Original articles

Challenges in preventing a subsequent pregnancy in adolescents: perspectives of adolescents' mothers

Retos en la prevención del embarazo adolescente subsiguiente, un estudio desde la perspectiva de madres adolescentes

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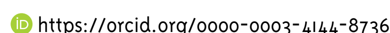
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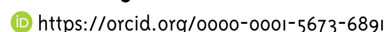
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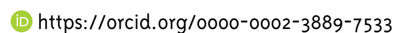
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Abstract

This article presents the result of a qualitative evaluation of the actions that the public health services develop for the prevention of subsequent adolescent pregnancies in a state in north-central Mexico. The objective was to document the perceived obstacles to preventing subsequent teenage pregnancies in teenage mothers. The information was obtained in the period 2016-2018, by individual interviews in the homes of young users of public health services. The analysis of the information was based on Strauss and Corbin's proposal for the grounded theory. The experiences shared by the young mothers were analyzed and classified into two categories, obstacles associated with: (1) professional competences, and (2) with moral imagery. It is concluded that the most important limitations are related to the fact that the strategy of adolescent friendly services is no longer implemented in those who have been mothers, without considering the biological and psychosocial impact that subsequent pregnancies have in adolescence and the need to delay reproduction until adulthood.

Keywords: Pregnancy in Adolescence; Tertiary Prevention; Adolescent; Qualitative Research.

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Resumen

El presente artículo expone el resultado de una evaluación cualitativa sobre las acciones que los servicios públicos de salud desarrollan para la prevención de embarazos subsiguientes en adolescentes, en un estado en el centro-norte de México. El objetivo fue documentar los obstáculos percibidos para prevenir embarazos subsiguientes en madres adolescentes. La información se obtuvo entre 2016-2018, mediante entrevistas individuales en los domicilios de jóvenes usuarias de servicios públicos de salud. El análisis de la información se hizo a partir de la propuesta de Strauss y Corbin para teoría fundamentada. Las experiencias compartidas por las jóvenes madres fueron analizadas y clasificadas en dos categorías, obstáculos asociados a: (1) competencias profesionales, y (2) a imaginarios morales. Se concluye que las limitaciones más importantes tienen que ver con el hecho de que la estrategia de servicios amigables para adolescentes deja de implementarse en aquellas que han sido madres, sin considerar el impacto biológico y psicosocial que tienen los embarazos subsiguientes en la adolescencia y la necesidad de postergar la reproducción hasta la edad adulta.
Palabras clave: Embarazo en la Adolescencia; Prevención Terciaria; Adolescente; Investigación Cualitativa.

Introduction

In Mexico, as in most of Latin America and the Caribbean, adolescent pregnancy (AP) represents one of the most important public health challenges, given its biological and psychosocial impacts (UNFPA, 2016). In the biological field, because of its close link to maternal mortality and extreme prematurity (Silva et al., 2018); in the psychosocial field because of its close relation to school dropout, the insertion of young mothers into precarious employment and in general the contribution of the above to the feminization of poverty (Medina; Ortiz, 2018).

Policies aimed at containing AP require addressing the problem at three levels of prevention: **primary prevention**, to avoid the experience of a first pregnancy; **secondary prevention**, to reduce the biopsychosocial risks associated with AP in this specific population; and, last but not least, **tertiary prevention**, to prevent subsequent pregnancies and reduce as much as possible the biopsychosocial risks associated with early motherhood (Rodríguez, 2012).

Regarding the relevance of incorporating tertiary prevention in the approach to AP, it is important to remember that the importance of promoting intersectoral strategies to prevent subsequent pregnancy in adolescents, as well as the need to ensure that girls and adolescents have access to “prenatal, childbirth and postpartum care, access to contraceptive methods, protection and assistance measures and justice” was noted in Montevideo Consensus on Population and Development (CEPAL, 2013, p. 9). Despite this exhortation, most of the effort of States around the world has been focused on primary prevention, including educational strategies about integral sexuality and empowering human resources in health to intervene in counseling from “friendly” approaches (WHO, 2012, p. 56).

Little attention has been given, however, to secondary and tertiary prevention, particularly the prevention of subsequent pregnancies, understood as those new pregnancies, which take place one or two years after a first abortion or birth in an adolescent (Escobar, 2006) and which imply an even greater threat to the development and social well-being of young women. It has been documented that, in the biological setting, the second child of a

teenage mother faces twice the risk of intrauterine growth retardation and three times the probability of developing neonatal death (Mendoza; Arias; Mendoza, 2012). In the psychosocial field, subsequent pregnancy is positively correlated with early marriage, which increases women's vulnerability to situations of domestic violence (Baldwin; Edelman, 2013; Rosas et al., 2017).

