Adolescent Pregnancies in the Amazon Basin of Ecuador

- a rights and gender approach to girls’ sexual and reproductive health

Isabel Goicolea
2009
ABSTRACT

Adolescent pregnancy has been associated with adverse health and social outcomes, but it has also been favorably viewed as a pathway to adulthood. In Ecuador, where 20% of girls aged between 15-19 years get pregnant, the adolescent fertility rate has increased and inequalities between adolescent girls from different educational, socio-economic levels and geographical regions are prominent: 43% of illiterate adolescents become pregnant compared to 11% with secondary education. The highest adolescent fertility rates are found in the Amazon Basin.

The overall aim of this study was to explore adolescent pregnancy in the Amazon Basin of Ecuador (Orellana province) from a rights and gender approach. Specific aims and methodologies included: to explore women’s reproductive health situation, focusing on government’s obligations, utilization of services, inequities and implementation challenges, assessed through a community-based cross-sectional survey and a policy analysis (Paper I); to examine risk factors associated with adolescent pregnancy, through a case-control study (Paper II); to explore experiences and emotions around pregnancy and motherhood among adolescent girls, using content analysis (Paper III); and to analyze providers’ and policy makers’ discourses on adolescent pregnancies (Paper IV).

Reproductive health status findings for women in Orellana indicated a reality more dismal than that depicted in official national health data and policies. Inequities existed within the province, with rural indigenous women having reduced access to reproductive health services. In Orellana, 37.4% of girls aged 15-19 had experienced pregnancy, almost double the national average. Risk factors associated with adolescent pregnancy at the behavioral level included early sexual debut and non-use of contraception, and at the structural level poverty, having suffered from sexual abuse, and family disruption. Gender inequity played a key role through the machismo-marianismo system. Girls were raised to be fearful and ignorant regarding sexuality and reproduction, to be submissive and obedient, to be fatalistic, and to accept the established order of the male and adult dominance. Sexuality was conceptualized as negative, while motherhood was idealized. Those gender structures constrained girls’ agency, making them less able to make choices regarding their sexual and reproductive lives. Providers’ discourses and practices were also strongly influenced by gender structures. Adolescent sexuality was not sanctioned, girls’ access to contraceptives still faced opposition, adolescent autonomy was regarded as dangerous, and pregnancy and reproductive health issues were conceptualized as girls’ responsibility. However, mechanisms of resistance and challenge were also found both among adolescent girls and providers.

Programs addressing adolescent pregnancies in the area need to look at the general situation of women’s reproductive health and address the gaps regarding access and accountability. Adolescent pregnancy prevention programs should acknowledge the key role of structural factors and put emphasis on gender issues. Gender inequity affects many of the factors that influence adolescent pregnancies; sexual abuse, girls’ limited access to use contraceptives, and girls’ curtailed capability to decide regarding marriage or sexual intercourse, are strongly linked with young women’s subordination. By challenging negative attitudes towards adolescents’ sexuality, the encounter between providers and adolescents could become an opportunity for strengthening girls’ reproductive and sexual agency.

Key words: adolescent pregnancy; adolescent motherhood; reproductive and sexual health; right to health; gender relations; gender structures; Ecuador; Amazon; sexuality; agency.
SUMMARY IN SPANISH

Embarazos y maternidades adolescentes en la Amazonía ecuatoriana

- explorando la salud sexual y reproductiva de las adolescentes desde un enfoque de derechos y género

Las investigaciones sobre embarazos en la adolescencia arrojan resultados contrapuestos: mientras algunos estudios ponen de manifiesto las consecuencias negativas de estos embarazos para la salud y condiciones de vida de las adolescentes, otros destacan las conceptualizaciones positivas de este evento como puerta de entrada al mundo adulto. En Ecuador el 20% de las adolescentes se embarazan antes de cumplir los 20 años, la fecundidad adolescente- al contrario que en el resto de edades- ha aumentado durante los últimos años y existen marcadas inequidades según niveles educativos, socio-económicos y áreas geográficas: por ejemplo, mientras el 43% de las chicas en situación de analfabetismo se embarazan durante la adolescencia, sólo el 11% de las que acceden a educación secundaria lo hace. En lo que respecta a las áreas geográficas, la tasa de fecundidad adolescente más elevada se registra en la región Amazónica.

El objetivo general de este estudio fue explorar los embarazos adolescentes en la Amazonía ecuatoriana (provincia de Orellana) desde un enfoque de derechos y género. Los objetivos específicos y las metodologías utilizadas se detallan a continuación:

- Artículo I: Analiza la situación de la salud reproductiva de las mujeres, contrastando las obligaciones estatales enunciadas en políticas y planes, con el acceso y utilización real de servicios, las inequidades observadas y los desafíos para fortalecer la implementación de las políticas existentes. Para esto realizamos un sub-estudio de corte transversal basado de la comunidad y posteriormente los resultados de la situación local se contrastaron con las políticas nacionales y estadísticas oficiales, utilizando un instrumento para análisis de políticas de salud- HeRWAI o Health and Rights of Women Assesment Instrument [Instrumento para Análisis de Salud y Derechos de las Mujeres].

- Artículo II: Evalúa los factores de riesgo para embarazarse durante la adolescencia a través de un estudio de casos y controles. Los casos y controles se seleccionaron en las comunidades participantes en el estudio de corte transversal anteriormente mencionado y la asociación entre embarazo en la adolescencia y diferentes variables se analizó con regresión logística condicional.

- Artículo III: Explora cualitativamente las experiencias y emociones que rodean el embarazo y la maternidad durante la adolescencia. Para este estudio se analizaron entrevistas individuales con once adolescentes embarazadas o madres viviendo en la provincia de Orellana, utilizando análisis de contenido.

- Artículo IV: Analiza los discursos sobre embarazos en la adolescencia de tomadores de decisión y proveedores de servicios de la provincia de Orellana. Para ello realizamos análisis de discurso de seis grupos focales y once entrevistas individuales, identificando “interpretative repertoires”.


Los resultados del estudio de corte transversal evidencian que la situación de la salud reproductiva de las mujeres en Orellana es peor de lo que reflejan las estadísticas nacionales y de lo que establecen los planes y políticas. La prevalencia de atención calificada del parto y de uso de anticonceptivos modernos es muy inferior a las medias nacionales, pero además dentro de la provincia existen marcadas desigualdades: las mujeres indígenas que viven en la zona rural son las que menos acceso tienen a servicios de salud reproductiva y esto se refleja en porcentajes elevados de embarazos no deseados (43,6%) y muy bajo acceso a atención calificada del parto: entre 2002 y 2006 sólo el 15% de esos partos fueron atendidos por personal calificado.

En lo que respecta a los embarazos en adolescentes, 37,4% de las adolescentes entre 15-19 está o ha estado alguna vez embarazada, frente al 20% de media nacional. Algunos de los factores que elevan el riesgo de embarazarse durante la adolescencia para las chicas de Orellana, como el no uso de anticonceptivos durante la primera relación sexual y el inicio sexual temprano, podrán calificarse como conductuales. Sin embargo, los otros tres factores de riesgo -la pobreza, el abuso sexual durante la niñez y adolescencia y la ausencia de padre y madre durante prolongados periodos de tiempo- pertenecen al espectro de los factores estructurales, sobre los que la adolescente apenas puede influir.

Las desigualdades de género juegan un papel clave a través del sistema de machismo-marianismo. Así, las chicas crecen en un ambiente que las disciplina hacia la sumisión, la obediencia, la resignación y la aceptación del orden establecido, donde son los hombres y los adultos quienes ejercen el poder. Para las mujeres jóvenes la sexualidad es satanizada, mientras que la maternidad se idealiza; un reflejo del síndrome de la virgen María o marianismo que establece para las adolescentes un estándar imposible de alcanzar. Estas estructuras de género limitan fuertemente la agencia de las adolescentes, y dificultan que estas puedan tomar decisiones libres con respecto a su sexualidad y reproducción.

Los discursos de prestadores de salud y tomadores de decisiones también están fuertemente influenciados por las estructuras de género. Sus discursos, por un lado, construyen la sexualidad de los adolescentes como fuente de problemas y enfermedades, mientras, por el otro, les limitan el acceso a anticonceptivos a través de mensajes ambiguos, privilegiando así la abstinencia como mejor opción. Estos discursos construyen la autonomía de los y las adolescentes como un riesgo y focalizan las responsabilidades en relación al embarazo, parto y salud reproductiva en las adolescentes mujeres. Sin embargo, tanto entre las adolescentes como entre los proveedores, van apareciendo actitudes de resistencia e incluso desafío hacia esas estructuras de género imperantes: la crítica abierta frente a las normas discriminatorias contra estudiantes embarazadas, por parte de algunos/as profesores/as, y el interés de las adolescentes embarazadas y madres por continuar sus estudios y tener independencia económica, son dos ejemplos de que hay cambios gestándose.

Los programas dirigidos a la prevención de embarazos adolescentes en esta área del Ecuador se beneficiarían de una mirada general a la situación de la salud reproductiva de las mujeres para explorar las formas de reducir las inequidades de acceso a servicios y fortalecer los mecanismos de rendición de cuentas de las políticas de salud sexual y reproductiva. Sería importante también tomar en cuenta la enorme influencia de los factores estructurales y las desigualdades de género en las decisiones reproductivas de las adolescentes. En ese sentido los programas no deberían sólo enfocarse en tratar de modificar las conductas sexuales de las adolescentes, sino en fortalecer el sistema de protección de la salud de las adolescentes y en influir positivamente en los determinantes sociales de su salud. Este estudio
refuerza la tesis de que las desigualdades de género juegan un papel clave en los embarazos en la adolescencia: el abuso sexual, la capacidad de acceder y usar anticonceptivos, el poder de decidir sobre cuándo y con quien tener relaciones sexuales o casarse y la capacidad de superar experiencias adversas dependen mucho de la posición que las mujeres jóvenes ocupan en esta sociedad y de las normas y expectativas bajo las que estas establecen relaciones sociales. El papel de los y las proveedores de servicios para adolescentes es clave. Si se reconstruye críticamente la manera en que actualmente se están estableciendo las relaciones entre las adolescentes y los proveedores, estos encuentros podrían transformarse de espacios de paternalismo y desaprobación en oportunidades para fortalecer la agencia y autonomía de las adolescentes.
ORIGINAl PAPERS

The thesis is based on the following papers:


