that women have showed in this investigation in terms of sexually transmitted infections refers to the need to disseminate information to all people - men, women, single, married, young adults - about transmission routes and forms of prevention.

Beyond the issue of pregnancy, contraception and STIs, women expressed doubts about other issues of sexual and reproductive health, for example, menstruation and spontaneous abortions. These questions highlight the importance of working on access to information, lay and scientific on sexuality and reproduction from the education sector.

The ways in which women reported that they share and find information on sexual and reproductive health show the lack of official sources and the importance of social networks. Innovative dissemination strategies under specific programs in this field such as caravans and mobile units, represent a breakthrough in this regard.

The experiences that women reported having in sexual and reproductive health services show that major gaps still exist, requiring an immediate remedy to ensure the full exercise of sexual and reproductive rights of the population. These shortcomings are varied and some are structural. In addition to mainstreaming a gender perspective, a reconceptualization is required to put the users –male and female- at the center of attention, in a rights framework.

The sexual abuse that women have been reported in this research is alarming and refers to the importance of encouraging change in the patterns of violence as well as strengthening the prevention and detection strategies undertaken by public institutions, including the Ministry of Health .

This work has outlined the path towards the construction of policies, programs and interventions for sexual and reproductive health of women, from the stories themselves. The experiences and practices that have been organized should be used to form the guidelines for the elaboration of prevention activities and promotion of sexual and reproductive health in Mexico to undertake any of the public institutions of this country.

References

AMUCHÁSTEGUI, A. (2005). Saber o no saber sobre sexo: los dilemas de la actividad sexual femenina para jóvenes mexicanos. In: Szasz, I., Lerner, S. (Editoras). *Sexualidades en México.* Mexico City, El Colegio de México, p. 107-135.

AMUCHÁSTEGUI, Ana (2001), *Virginidad e iniciación sexual, experiencias y significados*, Mexico City, EDAMEX / Population Council.

ATKIN, Lucille *et al.* (1998), "Sexualidad y fecundidad adolescente" in: Ana LANGER et Kathrin TOLBERT (eds.), *Mujer: sexualidad y salud reproductiva en México*, Mexico City, The Population Council / Edamex,.

BOBADILLA, José Luis, SCHLAEPFER, Lorraine and ALAGÓN, Javier (1990), "Family Formation Patterns and Child Mortality in Mexico", *Demographic and Health Further Analysis Series* **5**.

Cámara de Diputados del H. Congreso de la Unión. (2007). Ley General de Acceso de las Mujeres a Una Vida Libre de Violencia. Consulted november 22, 2008 at: www.cddhcu.gob.mx/LeyesBiblio/pdf/LGAMVLV.pdf.

CASTRO, R., ERVITI, J. (2003). La violación de derechos reproductivos durante la atención institucional del parto: un estudio introductorio. in: López, P., Rico, B., Langer, A., Espinosa, G. (Editoras). *Género y Política en Salud*. Mexico City, Secretaría de Salud, p. 255-273.

ECHARRI CÁNOVAS, Carlos Javier (2003), *Hijo de mi hija… estructura familiar y salud infantil en México*, Mexico City, El Colegio de México.

ECHARRI CÁNOVAS, Carlos Javier (2004), "La casada casa quiere. Un análisis de los patrones de residencia posterior a la unión de las mujeres mexicanas", in: Fernando LOZANO (Coord.) *El amanecer del siglo y la población mexicana (VI Reunión Nacional de Investigación Demográfica en México)*, Cuernavaca, Morelos, CRIM-UNAM / SOMEDE, pp. 325-350.

FIGUEROA PEREA, J.G., SÁNCHEZ OLGUÍN, V. (2000). La presencia de los varones en el discurso y en la práctica del aborto. *Papeles de Población* 25, 59-82.

Fondo de Población de las Naciones Unidas. *Programa de Acción de la Conferencia Internacional sobre la Población y el Desarrollo*.

GERONIMUS, Arline T. (1987), "On Teenage Childbearing and Neonatal Mortality in the United States", *Population and Development Review*, XIII, pp. 245-279.

Gobierno del Distrito Federal. (2007). *Gaceta Oficial del Distrito Federal* (No. 70). Mexico City, Distrito Federal.