The arrival of a second or third child in adolescence often surpasses the resources of support networks to ensure the permanence of young mothers in educational spaces, resulting in school dropouts (Villalobos et al., 2015). Adolescents with intergenic periods under 24 months are also more likely to have a bad delivery and postpartum problems than when they became mothers for the first time (Gonzales, 2016) and are more than twice as likely to have educational lags as those who had only one pregnancy (Binstock; Cerrutti, 2005).

In the context mentioned above, and although the reason why the States emphasize more the primary prevention actions may be due to the fact that these imply less budgetary investment. It is possible that the absence of actions aimed at tertiary prevention was based on moral representations, values and social norms that, based on the stigma historically built about adolescent mothers, discourage the continuity of counseling and "friendly" accompaniment in this group (Núñez; Ayala, 2012). The fact that policies in Mexico and in Latin America in general are decided within conservative societies should not be underestimated (Benavides; Delclós; Consol, 2018).

This study documents the experiences that a group of teenage mothers have had regarding the prevention of subsequent pregnancies in the Mexican context, where since 2015 the *Estrategia Nacional para la Prevención del Embarazo Adolescente* (ENAPEA - National Strategy for the Prevention of Teenage Pregnancy) is implemented, a policy by which the Mexican State seeks, until 2030, to reduce by 50% pregnancies in adolescents between 15 and 19 years old, and to eradicate pregnancy in girls under 15 years old (MÉXICO, 2015).

ENAPEA has 18 lines of action, only one of which is aimed at the tertiary prevention of teenage pregnancy. The three activities included in this line are described in Table 1.

Table 1 – Activities aimed at tertiary prevention of adolescent pregnancy (prevention of subsequent pregnancies)

1. To strengthen the quality of counseling and the supply of post-event obstetric contraceptive methods for adolescents at the first and second levels of care.
2. Reinforce postpartum family planning counseling to teenage mothers when they attend the well-baby check-ups at the first level care.
3. Incorporate contraceptive counseling during prenatal care for adolescents into clinical practice guidelines for pregnancy and postpartum care, with emphasis on the advantages of spacing pregnancies and privileging free choice by offering the full range of methods, including LARC.

Within this framework, the objective of this research was to evaluate qualitatively the obstacles perceived by a group of teenage mothers regarding the actions that public health services implement to prevent subsequent teenage pregnancies.

Methodology

Qualitative evaluation from the perspective of young people. Qualitative evaluation makes it possible to collect information, and this process initiates reflexive and emancipatory processes in which people take on part of the social processes and of government and public policies that frame their daily lives. It makes it possible to generate conditions that contribute to social justice (Peñaranda, 2015). The youth perspective explains how power relations limit the autonomy of young people in the exercise of their rights - in this case, particularly their sexual rights - based on a structural element such as age (Ramiro; Alemán, 2016).

During 2016-2018, we worked with adolescent mothers in two of the municipalities with the

highest adolescent pregnancy rate in a state in north-central Mexico. The informants were 12 young women contacted via PROMAJOVEN, a social support program that provides educational scholarships for pregnant adolescents or young mothers, in order to prevent them from dropping out of school. The reason for working with young people in this program is that it concentrates a considerable number of adolescent mothers, in addition to the fact that invite them via the program gave them the confidence to participate in the research.

Information was collected by individual interviews, non-participatory observation and notes in field diaries, which made data triangulation possible (Angrosino, 2012, p. 61). Participating and non-participating observation was carried out in two of the meetings offered by PROMAJOVEN every six months. The first meeting was attended anonymously with the aim of documenting what was discussed there, as well as the dynamics that the young women experienced at these events. At the second meeting, the researchers introduced themselves, the young women were informed about the study that would be carried out, and they were invited to participate in it. The researchers wanted to ensure that the information about the project was concise, avoiding information that would allow potential informants to assume what the researchers were trying to find.

The young women were visited in their homes in order to obtain informed consents and to adhere to national and international ethical and legal standards in health research. The study was considered of minimum risk - as established by the General Health Law of Mexico - and had the approval and monitoring of the Ethics Committee of the *Facultad de Enfermería y Nutrición de la Universidad Autonóma de San Luis Potosí* (registration CEIFE-2017-223).