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# GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Accountability</td>
<td>The process that enables right-holders to assess how duty-bearers have</td>
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<td></td>
<td>discharged their obligations, and provides duty-bearers with the opportunity</td>
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<td></td>
<td>to explicate the level of progress achieved.</td>
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<tr>
<td>Adolescent fertility rate</td>
<td>Number of births per 1000 women aged 10-19.</td>
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<td>Adolescent pregnancy</td>
<td>Any pregnancy from a girl who is aged 10 to 19.</td>
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<td>Adolescent-friendly services</td>
<td>Health services that are relevant to the health needs of adolescents and</td>
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<td></td>
<td>that are accessible and acceptable to them.</td>
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<tr>
<td>Agency</td>
<td>The capability to act, to make choices and make a difference.</td>
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<tr>
<td>Case-control study</td>
<td>An epidemiological study in which subjects are selected on the basis of</td>
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<td></td>
<td>having (cases) or not having (controls) an outcome. In this study it refers</td>
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<tr>
<td></td>
<td>to cases and controls being selected according to either having experienced</td>
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<tr>
<td></td>
<td>(cases) or not (controls) adolescent pregnancy.</td>
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<tr>
<td>Content analysis</td>
<td>A qualitative methodology that seeks to interpret the manifest and the</td>
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<td></td>
<td>underlying meaning of a text.</td>
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<tr>
<td>Cross-sectional study</td>
<td>Epidemiological study that measures selected health indicators at a</td>
</tr>
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<td></td>
<td>particular point in time in a well-defined population.</td>
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<tr>
<td>Discourse analysis</td>
<td>An analysis of people’s accounts as constructing reality, the way people</td>
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<td></td>
<td>make sense of those accounts and the possible consequences of that.</td>
</tr>
<tr>
<td>Freedom</td>
<td>The right and power to control one’s health and life.</td>
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<tr>
<td>Gender</td>
<td>In this study, Connell’s definition was followed: “The structure of social</td>
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<td>relations that centers on the reproductive arena, and the set of practices</td>
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<td></td>
<td>(governed by this structure) that brings reproductive distinctions between</td>
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<td></td>
<td>bodies into social processes.” (Connell, 2002)</td>
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<tr>
<td>Gender based violence</td>
<td>Encompasses acts of physical, sexual or psychological harm or suffering to</td>
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<td></td>
<td>women based on their gender, or any violence that affects women</td>
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<tr>
<td></td>
<td>disproportionately (WHO, 2005).</td>
</tr>
<tr>
<td>Gender order</td>
<td>The gender pattern of a society on a wider scale (Connell, 1987; Connell,</td>
</tr>
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<td></td>
<td>2002).</td>
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<tr>
<td>Gender regimes</td>
<td>The gender arrangements of institutions such as health services, schools or</td>
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<td>companies (Connell, 1987; Connell, 2002).</td>
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</table>
Gender structures | The extensive patterns among gender relations that are arranged around four dimensions: power relations, production relations, emotional relations and symbolic relations (Connell, 1987; Connell, 2002).

Interpretative repertoires | Clusters of meaning that people use to build their own arguments in a way that they find sensible (Winther Jørgensen & Phillips, 2002).

Intimate partner violence against women | Acts of physical, sexual or psychological harm or suffering to women inflicted by current partners or ex-partners (WHO, 2005).

Machismo | A cult around masculinity that emphasizes the notion of men as sexually-driven and in need of exercising domination and which strongly influences gender relations in the Latin American context.

Marianismo | Represents a cult around virginity and motherhood that idealizes the figure of the Virgin Mary as a model of chastity, submission and sacrifice for women, and that highly influences gender relations especially in the Latin American context.

Policy analysis | The study of the nature and development of a policy, its implications, level of implementation and consequences.

Reproductive health | At the International Conference of Population of Development it was defined as: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes […] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.” (United Nations, 1994)

Right to health | The approach that considers the achievement of the highest attainable standard of health as a fundamental human right of all individuals and encompasses states’ responsibilities in taking appropriate measures to ensure it.

Sexual health | In this study, Paul Hunt’s definition was used: “The state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity; […] requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.” (Hunt & Bueno de Mesquita, 2006)

Social determinants of health | The social conditions under which people live that affect their health.
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INTRODUCTION

This thesis explores adolescent pregnancies\(^1\) in the Amazon Basin of Ecuador (Orellana province) from a rights and gender approach, looking at the connections between adolescent pregnancies and girls’ sexual and reproductive rights.

Getting pregnant during adolescence is a common experience for many girls, especially if they live in a low income country. It is estimated that in low income countries where 90% of all adolescent pregnancies occur, one out of three girls gets pregnant before the age of 20 (Mayor, 2004). In Latin America, around 20% of girls get pregnant during adolescence, with the highest proportions in Central American countries. The mean adolescent fertility rate for Latin America is 76 births per 1000 girls aged 15-19 (UNFPA, 2008) and differences between countries and regions are wide; while countries such as Cuba show an adolescent fertility rate of 47, countries such as Guatemala and Nicaragua exceed 100. Despite the decline in total fertility rates for all Latin American countries since the 1970s, adolescent fertility rates follow a different trend: declines are not so pronounced, and some countries are even experiencing an increase during the last years: for example Colombia, where the adolescent fertility rate has increased from 84.4 in 1995-2000 to 90 in 2005. Inequities within countries are prominent: the adolescent fertility rate is higher in rural areas, among girls with lower levels of education, and among girls from poorer households (Guzman \textit{et al}., 2001; MSP, 2007a).

Adolescent fertility rates are higher among girls than among boys, an indication that many offspring from adolescent mothers are fathered by an adult (Guzman \textit{et al}., 2001; MSP, 2007a). Even if the adolescent fertility rate is the most commonly used indicator for assessing the prevalence of adolescent pregnancy, it does not show the entire picture, since some pregnancies might end in abortion. In Latin America, the abortion incidence ratio for girls 15-19 is 28 per 100 live births (Shah & Ahman, 2004), and since abortion remains illegal in most Latin American countries, unsafe abortions are common. Adolescents tend to seek less-qualified practitioners and resort to later abortions, consequently the risk of complications and mortality is higher among this group (Munasinghe & van den Broek, 2005).

Adolescent pregnancies have been associated with adverse social and health outcomes for both mother and children (Guzman \textit{et al}., 2001; UNFPA, 2007). In fact, pregnancy and childbirth related complications are the leading causes of death for girls aged 15-19, meaning that 70,000 adolescent girls die each year from those causes (Mayor, 2004). However, pregnancy during adolescence can also be perceived as a positive experience, as many qualitative studies point out. It can be conceptualized as an entry to adulthood, a way for gaining status, or even an escape from abusive families (Clemmens, 2003; Spear & Lock, 2003).

Contrary to what happens in the USA or Europe, a high proportion of adolescent pregnancies in Latin American countries are labeled as “wanted” (Guzman \textit{et al}., 2001). In countries where adolescent fertility is high (like El Salvador, Paraguay, Ecuador, Guatemala, Honduras and Nicaragua) the percentage of births from adolescent mothers that are labeled as “wanted” exceeds 70% (Guzman \textit{et al}., 2001).

\(^1\) In this thesis adolescent pregnancies refer to pregnancies of girls aged 10-19, following the WHO definition. The author is aware that this is a simplification that overlooks aspects such as: the diversity of experiences; the different definitions of adolescence according to various national legislations; the differences between early, middle and late adolescence; and the difference of the construction of adolescence across societies and cultures.
Another feature of adolescent pregnancies in Latin America is that many pregnancies take place within formal unions, where girls might face higher constraints in negotiating safer sex (Bruce & Mensch, 1999; Guzman et al., 2001; Pons, 1999; Raguz, 2001; UNFPA, 2007).

Image 1. Adolescent mother and her baby at a sex education event in Coca.

Structure of the thesis

The first part of the thesis describes the situation of adolescent pregnancies in Latin America, drawing on research coming from countries within this region and on the situation of policies and programs regarding adolescent pregnancy and adolescents’ sexual and reproductive health and rights. After this contextualization, the conceptual framework in which the thesis is based will be presented. The rights approach to sexual and reproductive health and the gender approach will first be described, alongside the gaps and links between the two, and how this conceptual framework can be useful for exploring adolescent pregnancies.

The second part of the thesis focuses on the original research carried out in Orellana province. The aims and specific objectives, alongside the methods used, the ethical considerations carried out, and the main findings emerging from this research are described.

The discussion section follows, and here the findings are located within the conceptual framework of rights and gender, looking at aspects of agency-freedom, entitlements, gender regimes and gender order in connection with adolescent pregnancies and girls’ sexual and reproductive health and rights in Orellana.

The thesis ends with some conclusions and implications for practice and for further research.
Locating myself
During my eight-year period of work in Orellana, I came across adolescent pregnancies in different scenarios. Since I was in charge of a sexual and reproductive health and rights program funded by the United Nations Population Fund (UNFPA) in this area, adolescent pregnancy was an issue included at sex education programs and training curricula of health providers. While visiting communities, I noticed there were many adolescent girls pregnant or mothering children. Every now and then there were complaints from girls who had been banned from schools because of their being pregnant and complaints from teachers who felt that “since we [the teachers] started talking about sexuality, more and more girls are getting pregnant”, and, what seemed more striking to me: several of the young female health promoters, despite having all the information available and easy access to contraceptives, became pregnant or got married before 20. It looked as if more in-depth knowledge regarding adolescent pregnancies was needed to improve the work we were doing.

My personal engagement with UNFPA’s mission of promoting reproductive and sexual rights, and the obvious connection between adolescent pregnancies and the sexual and reproductive health and rights of adolescent girls, made me choose the rights approach. The acknowledgment that the extent of sexual and reproductive rights exercise is modulated by gender relations was the rationale behind including a gender perspective as well.

Studies on adolescent pregnancies in Latin America
There is a huge amount of research around adolescent pregnancies, the majority based on the USA and Europe where the issue has received significant political attention. Regarding Latin America, published research on adolescent pregnancies is not so profuse. The majority of articles come from Brazil, take a biomedical perspective, look at adolescents from a risk approach, conceptualize adolescent pregnancy as problematic, and are based in big cities and health facilities.

Literature from Latin America evidences that when pregnancy occurs among adolescents younger than 15, the risk of negative reproductive outcomes increases, including maternal mortality (Conde-Agudelo et al., 2005; Simoes et al., 2003). A large study by Conde-Agudelo investigating more than 800,000 deliveries in Latin American hospitals, states that while adolescent mothers face increased risk of adverse outcomes, such as postpartum hemorrhage, and puerperal endometritis, they are also at lower risk of third-trimester bleeding and gestational diabetes when compared to older women (Conde-Agudelo et al., 2005). Despite some contradictory findings, researchers also tend to agree that babies born from adolescent mothers face a higher risk of infant mortality, low birth weight, and premature delivery (Conde-Agudelo et al., 2005; de Silva et al., 2001; García et al., 2008; Machado, 2006; Vigil-De Gracia et al., 2007). However, some studies also argue that the negative outcomes associated with adolescent pregnancy can be prevented if appropriate care is provided (de Silva et al., 2001).

The social and economic consequences of adolescent pregnancies have not been explored sufficiently. Researchers point out that negative outcomes may depend on the socio-economic condition of families and other contextual factors and not on the mother’s young age (Esteves & Meira, 2005). Despite the
common perception of adolescent mothers as being unprepared for adequately raising their children, the scarce research available points out that adolescent mothers are, in fact, supportive of their babies (Bergamaschi & Praça, 2008).

The factors that have most consistently been associated with adolescent pregnancies are the dropping-out of school and poverty (Dias & Aquino, 2006; Florez, 2005; Flórez & Soto, 2008; Gigante et al., 2008; Gogna et al., 2008; Guzman et al., 2001; Molina et al., 2004; Pereira et al., 2002; Sant’Anna et al., 2007; Zelaya, 1999). However, it still remains unclear whether they are causal factors or consequences of adolescent pregnancies.