GUZMÁN, José Miguel, HAKKERT, Ralph and CONTRERAS, Juan Manuel (2001), "II: La situación actual del embarazo adolescente y del aborto" in: José Miguel GUZMÁN, Ralph HAKKERT, Juan Manuel CONTRERAS and Martha FALCONIER DE MOYANO (2001), *Diagnóstico sobre Salud Sexual y Reproductiva de adolescentes en América Latina y el Caribe*, Mexico City, Fondo de Población de las Naciones Unidas.

HAKKERT, Ralph (2001) "VII. Consecuencias del embarazo adolescente" in: José Miguel GUZMÁN, Ralph HAKKERT, Juan Manuel CONTRERAS and Martha FALCONIER DE MOYANO (2001), *Diagnóstico sobre Salud Sexual y Reproductiva de adolescentes en América Latina y el Caribe*, Mexico City, Fondo de Población de las Naciones Unidas, pp. 143-180.

HOBCRAFT, John N., McDONALD, John W., and RUTSTEIN, Shea Oscar (1985), "Demographic Determinants of Infant and Early Child Mortality: A Comparative Analysis", *Population Studies*, **39**:363-385.

Instituto de las Mujeres del Distrito Federal. (2008, 27 de febrero). Anuncian Actividades Para Reconocer La Diversidad Familiar. *Boletín de Prensa*. Consultado el 23 de noviembre de 2008 en: www.inmujer.df.gob.mx.

Instituto de las Mujeres del Distrito Federal. (s/f). *Ley de Acceso de las Mujeres a Una Vida Libre de Violencia del Distrito Federal.* www.inmujer.df.gob.mx.

MENKES, Catherine and SUÁREZ, Leticia (2003), "Sexualidad y embarazo adolescente en México", *Papeles de Población*, Nueva época, Año 9, N° 35, pp.233-262.

MIER Y TERÁN, Marta and PARTIDA BUSH, Virgilio (2001), "Niveles, tendencias y diferenciales de la fecundidad en México", in: José GÓMEZ DE LEÓN and Cecilia RABELL (Coord.), *La población de México. Tendencias y perspectivas sociodemográficas hacia el siglo XXI*, Mexico City, Consejo Nacional de Población and Fondo de Cultura Económica.

RAMOS-LIRA, L., SALDÍVAR-HERNÁNDEZ, G., MEDINA-MORA, M.E., ROJAS-GUIOT, E., VILLATORO-VELÁZQUEZ, J. (1998). Prevalencia de abuso sexual en estudiantes y su relación con el consumo de drogas. Salud Pública de México, 40, 221-233.

RODRÍGUEZ, G. (s/f). Sexualidad, construcción social y conservadurismo. *Educación y Salud Sexual*. http://www.afluentes.org/documentos/construccion.doc

ROMÁN, Rosario, (2000), *Del primer vals al primer bebé : vivencias del embarazo en las jóvenes*, Mexico City, Centro de Investigación y Estudios sobre Juventud, Colección jóvenes, no. 9.

SCHLAEPFER, Loraine and INFANTE, Claudia (1996) "Patrones de inicio de la vida reproductiva: su relación con la mortalidad infantil y comportamientos reproductivos futuros", in: Teresa LARTIGUE and Héctor ÁVILA (eds.), *Sexualidad y reproducción humana en México*, Mexico City, UIA / Plaza y Valdés.

Secretaría de Salud del Distrito Federal. (2008). *Catálogo de Servicios 2008, Unidades Médicas Móviles.* www.salud.df.gob.mx.

SELMAN, Peter (2002), "El embarazo en la adolescencia, la pobreza y el debate de la seguridad social en Europa y en Estados Unidos", in: Cecilia RABELL ROMERO and María Eugenia ZAVALA DE COSÍO, *La fecundidad en condiciones de pobreza. Una visión internacional*, Instituto de Investigaciones Sociales, Mexico City, UNAM, pp.315-341.

STERN, C. (1995). Embarazo adolescente. Significado e implicaciones para distintos sectores sociales. *Demos*, No 8, p. 11-12.