A field diary was created both in the forums and in the interviews. The purpose was to record the methodological and theoretical issues that arose in each meeting and that served in the analysis stage to interpret and construct the data. The individual interview was carried out based on a semi-structured script that was constructed from the actions established by ENAPEA for the health sector, specifically regarding tertiary prevention.

Based on the criterion of theoretical saturation, it was determined pertinent to suspend the collection of information after interview number twelve, once the information became redundant and the relationships between the categories of analysis based on constant comparison were well established to guarantee the internal logic of the data. The interviews were recorded and completely transcribed with the support of the Otranscribe program. The transcripts were analyzed, coded and categorized based on Strauss and Corbin's proposal (Strauss; Corbin, 2002). The triangulation of the identified categories was carried out, with consensus on the logic of the categories and their relationships among all the members of the research team. The relationship matrices between the categories were based on theoretical and conceptual arguments specific to tertiary prevention.

Results

Characterization of the reporting population

The average age was 17 years old. 83.3% lived in a consensual union and 16.4% were separated from their children's fathers. 41.6% had completed basic education, 50% were in secondary education and 8.3% were in high technical education. Regarding their reproductive history, 9 (83.3%) were mothers of one child, 2 (16.6%) had two children and 1 (8.3%) was in the second pregnancy. The young women who had more than one child as well as the pregnant woman had suspended their studies.

In women who had more than one child or were currently pregnant, the period between each pregnancy was an average of 14 months. At the time of the interviews, 91.6% reported having some method of Family Planning (FP), of these, 9 (75%) used the subdermal implant, 1 (8.3%) Copper IUD and 1 (8.3%) Hormonal IUD, 1 was not using a method because she was pregnant.

The experiences shared by the young mothers were analyzed and classified into three categories, obstacles associated with: (1) professional skills, (2) institutional policies and (3) moral imagery.

Obstacles associated with professional skills

We identified that all participants were uncertain about the risks involved in a subsequent teenage pregnancy. Although they reported being told to not become pregnant again, when girls looked more deeply into the awareness they had developed about the risk involved, none of them could describe the undesirable events (biological or psychosocial) associated with a second adolescent pregnancy.

> *In the appointment they told me* [medical and nursing staff] *that it was very dangerous, they explained to me the age of the pregnancy or something like that, that I should have been pregnant I think when I was twenty-one [years old], they told me that I was at risk, they put me in the red, "pregnancy at risk" something like "high risk," then they told me that it was very dangerous for me to become pregnant like that so soon... I don't know exactly what could happen, but they did tell me it was a risk.* (Interviewee no. 6)

The postponement of a new pregnancy is seen more as a prescription than as an informed decision that young women have to make. Narratives such as the one above were common and reflect not only a lack of risk awareness but also the lack of competence of health professionals to communicate obstetric risk to this specific population.

On the other hand, it was identified that while most of the informants were using a long-acting reversible contraceptive method at the time of the interviews, most of them said they were not sure, convinced or satisfied with the method implemented. In addition, more than half reported having accepted the insertion of a method they had not chosen and most were dissatisfied with the method used.

Another relevant finding is the fact that the contraceptive method these young women choose initially is strongly influenced by the experiences they hear from other women close to their social network, within a reality in which counseling is not addressed within prenatal appointments. All informants reported having "accepted" the implantation of a contraceptive method in the delivery room or during their postpartum stay, experiencing physiological and emotional conditions that did not allow them to understand the advantage of one method over another.

In line with the above, the perceived attitude towards the performance of health personnel in the delivery or postpartum room was more narrated as an act of coercion and routine than of counselling. This is shown in the following narrative:

> *Well, they* [nurses] *just came and told me they were going to take care of me, and they were coming all the time, and talking about the arm implant, and they came again and asked me the same thing, and again, and again, but they didn't tell me anything else about the implant, until they came and told me "We're going to put the implant in," and nothing else, they didn't mention anything to me, about how to take care of the implant or anything else like that.* (Interviewee no. 8)

Obstacles associated with institutional policies

The goal with adolescent women who have been mothers should not be limited to the placement of long-acting reversible contraceptives (LARC) and, although of course it is a huge advance, the focus should be on offering counseling that considers the scenarios to protect against the possibility of a subsequent pregnancy.

Counseling based on an intercultural "friendly" model should incorporate adolescent mothers and be applied as part of their follow-up in the late postpartum period and in appointments for monitoring the growth and development of their children. However, it was identified that a lack of follow-up and counseling prevails after the insertion of the method, and that the monitoring of the IUD or subdermal implant in this population is done exactly the same way and with the same regularity as it is done in an adult woman, who, it is worth mentioning, does not face the same reproductive risk as an adolescent.