Other factors that have been associated with adolescent pregnancy in certain Latin American settings include family factors, such as lower parental education, being the daughter of an adolescent mother, living with siblings from different fathers (Gigante et al., 2004; Sant’Anna, et al., 2007), and a lack of communication and affection within the family (Guijarro et al., 1999). Within the area of reproductive and sexual behavior, early sexual debut (Gigante et al., 2004; Sant’Anna et al., 2007), and inconsistent use of contraceptives (Almeida et al., 2003; Flórez & Soto, 2008; Sousa & Gomes, 2009) have also been associated with adolescent pregnancies.

The high prevalence and hazardous effects of intimate partner violence against women during pregnancy have been well documented in Latin America (Valladares, 2005; WHO, 2005). Regarding adolescent pregnancies, there is increasing evidence worldwide, and also from some Latin American settings, of the association between sexual and/or physical abuse during childhood and intimate partner violence, with an increased risk of unsafe sexual behavior and adolescent pregnancy (Noll et al., 2009; Olsson et al., 2000; Pallitto & Murillo, 2008).

While the information presented above comes from quantitative studies, findings from qualitative studies exploring adolescent pregnancy and motherhood in different settings in Latin America stress the heterogeneity of experiences (dos Santos & Schor, 2003; Gontijo & Medeiros, 2008; Hoga, 2008), and show that girls mainly experience pregnancy as negative and stressful (Brandão & Heilborn, 2006; Moreira et al., 2008), while motherhood bears positive connotations. Motherhood is conceptualized as an entrance to adulthood, as an opportunity to gain status, to belong to a family or to escape from abusive relatives. It can also become a way of showing commitment to a partner, and a rite of passage opposed to external stigmatization (de Carvalho, 2007; de la Cuesta, 2001; Folle & Geib, 2004; Levandowski et al., 2008; McCallum & Reis, 2005). The ambivalence of feelings regarding pregnancy and motherhood, and the relevance of gender inequity and structural factors, such as poverty is also highlighted (Berglund et al., 1997).

There are not many articles exploring or evaluating initiatives related to adolescent pregnancies in Latin America. Congruently with research in other parts of the world, one article from Argentina shows that pregnancy and motherhood could become a good opportunity to promote healthy behavior among adolescents (Gogna et al., 2008). Even if there are no conclusive findings, it is assumed in the research that providing support to adolescent mothers, through the family or integral health services, could improve the quality of life of those girls and their babies (de Silva et al., 2001; Oliva et al., 2008; Sant’Anna et al., 2007).
Reproductive and sexual health services and sex education are perceived as essential for adolescent pregnancy prevention (Molina et al., 2004). However, the approaches differ considerably. There are researchers that present the positive outcomes of abstinence-only education programs in Chile (Cabezon et al., 2005; Vigil et al., 2005), despite the less promising results that those programs have showed elsewhere (Franklin & Corcoran, 2000; Santelli et al., 2006; Thomas, 2000). Other authors support a more comprehensive approach, stressing the need to increase contraceptive access (Gogna et al., 2008; Gomes et al., 2008; Meuwissen et al., 2006), and address gender power imbalance (Gogna et al., 2008).

**Policies and programs on adolescent pregnancies in Latin America**

During the last ten years, adolescents’ health has been receiving increased attention in the public health agendas of Latin American countries. Most of these countries have adopted Codes or Laws for Children and Adolescents, in line with the Convention of the Rights of Children (UN, 1989) and a number of them have promulgated Youth Laws which, in selected cases, explicitly include young people’s right to information and access to reproductive and sexual health services. Some of those Youth Laws specify the illegality of any form of discrimination against pregnant girls, like expelling them from school. There are even countries with special laws focusing on adolescent mothers, such as the “Ley General de Protección de la Madre Adolescente”[General Law for the Protection of the Adolescent Mother], in Costa Rica (UNFPA, 2005a).

Regarding policy implementation, adolescents’ reproductive and sexual health programs have emerged in Latin America during the last five years, which is relatively recent. In the majority of countries, those programs are led by the Ministries of health, with some degree of coordination with the Ministries of education and civil society organizations. Differentiated health services for adolescents only exist in certain places in certain countries. Where they exist, unwanted pregnancy is one of the most frequently cited themes during counseling (Nirenberg et al., 2002; Schutt-Aine & Maddaleno, 2003; UNFPA, 2005a; UNFPA, 2005b). Apart from the initiatives coming from the public sector, in many Latin American countries there are social networks that focus on adolescent pregnancy prevention and the provision of support for adolescent mothers and their children (Nirenberg et al., 2002; Schutt-Aine & Maddaleno, 2003; UNFPA, 2005a).

Regarding sex education, there are policies, plans and programs in certain countries, although the degree of implementation is not clear. Approaches vary from the most conservative ones - such as Chile - , to the most progressive - such as Uruguay. Many programs focus on secondary education, even if a large number of adolescents do not reach that level. Sex education programs for adolescents that are out-of-school are mostly developed by non-governmental organizations (UNFPA, 2005a; UNFPA, 2005b).

Despite all these advances, the United Nations Committee for the Rights of Children has expressed worries regarding the high prevalence of adolescent pregnancy in many Latin American countries. The Committee highlights that adolescents’ access to sexual education and reproductive services remains inadequate (UNFPA, 2005a). The Cairo+10 evaluation made by the Latin American and Caribbean Demographic Centre and United Nations Population Fund, has recommended that the region should make available adequate sexual information for adolescents, provide differentiated adolescent-friendly services...
with well-trained health professionals, and implement specific actions for adolescent pregnancy prevention and in support of adolescent mothers (UNFPA & ECLAC, 2004).

Following these recommendations, the ministries of health of the six countries of the Andean sub-region - Chile, Bolivia, Peru, Ecuador, Colombia and Venezuela - signed a resolution in 2007 to develop the Andean Plan for Adolescent Pregnancy Prevention. The main objective of the Plan is to contribute to enhancing adolescents’ access to health services by promoting reproductive and sexual rights, social equity and gender equity, with an intercultural and social participatory approach. Four strategic lines and specific objectives for each of them have been established (MSP, 2007a):

- Information, monitoring and evaluation systems. Aimed at developing a situation analysis of adolescent pregnancies in the Andean sub-region.
- Institutional strengthening and horizontal technical cooperation. Aimed at the implementation of health care services accessible by adolescents.
- Adolescents’ participation. Aimed at promoting the participation of adolescents through exchange of experiences.
- Advocacy, alliances and social participation. Aimed at sensitizing authorities, mass media, health providers and civil society, regarding the importance of developing policies and actions for adolescent pregnancy prevention.

Both research and actions regarding adolescent pregnancies in Latin America are taking place at the moment. However, one of the limitations is the disconnection between research and programs on adolescents’ reproductive and sexual health (UNFPA, 2005a). The Andean Plan for Adolescent Pregnancy Prevention could be an opportunity to close this gap, since research and information production is contemplated within the planned activities (MSP, 2007a).

Despite the gained knowledge regarding adolescent pregnancies, there remain research areas that have received little attention. There are scarce studies based in rural areas and communities - instead of large city hospitals -, and few studies focus on groups expected to be living in vulnerable situations, such as refugees or girls living in isolated areas. Even if in other parts of the world there are authors that criticize the conceptualization of adolescent pregnancy as a social-health problem (Bonell, 2004; Breheny & Stephens, 2007; Macleod, 1999a; Macleod, 1999b; Wilson & Huntington, 2006), such critics are not so common in published research from Latin America, although there are some examples (Heilborn et al., 2007; Rodríguez Vignoli, 2008). Other limitations are the emphasis on the risk approach to adolescent
pregnancies, and the neglect of other alternative approaches, such as rights and gender approaches, which could be more holistic and positive (Berglund et al., 1997; Schutt-Aine & Maddaleno, 2003; UNFPA, 2005a).

This thesis explores adolescent pregnancies within the framework of adolescents’ sexual and reproductive rights and gender-power relations, based on the assumption that pregnancy, and motherhood, cannot be understood outside the wider area of girls’ sexual and reproductive health and rights. At the same time, girls’ sexual and reproductive decisions and actions take place within gender-power relations where girls’ choices are, most of the time, subordinated to others’ desires and needs. In the following section I explore more in-depth this conceptual framework, alongside its limitations and strengths for exploring adolescent pregnancies.
CONCEPTUAL FRAMEWORK

The rights approach to sexual and reproductive health

The rights approach to health

Health as a human right was first enunciated in the 1946 World Health Organization’s Constitution which states that: “Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity” (United Nations, 1976). During the following years, several conventions incorporated the right to health, but it was not until 1979 that women’s right to health was explicitly stated in the Convention on the Elimination of All Forms of Discrimination Against Women - CEDAW (Cabal & Todd-Gher, 2009; Cook, 1995; Radicic, 2008; Riedle, 2009; UN, 1979).

Recognizing health as a human right implies that every human being is free to make decisions that benefit his or her well-being, and that he or she is entitled to a system of health protection. Enjoying freedom is the individual’s right (right-holder), while ensuring a system of health protection is mainly the state’s responsibility (duty-bearer). The state’s responsibilities include not only the provision of an adequate array of health services, but also the reduction of inequities that limit the opportunities of certain groups and individuals to be healthy. Those factors that affect health beyond health care services have been called the “underlying determinants of health” or “social determinants of health”, and include aspects such as socioeconomic status or educational level. Freedoms and entitlements are closely connected, for example, if a woman wants an sterilization she needs to be free to get the procedure done without any constraints - such as the need for her husband’s consent or moralistic criteria from the doctor who have to perform the procedure -, but she also needs to have access to health services providing it (Braveman & Gruskin, 2003; Hunt, 2006; Hunt & Bueno de Mesquita, 2006; Riedle, 2009; Robinson & Clapham, 2009; UNHCHR & WHO, 2008; Yamin, 2008).

Agency, defined by Giddens as the capability to act is an important concept in the rights approach (London, 2008). For Giddens, agency refers to the power to intervene, to the individual’s capability of doing things, and making choices. Exercising agency could refer to doing an action but it could also include an abstention from action. By exercising agency individuals become able to influence structures (Giddens, 1984; Christianson, 2006). Individuals’ practices presuppose social structures, but at the same time structures always emerge from practice. The rights approach acknowledges the importance of individual agency for both exercising rights and ensuring governments fulfill their responsibilities, and some authors argue that understanding oneself as a right-holder entails a transformation of both personal empowerment and increased accountability of duty-bearers (Yamin, 2008). From my interpretation, freedom, within the rights approach to health, is not merely having the legal right to act in one way or another, but actually having the capability to act freely, to make decisions; it has much to do with agency.