STERN, C., FUENTES-ZURITA, C., LOZANO-TREVIÑO, LR., REYSOO, F. (2003). "Masculinidad y salud sexual y reproductiva: un estudio de caso con adolescentes de la Ciudad de México". *Salud Publica de México*, Vol. 45, supl 1, p. S34-S43

STERN, C., MENKES, C. (2008). Embarazo adolescente y estratificación social. In: I. Szasz and S. Lerner (Editoras), *Salud reproductiva y condiciones de vida en México, Tomo I*. Mexico City, El Colegio de México, p. 347-295.

STERN, Claudio (1997) "El embarazo en la adolescencia como problema público: una visión crítica", *Salud Pública de México*, Vol. 39, Núm. 2

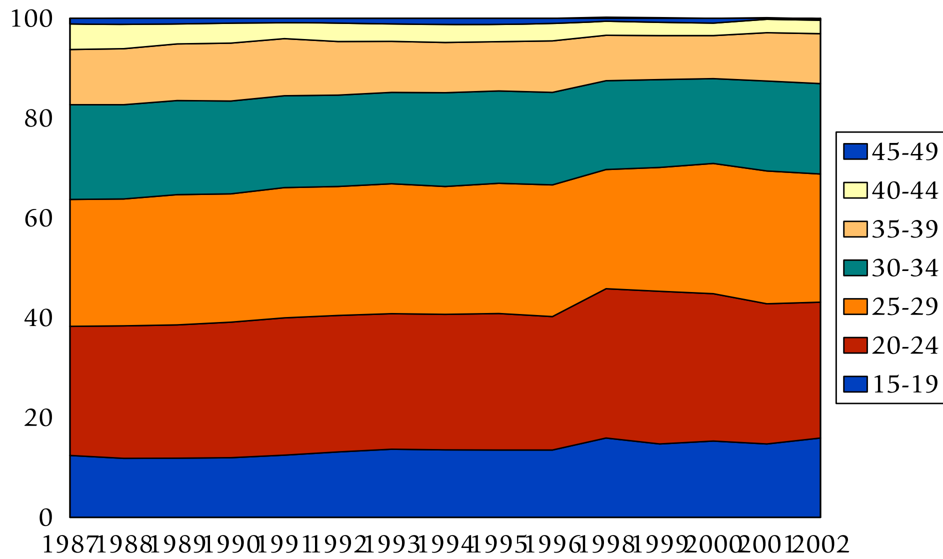
STERN, Claudio and GARCÍA, Elizabeth (1999), "Hacia un nuevo enfoque en el campo del embarazo adolescente", *Reflexiones: sexualidad, salud y reproducción*, Num. 13, Programa Salud Reproductiva y Sociedad, El Colegio de México, Mexico.

SZASZ, I. (2004). Las construcciones sociales sobre las relaciones de género y su influencia en las prácticas sexuales. *Género y Salud*, Vol. 2, No. 1, p. 3-5.

WELTI, Carlos (2000), "Análisis demográfico de la fecundidad adolescente en México", *Papeles de Población*, Nueva época, Año 6, N° 26.

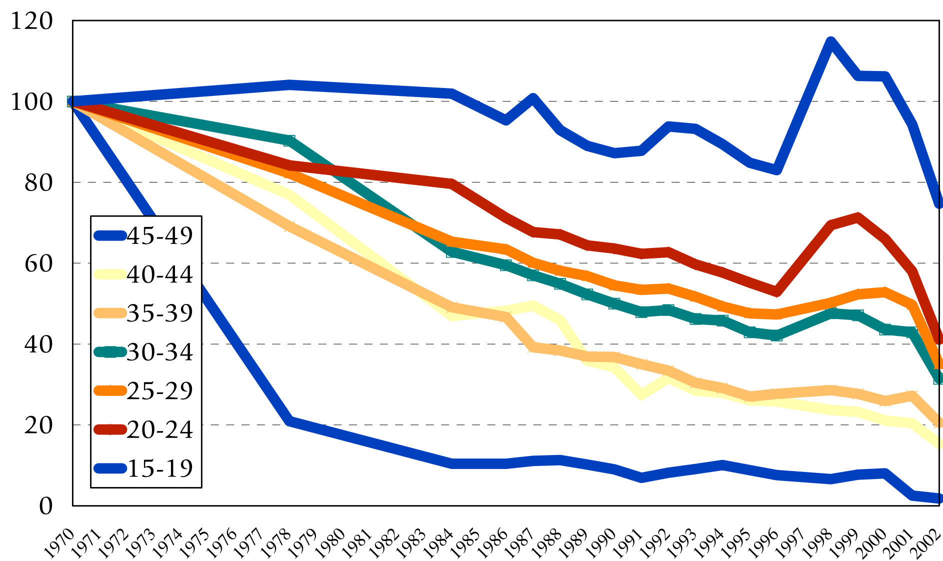
ZAVALA DE COSÍO, María Eugenia (2001), "La transición de la fecundidad en México", in: José GÓMEZ DE LEÓN and Cecilia RABELL (Coord.), *La población de México. Tendencias y perspectivas sociodemográficas hacia el siglo XXI*, Mexico City, Consejo Nacional de Población and Fondo de Cultura Económica.