The following narrative shows how young women are instructed to return to health services when they fell some "change," in programs that do not recognize the importance of continuous counseling for this specific population.

> *Yes, they told me* [medical and nursing staff] *to go every three years, they gave me a pass to have it removed and to have another one implanted* [subdermal implant] *so I didn't go to get checked... they just implanted it and told me to come back after three years, it would be changed, and they just gave me the pass.* (Interviewee no. 3)

The "friendly" services for adolescents appear, according to the narratives of these informants, applied only to young people who have not been mothers. It is based on conceptions lacking in intercultural support, a gender and youth perspective, impeding the recognition that young women who have been mothers require the same attention given to girls who does not have children, they need follow-ups and care based on the sensitivity and empathy that characterize "friendly care."

The absence of conditions – derived from the "friendly care" policy – discourages these women from approaching health services, as shown in the following narrative:

> [Are you going to check your implant at the health center?] *Yes, they told me* [medical and nursing staff] *to go there every year, I have to go there until December... I have to go there at six o'clock in the morning to get my card to be attended, here at the health center, because they say that supposedly after this time they stop attending, because the cards finish.* (Interviewee no. 7)

Young women are not accompanied in expressing doubts or dissatisfaction with the method, which results in their premature renunciation of the method, or in resigning themselves to living the experience of its use in a framework of uncertainty and discomfort, which makes them to live the contraception more as a sacrifice than a right.

Adolescent girls face other situations that make it difficult for them to access services, many having to decide between going to school or seeking professional advice in the face of secondary reactions to the methods, and this is particularly serious for those who also have insufficient support networks. Another limitation concerns the fact that in Mexico, "friendly counselling" services do not have an infrastructure with toys or spaces where children can go during mother's appointments, since this model of friendly care does not consider the demand for care by adolescent mothers.

> *I didn't want to go anymore, because I am alone with my daughters, it happens often because they used to make the appointment for me and my children together. I have a little girl and one a little smaller and I couldn't, I held one of them while they examine the other and when they went to examine me, I didn't have anybody to hold them both. That's the reason.* (Interviewee no. 6)

In addition to the above, it is necessary to highlight the difficulties faced by health personnel to establish a therapeutic relationship that is not only "friendly" but also assertive and respectful with young women. Several girls reported giving up follow-up visits for their children because they felt mistreated by public health service personnel.

> *I took the child to a private* [doctor]*, because there was a doctor who used to criticize me, that I do not do this or that for my child, so she used to scold me, I say there are ways of saying things, then she could tell me, don't look at this and this, like this, like that, but no, what she did was scold me and scream at me.* (Interviewee no. 9)

Obstacles associated with moral imagery

Other narratives that predominated are those that show the persistence of moral imagery that directly or indirectly supports forms of discrimination perceived by young mothers. The action of health personnel in front of a pregnant adolescent is framed in a paternalistic position that rebukes or demands an explanation of the reasons for their pregnancies establishing itself as a barrier for professional-user communication.

> *There were times when* [doctors] *said to me, "Why didn't you take care of yourself? You are very young, at the moment you are relieved, but they will tell you about the risk." I would say "Oh well, what can I do? Before, they did not tell me anything about it and*

> *see what is happening right now! I already have a child. What can I do now? I can't turn back time."* (Interviewee no. 10)

The young women point out that the actions of the staff are violent sometimes, in the search to force them to protect themselves against the possibility of new pregnancies.

> *Well, people used to look at me because I was bringing the girl when a boy from there* [does not know if a nurse, doctor or promoter] *approached me and said "This is for you to take care of yourself," he gave me the condoms, I felt strange because people ... everybody turned to look at me.* (Interviewee no. 8)

Furthermore, health personnel often talk to the parents and not to the girls for the authorization to use long-acting reversible contraceptive method.

> *At that time* [medical, nursing and social work personnel] *told me they were put it on me* [the IUD], *that it was mandatory for me to use it because I was a minor and my mom had decided, and yes, my mom was the one who authorized the method to be used, but I also agreed to use it, I did not refuse.* (Interviewee no. 7)

Discussion

The purpose of this investigation was to evaluate the obstacles perceived by a group of adolescent mothers about the actions that the public health services implement for the prevention of subsequent pregnancies. The first to be mentioned is that this research recovers the perspective of a group of informants whose sociocultural characteristics, - poverty, low schooling and formalization of life as a couple -, have been documented as an aggravating vulnerability for subsequent pregnancies (Jiménes; Granados; Rosales, 2017). However, they are still immersed in the school system, in school or early learning centers, which has been recognized as a protective factor against initial and subsequent adolescent pregnancy (Aléman; Insfrán; Castillo, 2018).