Critics of the rights approach to health argue that the concept is too abstract and rhetorical and has achieved little (Batliwala, 2007; Braveman & Gruskin, 2003). However, the example of the fight for increased accessibility to antiretroviral drugs against HIV for impoverished countries is a practical achievement of the right to health movement (Yamin, 2008). Even if there are criticisms of the ethnocentrism of human rights (Batliwala, 2007; Hellsten, 2001), the right to health could be perceived as more culturally sensitive than the framing of other rights; for example, its holistic approach to health
remains in line with the indigenous concept of “good living” or “ally kawsay” (UNFPA, 2004). The emergence of collective rights, and the recognition of human rights not as a fixed but as a developing concept, is also an argument against the critics of the individualistic bias of the rights approach (Merry, 2001; Radicic, 2008).

The rights approach to sexual and reproductive health
Reproductive and sexual rights were incorporated as part of the right to health as recently as 1994, in the Cairo Conference of Population and Development (UN, 1994). Before Cairo, the focus was put on population control policies and demographic goals and not on reproductive and sexual health as a right of individuals (Cabal & Todd-Gher, 2009; Glasier & Gulmezoglu, 2006; Glasier et al., 2006; Petchesky, 2000). The change occurred alongside an increased recognition of the andro-centric bias of human rights, and the need to expand the human rights movement to include women’s experiences and to incorporate violations of rights that occurred specifically to women, such as war rapes or forced sterilizations, as human rights violations (Petchesky, 2000). This shift did not happen spontaneously but was the result of the struggle of the feminist and human rights movements, that successfully advocated the transformation of the population control perspective into a sexual and reproductive rights approach (Petchesky, 2000; Sen et al., 1994; Shalev, 2000).

In Cairo, reproductive health was defined as: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes […] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so” (UN, 1994). The definition of sexual health was much vaguer and almost subsumed into the reproductive health definition, as has been criticized afterwards (Shepard, 2000; Dixon-Mueller et al., 2009; Glasier et al., 2006; Hunt & Bueno de Mesquita, 2006). For this thesis I find the sexual health definition proposed by Paul Hunt and Bueno de Mesquita useful: “The state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity; […] requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence” (Hunt & Bueno de Mesquita, 2006:11).

Sexual and reproductive health care should include the promotion of healthy sexuality, maternal and infant health care, family planning (including infertility treatment), access to safe abortion, and prevention and management of sexually transmitted infections, HIV, cervical cancer, reproductive tract infections and other morbidities (Glasier et al., 2006). To those components proposed by Glasier et al, I would add the prevention and management of violence against women and sexual violence.
The rights approach to sexual and reproductive health should not only be limited to ensuring services for addressing those components, but it should also include the application of the human rights principles to sexual and reproductive health. That means that the exercise of sexual and reproductive rights depends on the individuals’ freedom-agency to control one’s health and body (Anand, 1994; Correa & Petchesky, 1994; Hunt & Bueno de Mesquita, 2006; Levison & Levison, 2001; Shalev, 2000). Genuinely free reproductive and sexual decisions need the presence of enabling conditions. From a rights approach this is understood as the state’s responsibility to provide access to a system of health protection that includes sexual and reproductive health services and a healthy environment regarding the social determinants of reproductive and sexual health (Correa & Petchesky, 1994; Gruskin, 2008; Hunt & Bueno de Mesquita, 2006; Shaw, 2006). For example, for a woman to enjoy a safe delivery she must be free to choose delivering with a skilled attendant, and this freedom is highly dependent on a gender-equal relationship with her husband, but she also must have access to a health service that offers delivery care 24 hours a day, 365 days a year, and in a way that is both of good technical quality and generally acceptable to her. Moreover, social determinants of health, like the level of education she was able to reach, the socioeconomic status of the household, and the gender order she has been raised in, might also reshape her chances of enjoying a safe delivery or risking death.

Sexual and reproductive health relates especially to social and economic rights, but civil and political rights are also involved- for example, the right to women’s autonomy, has been violated by regulations that criminalize abortion-, and defies the liberal distinction between positive and negative rights. From the rights approach, the state is not only responsible for not violating the rights of the individuals (the state’s responsibility to respect rights), but it is also responsible for protecting rights in public and private spaces,
and fulfilling rights. The state’s obligation to fulfill means that state’s role is not only to “neutrally” examine, judge and rule, but also to invest in services and to develop policies that support men’s and women’s capability to exercise and enjoy their right to health (Farmer, 2008; Farmer & Gastineau, 2002; Radicic, 2008; Riedle, 2009; UNHCHR & WHO, 2008).

Other important principles of rights concern health services’ characteristics. They should be accessible, available, acceptable, and of good quality (Braveman & Gruskin, 2003; Hunt & Bueno de Mesquita, 2006; UNHCHR & WHO, 2008). Accessibility issues are dependent not only on the availability of services, but on geographical distances, alongside other barriers such as costs or gender issues. Acceptability deals with cultural issues such as the language used and the way services and health providers approach the people they are supposed to serve. Good quality refers to both technical competence and fulfilling users’ criteria of good quality; for example, in the way the providers interact with them, waiting times, arrangements to ensure privacy or even the availability of female providers for performing certain gynecological procedures.

Accountability is also a relevant principle from the rights approach. It implies that states’ obligations do not end with signing a treaty, but they should take measures for achieving reasonable progress (Hunt & Bueno de Mesquita, 2006; London, 2008; Riedle, 2009; UNHCHR & WHO, 2008; Yamin, 2008). Part of those measures is ensuring resources for accountability mechanisms that allow citizens, and human rights bodies, to measure progress. Accountability is also closely related to the right of individuals to participate at all levels in the designing, planning and implementation of sexual and reproductive health policies and programs (Hunt & Bueno de Mesquita, 2006; Shalev, 2000). The principle of participation is both a right and a means for ensuring that actions and plans are relevant, and thus ensuring they have a greater impact (Sundby, 2006). Figure 1 shows a summary of some key principles of the rights approach to health.

Figure 1. Principles of the rights approach to health.

The gender approach

In this thesis a gender approach refers to being aware of three connected issues. The first issue relates to being aware of gender relations in this particular context where adolescent pregnancies and girls’ sexual and reproductive rights are explored. The second issue relates to being aware and making visible the
power imbalance within gender relations, and the consequences that this power imbalance - that benefits certain men and disadvantages most women - has for girls’ exercise of their sexual and reproductive rights. The last issue relates to exploring mechanisms and opportunities for enhancing girls’ agency and challenging gender structures that contribute to young women’s subordination.

Connell’s theorizing on gender relations has been particularly useful (Connell, 1987; Connell, 2002), alongside Fenstermaker and West’s concept of gender accomplishment (Fenstermaker & West, 2002). Connell defines gender as: “The structure of social relations that centres on the reproductive arena, and the set of practices (governed by this structure) that brings reproductive distinctions between bodies into social processes” (Connell, 2002:10). From this definition, gender relations imply a connection between social and natural structures, but it is not a causal connection: differences in the reproductive arena cannot explain, and even less justify, inequities. Connell, along with other authors, challenges the dichotomous division of sexes and genders, since sexual and gender practices face individuals with a wider diversity than the model that classifies humans into two sexes and two - or three - sexual orientations (Connell, 1987; Connell, 2002; DiPalma & Fergusson, 2006; Essed et al., 2005; Young, 2005). The dichotomous division between gender-social and sex-natural is also challenged, since sex - what society labels as male or female and under which premises - is also socially constructed (Connell, 1987; Connell, 2002; Fenstermaker & West, 2002; Harrison, 2006).

Gender is not a fixed category possessed or theatrically played by individuals but something under construction in relation to others at the individual level, institutional level, and social level. This concept of gender as something individuals do in relation with others leaves room for agency (Connell, 1987; Connell, 2002). Gender is not something imposed by external structures but something individual agents learn and do. However, agency is not exerted in a vacuum. There are gender regimes of institutions, and a gender order that influences individual practices (Connell, 1987; Connell, 2002). There is a connection between the gender relations at the individual level and the gender regimes and structures, and both influence each other: gender regimes and orders constrain, or enhance, individuals’ gender practices (Connell, 1987; Connell, 2002; Lorber, 2006). For example, the health services’ gender regimes that orient contraceptive services towards married women, may constrain unmarried young girls’ capability to have protected sexual intercourse. But also individuals (or groups of individuals) by their gender relations, might influence gender regimes and the gender order. However, the capability individuals have to influence structures might be much more limited than the other way round.

Gender is displayed through different dimensions of relations that are linked and contribute to women’s subordination. Connell recognizes four such dimensions: power relations, productive relations, emotional relations and symbolic relations (Connell, 1987; Connell, 2002). Sexuality and reproduction involve emotional relations, but the other dimensions are present as well; for example, how sexual intercourse may be used as a way of exercising power and control, how poverty and lack of access to paid jobs for women may force them into prostitution or marriage, and how symbolic constructions of virginity based on hymen integrity may influence sexual practices.

In the Latin American context, gender relations take place within the machismo-marianismo system, closely related with Connell’s concept of emphasized femininity (Berglund, 2008; Connell, 1987; Lagarde, 1990; Steenbeek, 1995; Stobbe, 2005; Torres et al., 2002). Machismo has been defined as a “cult around masculinity intrinsically related to power: the will and capacity to dominate others, men as
well as women” (Steenbeek, 1995:220), while marianismo emphasizes the notion of women as submissive, chaste, self-sacrificing, passive and modest, stressing the dangers of sexuality for women while, at the same time, idealizing motherhood (Berglund et al., 1997; Lagarde, 1990; Montecino, 1991; Torres et al., 2002).

Another important issue regarding gender relations at the individual, institutional and macro-social level, is that they are not static but historically and contextually bonded; moreover, they are subject to change (Connell, 1987; Connell, 2002). Changes might lead to the reinforcement of women’s subordination or might lead to stronger autonomy for women; for example, even in a rural impoverished area as Orellana, the enrolment rates of girls have increased, and women attach much more importance to getting a job outside the house and being economically independent from men. The context is also important (Fenstermaker & West, 2002; Mohanty, 2003): the way gender relations work, the resources available - like the inaccessibility to legal abortion in many countries worldwide - and the consequences cannot be truly understood without accounting for the particular context.

The intersection of other variables also modulate gender relations (Connell, 2002; Essed et al., 2005; Fenstermaker & West, 2002; Harding, 1987). In this thesis, the intersection of gender with age is especially relevant. Ethnicity could have also been a key issue to explore in such an ethnically-diverse society, but it was not deeply explored because it would have introduced further complexity into the framework.

Gaps and links between the two approaches

The 1948 Universal Declaration of Human Rights states that women and men have equal rights, but that is the only aspect where a gender perspective can be found (Radicic, 2008; Yamin, 2008). Androcentrism and ethnocentrism were features from the start of the human rights movement, with rights-holders conceptualized as genderless, and consequently disregarding gender discrimination (Batliwala, 2007; Cook, 1995; Correa & Petchesky, 1994; Hellsten, 2001; Radicic, 2008). The emphasis on states as the only duty-bearers that should be held accountable, on the one hand reinforced the false idea of a neutral state, unaffected by gender regimes and orders (Hellsten, 2001); but on the other hand, it also reinforced the separation between private affairs and public issues, highlighting the state’s responsibility in the public arena but disregarding its responsibility for intervening in other spaces such as communities and families, where many acts of discrimination and violence against women occur (Batliwala, 2007; Hellsten, 2001; Krantz, 2002; Krantz & Garcia-Moreno, 2005; Radicic, 2008).