Figure 1: Mexico: age distribution of fertility rates, 1987-2002



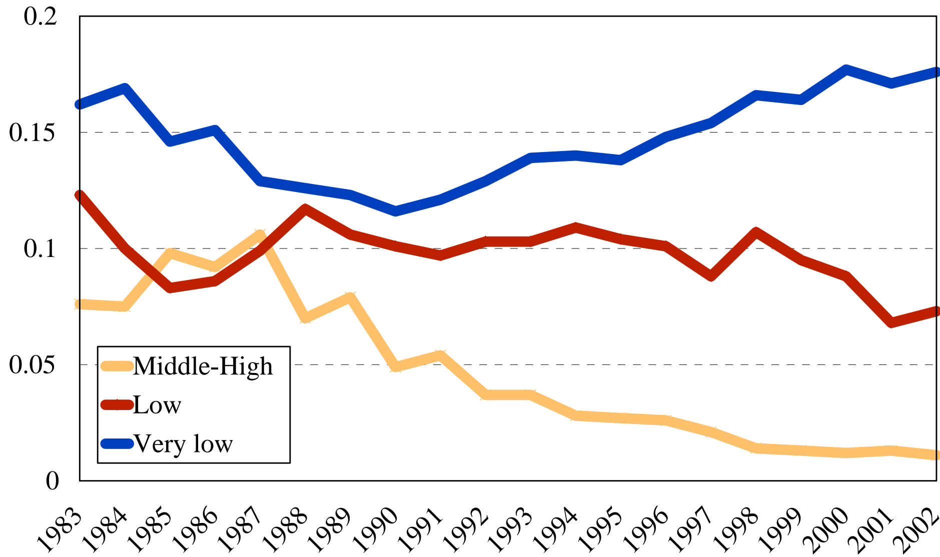
Source: ENADID 1992, ENADID 1997, ENSAR 2003