Considering the sociodemographic characteristics of the informants, it was particularly interesting to report a close link between being mother of more than one child or having a second gestation and giving up the educational project. It supports the hypothesis presented by other authors that having more than one child in adolescence increases the possibility of not completing studies (Barros, 2019). On the other hand, since most of them were living with a partner, it challenges the assertions that have been made that early unions discourage the continuity of the educational project for young mothers (UNFPA, 2016). While it supports the argument that other authors developed that, when resources are available, the couple is present and there are no family conflicts arising from the pregnancy situation, early motherhood does not represent a risk for the continuity of social and school development (Pacheco, 2016).

The number of participants is insufficient to discuss statistical trends on acceptance and use of long-acting reversible contraceptives (LARC) following an obstetric event in adolescent women. However, it is pertinent to recognize that more than 90% reported their use, a number high than referred in the latest National Health and Nutrition Survey in Mexico (MÉXICO, 2012), which reported its use in just 48%, or those mentioned in the National Survey of Demographic Dynamics (CONAPO, 2016) which reported its use in just 35.2% of young people with subsequent births and 30.9% of those with only one birth report.

In the previous context, it is necessary to hypothesize that this high percentage of use is related to the fact that a quarter of the informants at the time of the interview were mothers of more than one child or were in the process of a second pregnancy. This situation could raise awareness (among them and/or the health professionals) about the urgency of providing young women with this type of method.

The results obtained in this research coincide with those indicated by Zamberlin et al. (2017), concerning the implicit weaknesses in the work related to contraception with adolescents, including aspects related to the need to strengthen both professional and ethical-moral competencies in

health personnel, as well as the recognition there are areas of opportunity in health and institutional policies to ensure that young women have real access to health services.

This research documented the absence of comprehensive sexuality counseling for the prevention of subsequent pregnancies, showing how the participation of health personnel is limited to "prescribing" a contraceptive method and, with this, even a life project. On this last point, the healthcare team convince young mothers to accept the implantation of some contraceptive device, pointing out the impudence of having more children at the moment. Although there is no doubt that the purpose of use an ARAP method is a benefit, it cannot be ignored that this prescriptive and even routine practice (as perceived by the users) is exercised more as a policy of birth control than as a guarantee of their right to live a full, dignified and responsible sexuality, as established since the 1990s at the International Conferences of Vienna, Cairo and Beijing (Valenzuela; Villavicencio, 2015).

The participation that the young women have in deciding about the method is practically nil, and they are not certain about the reasons why a second adolescent pregnancy is inadvisable. This last point constitutes a risk, since they have been pregnant and have given birth, they have subjected themselves to this risk and survived. This situation leads them to the construction of a positive perspective on the experience (since they did not die) and can generate what in risk anthropology is called **subjective immunity**, a kind of feeling of confidence that makes it impossible for a person to understand the real dimension of a dangerous situation (Douglas, 1982). The risk of an adolescent pregnancy may seem lower to them and discourage the implementation of strategies needed to avoid it.

Although adolescents are familiar with the term "risk" and say they recognize that a new pregnancy would be a "condition of risk," they consciously fail to objectify the consequences that a new pregnancy and birth may have, the illnesses and causes of death associated with it, and even less the social risks that derive from it for their present and future.

This research documented how the prenatal monitoring stage constitutes a "lost opportunity" to sensitize and inform them about reproductive risk in adolescence, as well as the role that contraception has in reducing this risk, a situation that was documented by Zamberlin et al. (2017). In relation to the above, it is necessary to point out the role that health personnel are expected to play in communication about risk, not only to communicate to young women the high probability of negative results, but also to inform them about strategies to reduce risks, which include the use of contraceptive methods. Only by approaching risk from these two angles (risk communication and information about protection strategies) is it possible to promote the development of an attitude in the face of risk, understanding this from the framework of Giddens (1986, p. 9, our translation), as an action that "implies performing" in the body and through the body, and not only having the "intention to do."