Even if it still can be claimed that gender-based violence and reproductive rights are marginalized and there is still lacking a United Nations binding instrument on those issues, women’s rights have gained much attention in human rights discourse (Cabal & Todd-Gher, 2009; Cook, 1995; Radicic, 2008). Women’s rights were explicitly included in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979, and in Vienna’s World Conference on Human Rights in 1993 (UN, 1979; UN, 1993). The denunciations of sexual and reproductive rights violations through forced sterilizations and incentive policies, and the advocacy efforts of human rights and feminist groups, especially at the Cairo and Beijing Conferences, made possible a move towards a quite radical approach to sexuality and reproduction centered on the individual (Cabal & Todd-Gher, 2009; García Moreno &
Claro, 1994; Germain et al., 1994; Petchesky, 2000; Radicic, 2008; Shalev, 2000). At both Cairo and Beijing, gender relations were not peripheral to the action plans but pointed out as key issues when considering sexual and reproductive health and rights.

It is difficult to combine gender theory, which has a well-developed theoretical basis with the rights approach to health, which is much more action oriented and has less theoretical basis. Despite the difficulties and conflicts between the two, there are also some parallels. Rights are not conceptualized here as individual liberties or fixed categories, but as something people exercise, in relations with others, both at the individual and institutional level. There is no sense of a legal right that is not based on a need and that cannot be actually exercised. Gender, is also not a fixed attribute, but something under construction, practiced in social relations. Individuals exercise rights and do gender, and both actions that are closely intertwined, affect their bodies and lives.

Both the rights approach and the gender approach acknowledge that those actions (rights exercise, gender relations) are not exerted in a vacuum, but are influenced (curtailed or enhanced) by social structures. The rights approach emphasizes the state’s responsibility for ensuring “enabling conditions” for individuals exercising their freedom-agency. Those enabling conditions related both to a system of health protection (health care, educational systems, laws and social services), and to the social determinants of health such as education, socioeconomic status, environment, political situation and, obviously, gender relations. The gender approach highlights that gender relations at the individual level are influenced by the gender regimes of institutions and the gender order. Individuals’ capability of doing gender is influenced by the gender arrangements preeminent in the context of the time and place where they interact, dominated, according to Connell, by hegemonic masculinity and emphasized femininity (Connell, 1987). A gender approach should encourage a critical view of the rights concept of entitlements, understanding states, not as liberally neutral, but also as being shaped by the gender order, and thus contributing to the maintenance of discrimination against women. A gender approach to rights should also raise awareness of the dangers of relying on the state to respect, protect and fulfill women’s rights to sexual and reproductive health, being that it has often shown itself to be one of its main violators.

Despite these concerns, the entitlements concept of the rights approach shows many connections with the concept of gender relations. Gender equity is a crucial social factor for good health (Annandale, 2009; Krantz, 2002; Krantz & Garcia-Moreno, 2005). Discrimination against women violates their right to health, for example through HIV infection of young girls because sexual intercourse with a virgin is perceived as the cure to the infection. Connections between gender relations and entitlements also work at the level of health systems. The rights approach to health recognize that health systems are social institutions, where gender regimes are displayed (Yamin, 2008). Gender regimes modulate how health systems are planned, and health care is delivered; gender regimes shape what services will be offered, by whom and for whom, and in which fashion. Gender regimes of health systems are modulated by the gender order, but also have their own dynamics, moving closer or creating distance from it, and they are not fixed but also under construction by everyday gender relations. Thus, the reproductive and sexual health care that women in a particular area and time will be entitled to, will very much depend on gender issues. And, the other way round as well, the way women’s sexual and reproductive health is addressed in public policies and health care programs influences the way masculinity and femininity, health, sexuality and reproduction are configured, and thus how gender relations are produced and reproduced.
Exploring adolescent pregnancies from a rights and gender approach

The previous sections have outlined this thesis’ approach to rights and gender, as well as some of the connections and gaps between the two. The following section attempts to explain how adolescent pregnancies can be explored from an approach that takes into account both rights and gender.

Adolescent pregnancy has first to be embodied in a female body, with special attention to its sexual and reproductive functions (Krieger, 2005; Krieger & Davey Smith, 2004). Pregnancy is connected with many phenomena, including, but not limited to sexual intercourse, sexual relations, with reproductive tract pathologies, and with abortion and delivery care. Looking at all those related experiences help us to better understand the experience of pregnancy. Moreover, all those experiences are connected to a particular context and a historical time, and these particular conditions affect not only the experience of one body, but of many others that share a similar time and location, transforming an individual experience into a public health issue. In Figure 2 this is represented by placing the smaller circle representing adolescent pregnancy (AP) within the wider circle of sexual and reproductive health and rights (SRHR).

Moving deeper into the issue, we can give a name and a story to this female body. Pregnancy occurs under particular conditions that differ from one individual to another. How each girl experienced her pregnancy is intertwined with other sexual and reproductive experiences such as sexual intercourse, contraceptive negotiation and use, affection, relationships, power, dominance and subordination. To understand her pregnancy we have to explore her capability to make decisions towards her sexuality and reproduction, her agency-freedom to make choices, the way she interacts in gender relations and the consequences for her body and life. In Figure 2 this individual perspective is represented by the duality of agency-freedom which is both influential on and influenced by girls’ capability for exercising sexual and reproductive rights.

Girls’ capability to make free choices regarding their sexuality, reproduction and pregnancy is highly influenced by the social institutions with which she establishes contact: family, school, church, health services, and welfare services. These institutions might enhance a girl’s capability to exercise her sexual and reproductive rights, or might constrain it, by both the services they deliver and the way they deal with the social determinants of sexual and reproductive health. Those institutions also have gender regimes that influence the way they operate, and the way they approach girls’ sexual and reproductive rights. Those gender regimes are also influenced by the gender order. This structural perspective is represented on the right side of Figure 2: from the gender approach, it refers to the influence of institutional gender regimes and the gender order on girls’ capability of exercising their sexual and reproductive rights; from the rights approach, it refers to the role of health systems and social determinants of health on rights’ exercise. This gender perspective of a public health issue is not so commonly addressed and there is still a need for more public health research that integrates gender theory (Ohman, 2008).

Figure 2 also represents how this study attempts to look at adolescent pregnancies, combining both the gender perspective (the triangle on top) and the rights perspective (the triangle on the bottom) and the parallels and interaction between the two. Agency-freedom, reproductive and sexual rights, and gender order-entitlements are not independent arenas, they are all taking place at the same time, influencing each other and having their main effects - for good or for bad - on girls’ bodies. Finally the double-edged
arrows connecting the different issues within Figure 2 are intended to show the relationship between individual agency and social structures: gender regimes and gender order influence the way girls practice gender relations and their capability to exercise rights, but at the same time girls might influence -to limited extent- the way gender regimes operate and the system of sexual and reproductive health protection to which they are entitled.

Figure 2. Adolescent pregnancies from a rights and gender approach - Conceptual framework.
AIMS

The main aim of this study was to explore adolescent pregnancies in the Amazon Basin of Ecuador (Orellana province) from a rights and gender approach.

Specific aims:

- To explore the situation of women’s reproductive health in Orellana province, focusing on governmental obligations, the reality of access and utilization of services, inequities and implementation challenges (Paper I).
- To examine the risk factors associated with adolescent pregnancy in Orellana province (Paper II).
- To explore experiences and emotions around pregnancy and motherhood among adolescent girls in Orellana province (Paper III).
- To analyze providers’ and policy makers’ discourses on adolescent pregnancies in Orellana province (Paper IV).
CONTEXT AND METHODOLOGY

Context

Adolescent pregnancies in Ecuador

Ecuador has a population of 14 million and the Constitution itself recognizes Ecuador as a multinational state, as home to 31 indigenous nationalities (ACE, 2008). The country’s main source of income comes from crude oil exportation and emigrants’ remittances. Within the country, great disparities exist regarding social, health and educational indicators. Indigenous people, people living in rural areas, and people living in the Amazon region face a worse socioeconomic, health and educational situation (SNI, 2009) (Figure 3).

Adolescent fertility rates have increased slightly during the last years -from 85.4 births per 1000 women aged 15-19 in 1995-2000, to 100 in 2004-, while fertility in the other age groups continues to decline (CEPAR, 2005). The percentage of girls who get pregnant during adolescence varies highly depending on educational levels and socioeconomic status: while 43% of illiterate girls experience adolescent pregnancy, only 11% with the highest educational levels do; while 30% of the girls in the lowest socioeconomic quintile experience pregnancy, only 10% of the ones in the highest quintile do (MSP, 2007b). The age group 15-19 accounts for the highest percentage of wanted pregnancy, with 70% labeled as ‘wanted’ (CEPAR, 2005).

Figure 3. Location of Ecuador and Orellana (Worldatlas, 2009).
There are few published articles on adolescent pregnancies in Ecuador. A case-control study carried out in the capital, Quito, associates adolescent pregnancy with family characteristics (Guijarro et al., 1999). Research from Enrique Sotomayor Maternity Hospital, located in the largest city in Ecuador, Guayaquil, evidences that low knowledge of reproductive health, early sexual debut, family disruption, school drop-out, and domestic violence are associated with experiencing pregnancy before 16. The youngest adolescents face a higher risk of cervico-vaginal infections, malaria, and delivering premature and low-birth-weight babies. High rates of unplanned pregnancy and low previous use of contraception among pregnant adolescents attending the maternity service are also evidenced (Chedraui et al., 2004; Chedraui et al., 2007; Chedraui, 2008; Hidalgo et al., 2004). A thesis carried out in Quito’s Isidro Ayora Maternity Hospital takes a different approach to the issue looking at health providers’ discourses regarding adolescent pregnancy and motherhood. It highlights that health providers’ perceptions of girls’ experiences are distorted by stereotypes that prevent providers from understanding girls’ diverse experiences and needs. It describes how the health system disciplines adolescents’ bodies towards motherhood, while at the same time stigmatizes pregnancy during adolescence (Varea, 2008).

Throughout the last ten years, Ecuador has been paying increased attention to adolescents’ health, especially adolescents’ sexual and reproductive health. The country has approved policies and laws in accordance with international treaties, the most relevant being the Free Maternity Law, the Law for Sex and Love Education, the Law Against Violence Against Women and Domestic Violence, the National Policy and Plan for Sexual and Reproductive Health and Rights, the Children and Adolescents’ Code, and the Youth Law (CNE, 1995; CNE, 1998a; CNE, 1998b; CNE, 2001; CNE, 2003; MSP, 2005).

Since 2007, the country has also a National Plan for Adolescent Pregnancy Prevention, in accordance with the Andean Regional Plan for Adolescent Pregnancy Prevention. There is a National Commission in charge of the implementation of the Plan, headed by the Ministry of Health. Emphasis is put on ensuring friendly reproductive health services for adolescents, implementing sex education from primary education to high school, and the support of youth participation as peer educators for the promotion of sexual and reproductive health and rights (MSP, 2007a; MSP, 2007b). The Ministry of Education has finally produced a curriculum where sex education is inserted as a transversal axis, but manuals for practically applying it at schools have still to be published and the majority of teachers remain untrained in sex education.
The province of Orellana

The present study took place in the province of Orellana, located in the Amazon region of Ecuador. With 103,032 inhabitants and 22,500 km² of rainforest, the population is mainly rural (70%) and an important part is indigenous (30.4%). It is a young population with 47.8% younger than 15, and 26.8% adolescents aged 10-19 years (HCPO, 2007).