Figure 2. Mexico: recent evolution of age specific fertility rates



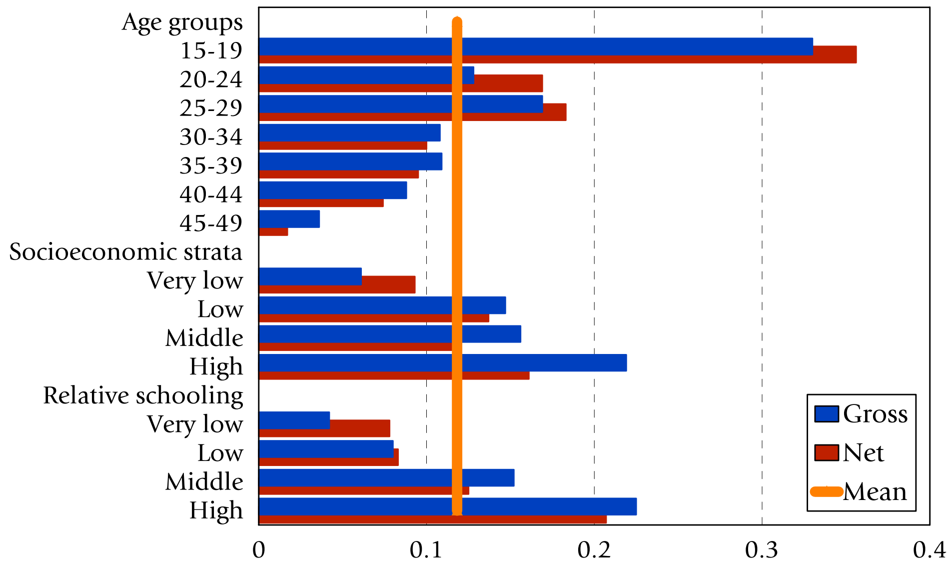
Source: INEGI, ENSAR 2003

Figure 3: Mexico: recent evolution of adolescent fertility rates by SES



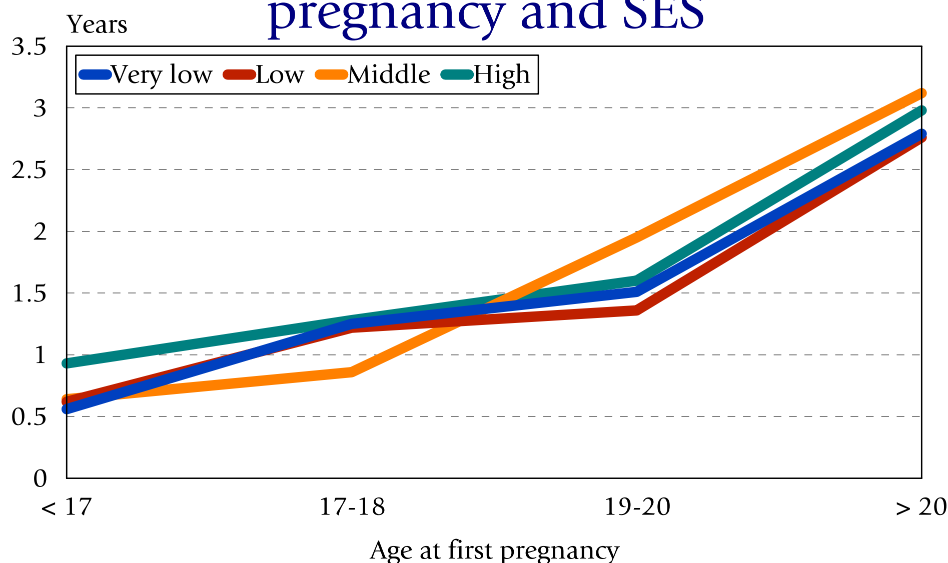
Source: ENSAR 2003

Figure 4: Effects of age, SES and schooling on contraceptive use on the first intercourse



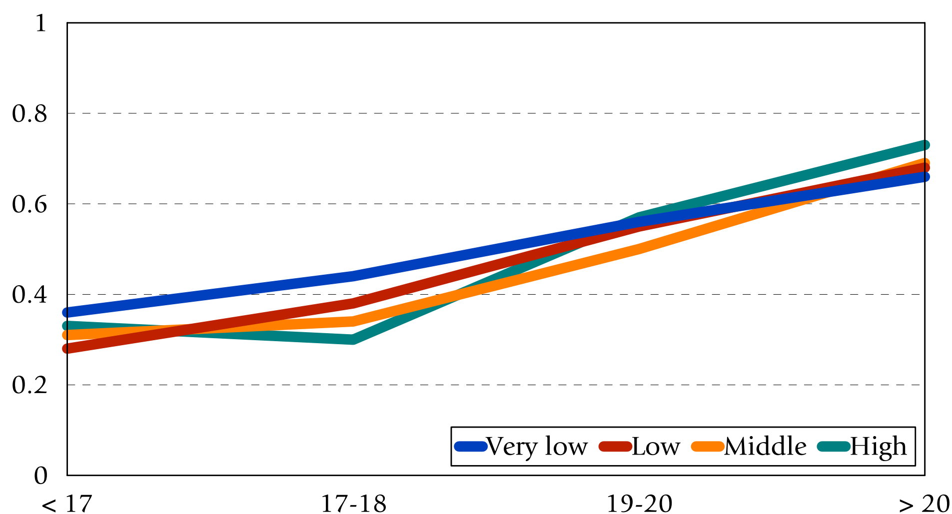
Source: ENSAR 2003

Figure 5: Age difference between first pregnancy and first intercourse by age at first pregnancy and SES



Source: ENSAR 2003

Figure 6: Proportion of women who wanted a baby at the time of first pregnancy by age at first pregnancy and SES



Source: ENSAR 2003