To speak about procedure implies deconstructing the action that health personnel have historically carried out in matters of family planning, as well as assuming the need for counseling intervention and abandoning the "prescription" of family planning methods. It is important the presence of a professional participation that recognizes that the accompaniment that the young women need cannot be based exclusively on the biology. It must be based on the recognition of the socio-cultural conditions that prevail in the contexts in which these young women (and their partners) live their sexuality. This recognition requires, as Gómez et al. (2017) have pointed out, deconstructing the idea that age is a condition for the use or non-use of some methods and accepting that there is no a contraceptive method **ideal for adolescents**. While recognizing that LARC methods guarantee more lasting and effective protection, in addition to avoiding subjecting adolescents to the management of a protective method in each sexual encounter, the main weakness associated with LARC methods derives from the fact that they lead young women to disregard the need to use barrier methods during sexual intercourse and thus be more susceptible to contagion of a Sexually Transmitted Infection (STI) (Raidoo et al., 2020).

The therapeutic relationship that is desirable in terms of family planning counseling – from a

youth perspective – should be offered within an environment that provides information with respect to personal autonomy. A place where the young woman is encouraged to question and argue her fears and reasons for choosing or not choosing a method, ensuring at all times that the information returned to these users is based on scientific evidences. Only by having the above as a preamble will it be possible for young women to develop and take care of their sexual and reproductive lives.

In seeking advice on the most appropriate method, health professionals should consider not only its effectiveness, but also the conditions available to young women to comply with its proper use, their resilience in tolerating or coping with the side effects, and the strategies available to them to solve its economic, symbolic and social cost (Sam et al., 2014). All of the above, recognizing that some methods are socially represented as undesirable in relation to women's morality, integrity and honesty (Solís; Silva, 2017).

Another area of opportunity identified in this research involves the follow-up of adolescents once they have accepted the application of a contraceptive method, which becomes important because of their state of maturity (physical and psychosocial), they are considered in a **very high reproductive risk**.

This research documented that even when young women are mostly users of long-acting contraceptive (LARC) methods, they accept the implantation of these devices without guaranteed access to counseling programs and professional accompaniment in adapting (or not adapting) to the method. There are several limitations to this, including administrative and structural issues. As to administrative limitations, the hours of operation are often incompatible with their stay in the school system, and it is noted that the "friendly approach" in counselling is limited exclusively to young women who are not mothers yet, a situation that was also documented in Rojas Ramírez et al. (2017). Regarding infrastructure limitations, the literature indicates that "friendly services" guarantee that the therapeutic encounter takes place in an atmosphere of intimacy, confidentiality and free of interruptions. However, it was identified that these "friendly services" are not guaranteed for adolescents who are mothers, since the centers do not have spaces appropriated to their children while the young women access appointment services.

This research has also documented the persistence of discriminatory behavior by health personnel, which, according to current legislation in Mexico and international human rights treaties, constitute actions that violate sexual and reproductive rights (Taquette, 2013). The story of encounters with health personnel who, in a paternalistic manner, judge, recriminate and demand an explanation about the sexual life of girls, constitutes one of the strongest barriers to therapeutic communication, since it is perceived as violent.

Finally, the fact that staff continue to view young women's sexuality as a matter of parental choice is in contrast to what has been proclaimed about the autonomy of adolescent girls in matters of sexuality and reproduction. Narratives were recurrent showing the continuous and systematic violation of their sexual and reproductive rights, which is particularly serious in a country that only in 2013 signed the Montevideo Consensus on Population and Development, an international instrument that recognizes (for the first time) sexual rights as human rights in Latin America (LA) and the Caribbean (CEPAL, 2013).

Final considerations

The exposed results derive from a rigorous approach from the methodological point of view, looking for evidences from different origins that have made possible the triangulation and validation of the obtained data. However, the results should not be generalized because the study took place in urban municipalities and including only young people who are still in the education system (in schools and early learning centers).

This research documents the existence of a series of limitations for the prevention of subsequent pregnancy in adolescent mothers who receive support to continue in the educational system. Among these limitations are those that derive directly from how institutional policies are implemented, from the competencies that health professionals must implement in the

"friendly care" and from the moral imagery that these professionals also have. The convergence of the aforementioned limitations leads to the fact that these young women, although most of them are protected through the use of a contraceptive method, make use of it from an experience framed in a lack of knowledge, dissatisfaction and convenience, which does not contribute to their sexual and reproductive empowerment.

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Authors' contribution

González Nava proposed the original idea and with Rangel Flores built the research protocol. Nava carried out the interviews, and the analysis was carried out under the supervision of Rangel Flores. Hernández Ibarra contributed to the design and implementation of the qualitative methodology. All contributed to the theoretical discussion of the results and to the preparation of the scientific article.

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