The province is divided into four counties with two small towns: the capital, Coca (20,000 inhabitants) and Sachas (7,000). In rural areas people live in small communities with approximately 300-500 inhabitants, and make their living mainly from agriculture. The oil industry has attracted a number of male workers from other areas of the country, who come to Orellana temporarily.

Orellana has faced the consequences of oil exploitation since the seventies (Cabodevilla, 1997; Kimerling, 1991), and the negative impact of oil contamination on the health of women living in the area has been well documented (San Sebastian et al., 2001; San Sebastian et al., 2002; San Sebastián & Córdova, 2000). A large percentage of the national oil production comes from Orellana but that had not been translated into greater investment in the area. Socioeconomic and health indicators are poorer than nationwide; for example, life expectancy in Orellana is 5 years less than the national mean (61 vs. 65 for men and 67 vs. 73 for women).
Image 5. The Napo river crossing Coca.

Image 6. Burner of gas from oil production at 50 km of Coca.
Educational levels are also much lower than in other regions of the country and inequities between urban and rural areas as well as ethnic groups are found (HCPO, 2007; INEC, 2001). Tables 1 and 2 show selected socioeconomic and educational indicators in Orellana (HCPO, 2007).

Table 1. Socioeconomic indicators for households in Orellana province.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Urban area³</th>
<th>Rural non-indigenous</th>
<th>Rural indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number of people per household</td>
<td>5.2</td>
<td>4.6</td>
<td>5.2</td>
<td>6.9</td>
</tr>
<tr>
<td>Dependency index¹</td>
<td>3.0</td>
<td>2.6</td>
<td>3.1</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Poverty index²

<table>
<thead>
<tr>
<th>Households within the lowest quartile</th>
<th>Total</th>
<th>Urban area³</th>
<th>Rural non-indigenous</th>
<th>Rural indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>327 (21.2)</td>
<td>1 (0.2)</td>
<td>43 (8.0)</td>
<td>282 (56.9)</td>
</tr>
<tr>
<td>Households within middle down quartile</td>
<td>707 (45.8)</td>
<td>161 (31.9)</td>
<td>344 (64.2)</td>
<td>199 (40.1)</td>
</tr>
<tr>
<td>Households within middle up quartile</td>
<td>407 (26.4)</td>
<td>245 (48.5)</td>
<td>147 (27.4)</td>
<td>15 (3.0)</td>
</tr>
<tr>
<td>Households within the highest quartile</td>
<td>102 (6.6)</td>
<td>98 (19.4)</td>
<td>2 (0.4)</td>
<td>0</td>
</tr>
</tbody>
</table>

¹ Dependency index: Number of people unemployed or without an income divided by number of people employed or with an income.
² Poverty index was calculated based on type of materials used for house building and water and sanitation arrangements. Values were assigned and added, the maximum being 20 and minimum 5 and afterwards they were grouped into quartiles. The lowest values indicate poorer conditions of the house regarding materials used and water and sanitation arrangements. Values refer to n (%)
³ Urban areas refer to small towns of less than 20,000 inhabitants.

Table 2. Educational level by sex and place of residence (age above 15 years).

<table>
<thead>
<tr>
<th></th>
<th>Total n (%)</th>
<th>Urban area³ n (%)</th>
<th>Rural non-indigenous n (%)</th>
<th>Rural indigenous n (%)</th>
<th>Men n (%)</th>
<th>Women n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate²</td>
<td>571 (13.4)</td>
<td>161 (11.2)</td>
<td>238 (15.3)</td>
<td>170 (13.6)</td>
<td>211 (10.6)</td>
<td>350 (16.0)</td>
</tr>
<tr>
<td>Primary education</td>
<td>2920 (68.5)</td>
<td>887 (61.8)</td>
<td>1105 (71.2)</td>
<td>916 (73.0)</td>
<td>1375 (69.1)</td>
<td>1485 (68.1)</td>
</tr>
<tr>
<td>Secondary education</td>
<td>744 (17.5)</td>
<td>372(26)</td>
<td>201 (12.9)</td>
<td>165 (13.2)</td>
<td>382 (19.2)</td>
<td>342 (15.7)</td>
</tr>
<tr>
<td>University degree</td>
<td>27 (0.6)</td>
<td>15 (1)</td>
<td>9 (0.6)</td>
<td>3 (0.2)</td>
<td>21 (1.1)</td>
<td>5 (0.2)</td>
</tr>
</tbody>
</table>

¹ Urban area refers to small towns of less than 20,000 inhabitants.
² Includes both illiterate people and people who have not completed primary education.
Reproductive and sexual health in Orellana

A qualitative study developed in Orellana in 2000 showed that issues related to reproductive and sexual health were considered as priorities for both women and providers living in the area. Women expressed that gender inequities and their consequences were their main worry. Intimate partner physical violence, strongly associated by women with psychological violence and partners’ alcohol abuse, were perceived as the main problems that women faced in Orellana. The study called for the starting of reproductive and sexual health interventions with a comprehensive approach that should take into account gender inequities (Goicolea, 2001). One year later, UNFPA-Ecuador started a reproductive and sexual health and rights program in the area. It focused on improving knowledge and access to reproductive services and stated four objectives: 1) to train teachers on sex education, 2) to integrate reproductive health into existing health services, 3) to strengthen local government’s capacity for linking research to policy making, and 4) to promote gender equity working with community-based and youth organizations.

During the last few years, improvements in policies and programs regarding sexual and reproductive health in Orellana have been significant. Regarding sex education, there is a provincial team that coordinates sex education activities and a number of teachers have been trained. Regarding health services, the hospital and health centers are now more numerous and better equipped and staffed. The training of health providers has become much more common and some training components, like adequate management of obstetric emergencies, are now institutionalized. There is also an HIV clinic, supplied with antiretroviral drugs and trained doctors.

Regarding the management of information for policy-making, all the municipalities have a strategic development plan and some local governments are implementing participatory budgets. Gender equity remains far away, but at least violence against women has been taken into account by local governments in campaigns and local policies. There is a women’s crisis center, which provides legal and psychological support, as well as forensic examinations when needed. Youth organizations are active; they have a youth center and have secured annual budgets from all the local governments for activities, many of them including issues regarding sexual and reproductive health and rights.

Despite those achievements, reproductive health indicators for Orellana continue to show a dismal situation. Unwanted pregnancy accounts for 34% of all births increasing to 43.6% among indigenous women. The mean number of children for women 40-44 years old is 6.2, (3.8 for the country) with differences between rural and urban areas and ethnic origin (from 5.0 for urban women to 7.4 for indigenous women). Adolescent pregnancy is common: 37.4% of girls aged 15-19 are or have been pregnant, which is twice as high as the national prevalence (CEPAR, 2005; Goicolea et al., 2008; HCPO, 2007).

Research process

In this study we explored adolescent pregnancies in Orellana using quantitative as well as qualitative methods. The assumption underlying that decision was that both methods were complementary and offered different perspectives. However, as it will be highlighted in the
methodological considerations section, it also became problematic because the different methodologies made the merging of results more complicated.

The first step entailed collecting quantitative data through a community-based cross-sectional survey for assessing the situation of women’s reproductive health in Orellana, and afterwards this information was confronted to national data and policy to highlight the gaps.

For fulfilling the second objective of exploring risk factors associated with adolescent pregnancy in Orellana, a case-control design was used. Information was collected through a questionnaire that was applied to cases and controls identified within the ongoing cross-sectional survey previously mentioned.

While doing the analyses of the quantitative data, the collection of qualitative data also started. In-depth interviews with adolescents experiencing pregnancy and motherhood were used for data collection and afterwards analyzed using content analysis. This contributed to fulfilling the third objective.

For the fourth objective, we held focus group discussions and in-depth interviews with service providers and local policy makers from different areas, regarding their points of view and experiences with adolescent pregnancies, all the while looking for interpretative repertoires.

When preliminary results were available, two workshops - one with young leaders and one with providers and policy makers - were held in Orellana in order to return the results and receive feedback.

The four specific objectives, the methods used for achieving them, and the results could be placed within the rights and gender framework described previously (See figure 2). While Paper I focused on the wider picture of women’s reproductive rights in Orellana, Paper II looked at the core of this thesis, adolescent pregnancies, with a narrow lens that focused on associated factors. Paper III took the perspective of the individual girl, her experience of pregnancy and motherhood and what it told us about her sexual agency and freedom to exercise her sexual and reproductive rights. Finally, paper IV approached the duty-bearers’ perspective, exploring institutional regimes and structures and their influence on girls’ exercise of their sexual and reproductive rights.

A summary of the four papers, alongside the methodologies used and main findings are presented in Table 3.
Table 3. Overview of Papers I-IV.

<table>
<thead>
<tr>
<th>Paper I</th>
<th>Paper II</th>
<th>Paper III</th>
<th>Paper IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Women’s reproductive rights in the Amazon Basin of Ecuador: challenges for transforming policy into practice</td>
<td>Risk factors for pregnancy among adolescent girls in Ecuador’s Amazon Basin: a case-control study</td>
<td>Gender structures constraining girls’ agency - exploring pregnancy and motherhood among adolescent girls in Ecuador’s Amazon Basin</td>
</tr>
<tr>
<td><strong>Aim</strong></td>
<td>To explore women’s reproductive health in Orellana province, focusing on government’s obligations, access and utilization of services, inequities and implementation challenges</td>
<td>To examine risk factors associated with adolescent pregnancy in Orellana province</td>
<td>To explore experiences and emotions around pregnancy and motherhood among adolescent girls in Orellana</td>
</tr>
<tr>
<td><strong>Study design</strong></td>
<td>Community-based cross-sectional study and policy analysis (HeRWAI)</td>
<td>Community based matched case-control study</td>
<td>In-depth interviews; content analysis</td>
</tr>
<tr>
<td></td>
<td>1631 households, 2025 women aged 10-44 years</td>
<td>402 adolescent girls (140 cases and 262 controls)</td>
<td>11 adolescent girls either pregnant or already mothers</td>
</tr>
<tr>
<td><strong>Main findings</strong></td>
<td>National policy poorly implemented in Orellana; situation more dismal that the one described by national statistics Rural indigenous women had lower access to reproductive health services, compared to urban women and rural non-indigenous women, leading to higher levels of unwanted pregnancy, lower levels of modern contraceptive use and of skilled delivery care Adolescent pregnancies: • Among girls aged 10-19 years: 19.7% had been pregnant • Among girls aged 15-19 years: 37.4% had been pregnant</td>
<td>Risk factors for adolescent pregnancy: • Living in a very poor household • Experiencing long periods without mother and father • Suffering from sexual abuse during childhood and/or adolescence • Early sexual debut (before 15) • Non-use of contraceptives during first sexual intercourse</td>
<td>Girls’ decision making regarding sexuality was limited by the need for secrecy, misinformation, and gender structures that reinforced girls’ subordination Pregnancy conceptualized as stressful while motherhood had positive connotations alongside personal sacrifices, and increased responsibility with little support from partners or welfare policies and programs Mechanism of resistance emerged from girls’ defiance of external criticisms and from girls’ interest in continuing education as a means for economic independence</td>
</tr>
</tbody>
</table>
**Cross-sectional and policy analysis study (Paper I)**

The starting point of this thesis was to explore women’s reproductive health situation in Orellana. With this aim in mind, we first conducted a prevalence study in the area, and afterwards this information was further analyzed using the HeRWAI (Health and Rights of Women Assessment Instrument) to obtain a measurable comparison between what was actually happening and what should be happening according to Ecuador’s sexual and reproductive rights obligations (Bakker & Plagman, 2008). For this last purpose, information from national policies and the ENDEMAIN - a demographic and maternal-child health national survey carried out every four years - was analyzed (CEPAR, 2005; CNE, 1998a; MSP, 2005).

The study population consisted of women between 10 and 44 years living in the province of Orellana, identified through a community-based cross-sectional survey conducted between May and December 2006. The selection of women followed a two-stage cluster sampling procedure, and the final sample consisted of a total of 2025 women from 1631 households (524 from indigenous communities and 1107 from non-indigenous).

Trained local female field workers visited each household within a selected community, explained the aims of the study and obtained permission for applying the questionnaire. The questionnaire comprised two parts; the first of which gathered socioeconomic, environmental and demographic information on the household. For socioeconomic characteristics, an index was constructed using information from certain household characteristics. The second part of the questionnaire was administered only to women 10-44 years living in the household and collected information on fertility, contraception use, infant mortality, delivery care and pregnancy intention. The questionnaire gathered information retrospectively for every pregnancy that each interviewed woman had experienced during her life. The questionnaire was based on Nicaragua’s “Encuesta Sobre Salud Infantil y Salud Reproductiva, Leon”, in Spanish (Zelaya, 1999).

For delivery care, the proportion of deliveries attended by skilled professionals was calculated. For access to family planning, two indicators were measured: prevalence of contraceptive use and pregnancy intention. For pregnancy among adolescent girls, the following were calculated: contraceptive use, pregnancy intention, proportion of adolescents experiencing pregnancy, and skilled delivery care among adolescents.

Data were entered and analyzed using EpiInfo Windows 3.4. The variable residence-ethnicity was split into three categories (urban areas, rural non-indigenous communities and rural indigenous communities), and prevalence was calculated by place of residence. Retrospective information about pregnancy was used to develop trends on skilled delivery care from the 1970s to the present.

When the prevalence study was completed, the results were compared with nationally gathered data and policies regarding women’s reproductive health and rights. For conducting this analysis we used a modified version of the Health Rights of Women Assessment Instrument (HeRWAI).

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2 Following WHO definition, the attendant was defined as skilled if she/he was a doctor, professional midwife or nurse.
The HeRWAI is an instrument developed by the organization Aim for Human Rights and it is used to establish a link between what is actually happening and what should be happening according to the human rights obligations of a country. It is based on the Convention for Eradication of Discrimination against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) and is structured in six steps (Bakker & Plagman, 2008), which are outlined in Figure 4.

Figure 4. The six steps of the HeRWAI analysis (adapted from Bakker and Plagman, 2008)

For our study we used a modified version of the HeRWAI, focusing on three stages. First, we described Ecuador’s National Policy of Sexual and Reproductive Health and Rights along with the state’s official commitment. The second stage presented the actual situation of women’s reproductive health in Orellana, drawing from the community-based cross-sectional study and data from the last ENDEMAIN, carried out in 2004. The focus was limited to three issues: delivery care, family planning, and pregnancy among adolescent women. The third stage highlighted the gaps between the policy commitments and the real situation of women’s reproductive health in Orellana and pointed out the main challenges that the implementation of the policy faced in this particular area of the country.

**Case-control study (Paper II)**

For this study a matched case-control design was implemented with a 1:2 ratio. A case was defined as any adolescent girl (according to WHO definition, 10-19 years) living in Orellana who was
pregnant at the moment of the interview or who had been pregnant for the first time during the previous two years. Controls were defined as adolescent girls who had never been pregnant. Controls were matched for community of residence and age (plus/minus two years) at pregnancy. Data were collected from 140 cases and 262 controls, and selected from the 1631 households that participated in the prevalence study.

Potential cases and controls were identified by the same female field workers that were using the questionnaire for the cross-sectional study. When a case was detected, permission was requested from both the girl and a parent (if living with her) to perform the questionnaire. Afterwards the field worker continued the survey in the next household, looking for potential matched controls for that case.

The questionnaire was a modified version of the Nicaraguan “Investigación en Salud Reproductiva de adolescentes” and was in Spanish (Zelaya, 1999). It included socio-demographic information and questions about family structure, educational information, and sexual and reproductive health. For the cases, information regarding the father of the baby was also collected.

Childhood trauma was assessed by using the Adverse Childhood Experiences (ACE) Questionnaire, which is used by the Center for Disease Control and Prevention to analyze relationships between childhood trauma and health and behavioral events later in life. It measures the occurrence of eight harmful incidents during the first 18 years of life: physical abuse, emotional abuse, sexual abuse, alcohol and/or drug abuse in the family, incarceration of household member, family mental illness, mother suffering intimate partner violence, and parental separation (CDC, 2008).

After explaining the aims of the study and obtaining permission from the adolescent girl (and parents if applicable), a place was found to ensure privacy. Confidentiality was assured and names were not asked for. The questionnaire interview lasted approximately twenty minutes. Adolescent girls who reported adverse events related to violence were informed and referred to a women’s health center which provided psychological, social, medical and legal advice in Coca.

Data were entered and analyzed using EpiInfo Windows 3.4. A bivariate analysis was performed first, estimating odds ratios and 95% confidence intervals. Variables that showed a statistically significant association (p<0.05) were further analyzed using conditional logistic regression.

**Content analysis of in-depth interviews with adolescents experiencing pregnancy and motherhood (Paper III)**

For collecting information on girls’ experiences and emotions about pregnancy and motherhood, we carried out in-depth interviews with eleven adolescent girls who were pregnant or who were already mothers. The interviews were carried out in Spanish by the first author (IG), lasted from 25 to 70

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3 Sexual abuse was identified with the question “Has an adult or other person at least 5 years older than you ever touched or fondled you in a sexual way, and/or have you touched their body in a sexual way, and/or have they attempted oral, anal, or vaginal intercourse with you and/or actually had oral, anal, or vaginal intercourse with you?”
minutes and took place in different locations, always ensuring privacy. Before the interview, the interviewer explained the aims of the study and asked permission for tape recording. All of the adolescents approached agreed to participate.

After some common introductory questions, the interviewer encouraged the participants to tell their story. Afterwards, participants were asked for clarification and further explanation about the participants’ experiences and feelings regarding pregnancy and motherhood. Questions regarding courtship, contraceptive use, and sex education were also asked. Finally, the interviewer explored participants’ opinions regarding adolescent pregnancy, single-motherhood, and recommendations for policies and programs. We included relevant issues that emerged from each of the interviews in subsequent interviews following an emergent design (Dahlgren et al., 2004; Lincoln & Guba, 1985).

Interviews were tape recorded and fully transcribed. To ensure confidentiality all names were erased. Transcriptions were entered into Open Code 3.4 for managing the analyzing process (Open Code, 2007).

The interviews were analyzed using content analysis. For this study we chose Graneheim and Lundman’s approach and followed the analytical stages as they propose (Graneheim & Lundman, 2004). After identifying the meaning units and coding them, codes were grouped into preliminary categories. A theme (latent content) was also identified, crossing through all the categories. The final step consisted of the negotiation of categories and themes between the three authors and linking our findings with existing social theory (Dahlgren et al., 2004). For this study we focused on Connell’s concepts of gender relations and gender-power (Connell, 1998; Connell, 2002).
**Analysis of service providers’ and policy makers’ discourses regarding adolescent pregnancies (Paper IV)**

For the last paper we conducted eleven in-depth interviews and six focus group discussions with service providers and policy makers to explore discourses regarding adolescent pregnancies. The first author (IG) conducted all the in-depth interviews and moderated the focus group discussions. The personal interviews lasted from 25 to 65 minutes. The focus group discussions lasted from 47 minutes to 94 minutes, with between three to seven participants in each group.

Before the individual interviews and focus groups discussions, the interviewer explained the aims of the study and asked permission for tape recording. Participants were encouraged to talk freely and, if in a focus group, to interact with each other and not just answer the interviewer’s questions. The interviews covered issues including participants’ experiences with adolescent pregnancy, and their perceptions regarding its causes and consequences. Perceptions regarding the partners and families of pregnant adolescents were also explored, alongside the participants’ perceived connections between adolescent pregnancy and violence. Opinions regarding related topics such as sex education, contraceptive access for adolescents, and services that should be implemented were also explored.

Interviews were performed in Spanish, tape recorded and fully transcribed. To ensure confidentiality all names were erased. Transcriptions were entered into Open Code 3.4 for managing the analyzing process (Open Code, 2007)

Verbatim transcriptions of the interviews were analyzed looking for “interpretative repertoires” or clusters of meaning (Wetherell & Potter, 1988; Wheterell & Potter, 1992; Winther Jørgensen & Phillips, 2002) to talk about adolescent pregnancies in Orellana and the effect of those repertoires for the exercise of sexual and reproductive rights by adolescent girls living in Orellana.

Coding was conducted using the original Spanish transcriptions and afterwards the interviews and codes were re-read looking for the following aspects: statements about adolescent pregnancies, subjects who personify the discourse of adolescent pregnancies, practices within institutions for dealing with adolescent pregnancies, and attempts to establish different discourses (Foucault, 1977; Hall, 2007). Through discussion between the researchers, we negotiated and refined the interpretative repertoires, ending up with four repertoires.
An effort was made to fulfill ethical standards during the research process (Dahlgren et al., 2004; Kvale, 1996; WHO, 2001). Since there was no ethics committee in the province of Orellana, permission for developing the study was obtained from the provincial authorities. Prior to starting the prevalence and cross-sectional study, the presidents of the selected communities were informed regarding the study aim and permission for entering into the community was asked for. Verbal informed consent was also requested from all the participants in the prevalence study, case-control study, individual interviews, and focus group discussions. For adolescents who were living with their parents, permission was also requested from one of the parents. All the participants were assured that they could withdraw from the process whenever they wanted.

Incentives for participating were not provided. However, during the interviews and focus group discussions, some drinks and snacks were offered and if the participant came with a baby, babysitting was made available.

Measures to ensure confidentiality and privacy were also carried out. For example, when a potential case or control was identified and they agreed to participate, if privacy was not achievable at home she was invited to go out or to search for a different and more private location if convenient for her. Confidentiality was not possible in the focus group discussions, because most of the participants knew each other since it was a small province. However, at the start of the focus group discussion the moderator stressed the importance of respect and of not disclosing any of the opinions expressed in the focus groups. Names were erased from all the documents and access to information was restricted to the research team.

Since the case-control questionnaire included questions regarding the witnessing and suffering of domestic and intimate partner violence, various precautions were taken, following the WHO guidelines for research on violence against women (WHO, 2001). First, the training of field workers included issues regarding violence that were addressed by the psychologist of the local women’s health center (Jambi Wasi). At that time, Jambi Wasi was a center offering medical, psychological, social and legal support for women suffering from violence. The field workers also provided informative leaflets about the center and were asked to refer to the center those adolescent women who were identified through the study as suffering or having suffered from violence. Informally, some debriefing regarding field workers’ experiences when encountering such cases was carried out during the supervision meetings.

Devolution of results has been initiated. A report in Spanish showing the situation of women’s reproductive health in Orellana has been published and distributed. One workshop for presenting preliminary results to young leaders in Orellana has been held. Participants’ comments served to enhance research trustworthiness, and the workshop also ended with a manifest of the young leaders regarding the way they wanted sexual and reproductive services to be delivered for adolescents and youngsters. After the young leaders’ workshop, another workshop was also held with service providers and policy makers. It served to present preliminary results, get feedback, and it was also an opportunity for positioning young leaders’ demands regarding the provision of adolescent-friendly services.
ETHICAL CONSIDERATIONS

Image 8. Workshop with young leaders for discussing preliminary results in Coca.

Image 9. Coordinator of the National Plan for Adolescent Pregnancy Prevention presenting at the workshop with stakeholders in Coca.
This research project also complies with the ethical principle of justice. Even if research on adolescent pregnancies abounds, it seldom comes from geographically remote locations such as Orellana. Consequently, the policies and programs delivered disregard the reality of such areas and are based on results from settings that could be rather dissimilar. This research is a modest attempt to both widen the perspective of research on adolescent pregnancies by including isolated areas scarcely represented in published papers, and to offer some input for already ongoing interventions in the area of Orellana.
MAIN FINDINGS

Reproductive health of women living in Orellana (Paper I)

The national policy framework

In 2005, Ecuador adopted the National Policy of Reproductive and Sexual Health and Rights to encourage and expand the exercise of reproductive and sexual rights. Prior to its adoption, there had been several related laws such as the Law for Free Maternity and Infant Care ("Ley de Maternidad Gratuita y Atención a la infancia," or LMGYAI). The implementation of the National Policy was monitored by the National Commission for Reproductive and Sexual Health and Rights that also elaborated an Action Plan which included nine different programs. This study focused on three of those programs: Maternal Mortality Reduction Program, Family Planning Program, and Adolescents’ Program.

Maternal health

The Maternal Mortality Reduction Program focused on the provision of Emergency Obstetric Care (EmOC) services, strengthening the LMGYAI, and reducing barriers to skilled delivery care with attention to issues of intercultural sensitivity. In Orellana, regarding the provision of emergency obstetric care, there was only one facility providing comprehensive emergency obstetric care in the capital city, Coca, and a shortage of beds and blood supplies made referrals to other provinces common. The large geographical area and low population density of the province, along with the poor communication system, made it impossible to ensure that every woman lived within two hours of a service offering emergency obstetric care. The prevalence study allowed us to look for trends in skilled delivery attendance from 1977 until 2006 in Orellana province (Figure 5).

Figure 5. Trends in skilled delivery attendance from 1977 to 2006 in Orellana province (% of deliveries attended by skilled personnel).
These numbers showed a different reality from the official ENDEMAIN data: while from the locally gathered data we found that only 47% of deliveries that took place in the period 2002-2006 were attended by skilled attendants; data from the ENDEMAIN established that the percentage was 74.2% for the country and 60.9% for the Amazon region. Moreover, within Orellana, differences between women living in urban areas and those living in indigenous rural communities were prominent.

**Family planning**

The Family Planning Program sought to reinforce sex education in schools, and to ensure the availability and accessibility of family planning services, focusing on the most vulnerable populations. Provision of contraception was included within the LMGYAI, and contraceptives should have been available at all health facilities, even at the smallest rural health posts. However, in Orellana (as in other places) shortcomings in the supply and distribution made it difficult to ensure the continuous availability of certain contraceptives. Female sterilization and intrauterine device insertion and removal were only performed at the provincial hospital, while male sterilization was minimal.

Data from the prevalence study showed that in Orellana the percentage of women who used any means of family planning were similar in all three groups (urban, rural non-indigenous, rural indigenous women), and even higher than ENDEMAIN’s data. However, use of modern methods showed wide differences, both between local data and ENDEMAIN’s data, and locally between different groups (See Table 1 in Paper I). Not surprisingly, the highest proportion of unwanted pregnancy was found among rural indigenous women (43.6%), compared with 30.6% for rural non-indigenous women and 29% among urban women. Again, these findings differed starkly from the official ENDEMAIN-2004 data, of 18.7% unwanted pregnancy nationally, and 25.9% for the Amazon region.

**Adolescent pregnancy**

The Adolescent Program in the National Plan for Sexual and Reproductive Health and Rights focused on delivering “adolescent-friendly health services,” emphasizing three issues: sexually-transmitted infections, HIV and AIDS, and adolescent pregnancy. Regarding the implementation, in Orellana youth clinics did not exist, and reproductive and sexual health services within the public sector could not be labeled as “adolescent-friendly”. A youth center existed in the capital of Orellana, at which information, condoms and emergency oral contraception were provided by peer educators. The majority of secondary schools were implementing sex education, but the quality of it had not been evaluated. It was illegal to expel a pregnant student but schools did not make efforts to help girls continue their education during pregnancy and motherhood.

Of the 2,025 women who participated in Orellana’s prevalence study, 41% (n=828) were adolescents. Of all the adolescents, 19.7% (n=164) had experienced pregnancy: 2.2% (n=9) of those aged 10–14 and 37.4% (n=155) of those aged 15–19. In the urban area, 26.7% (n=71) of all adolescents were or had been pregnant, while this proportion was lower in the rural area: 16.4% (n=50) among non-indigenous and 16.8% (n=43) among indigenous girls. For the oldest adolescents (15–19) proportions rose especially in the urban area, where 45.5% (n=69) had
experienced pregnancy, while in rural non-indigenous communities numbers dropped to 31.3% (n=46), and among rural indigenous communities the prevalence was 35.1% (n=40).

The adolescent group accounted for the highest proportion of wanted pregnancy (44.9%) among all age groups of women surveyed. When disaggregated by residence-ethnicity, the proportion of wanted pregnancy among urban adolescent girls was slightly lower (40%) than among their adult counterparts (42%). Numbers were the opposite among women living in rural communities. For non-indigenous: 56% of pregnancies among adolescents were wanted vs. 40% for adults; for indigenous: 50% for adolescents vs. 28% for adults. Adolescent girls reported a higher proportion of deliveries attended by skilled professionals than their adult counterparts (59% for adolescents vs. 47% for all women). Yet these figures still remained well below the ENDEMAIN report of 2004 (77.8% for adolescents and 74.2% for all women).

Risk factors associated with adolescent pregnancies in Orellana (Paper II)

Factors associated with adolescent pregnancy in Orellana were explored through the case-control study. The mean age of participants was 17.0 (SD 1.49) for cases and 16.5 (SD 1.59) for controls. The mean age of cases when pregnancy occurred was 16.5 (SD 1.44). Half (49.6%) lived in the rural area, and regarding ethnic origin, 72.6% were mestizo (non-indigenous) and 27.4% were indigenous. Differences among ethnic origin between cases and controls were not found because adjusting for place of residence in effect also meant adjusting for ethnicity. Most cases (n=103, 73.6%) were married or in a formal union whereas the majority of controls (n=243, 93.5%) were single.

Through multivariate analysis (See Table 4 in Paper II), we found four factors that increased the risk of experiencing pregnancy during adolescence: suffering sexual abuse during childhood and/or adolescence (OR 3.06, 95% CI 1.08-8.68), initiating sexual intercourse before 15 (OR 8.51, 95% CI 1.12-64.90), living in a very poor household (OR 15.23, 95% CI 1.43-162.45), and experiencing life periods of a year or longer without mother and father (OR 10.67, 95% CI 2.67-42.63).

Two other factors were statistically associated with adolescent pregnancy: being married or being in a formal union (OR 44.34, 95% CI 17.85-142.16) and not being enrolled in school (OR 6.31, 95% 3.70-11.27). For the 80 cases (58.0%) that were not currently studying, pregnancy (n=33, 41.3%) or marriage (n=29, 36.3%) were the main reasons for school abandonment. However, the questionnaire did not establish if those factors were present prior to the pregnancy, and consequently they cannot be labeled as true risk factors.
To compare factors present only among sexually initiated girls, a sub-sample was selected (47 cases and 52 matched controls). In the multivariate analysis adolescent girls who did not use contraception at first sexual intercourse were at higher risk of experiencing pregnancy during adolescence (OR 4.30, 95% CI 1.33-13.90).

Men as partners and fathers

This thesis did not explore the male’s perspective on adolescent pregnancies. However, the case-control survey collected some information regarding girls’ relationships with their actual partners and with the fathers of their children; it is presented below.

The majority of the cases (n=105, 79.5%) reported having a partner at the time of the interview. From those who reported having a partner, information regarding intimate partner violence was explored: 10.5% (n=11) reported sexual violence. Regarding physical violence, 14% (n=15) reported having been slapped by their partner and 7.7% (n=8) reported having been knocked down by him. Psychological violence was also common: 20.1% (n=21) reported having been humiliated, while 10.5% (n=11) reported having been menaced by their partner.

Some information was also collected regarding the father of the child. The mean age gap between the girl and the father of her child was 5.93 (median age 6). Only 12.2% (n=3) of the fathers were also adolescents. Regarding support provided by the father to the child: 72.6% (n=90) of girls reported that the baby received both economical and emotional support from the father, 11.3% (n=14) only economical and 16.1% (n=20) reported no support at all. The three most common occupations of the child’s father were: agricultural work (n=31, 24.8%), oil company employee (n=28, 22.4%), and student (n=25, 20%).

Emotions and experiences around pregnancy and motherhood (Paper III)

During the analysis, seven categories and one theme emerged, all of them closely related to gender relations. The categories, alongside with selected meaning units and codes are presented in Table 4.

Two categories – ‘fatalism’ and ‘modest girls and unreliable men’ - were connected with societal norms. Fatalism was expressed as a strong belief in external forces, such as God or chance, ruling individuals’ lives, creating the feeling of powerlessness for influencing ones’ destiny and a resigned acceptance of events.

‘Modest girls and unreliable men’ expressed how participants construed women and men. Women should struggle to be “good”, meaning that they should be serious, responsible, respectable and obedient. Sexuality and men were conceptualized as the main dangers in this struggle, while marriage and motherhood were felt as protections. Men were configured in a rather pessimistic way as unreliable, abusive, and violent.

“There are men who are good... but the majority of men are very bad... The moment they see a woman by herself, they quickly think wrongly... that she will be like this or like that.
When girls are alone..., sometimes they try to sexually abuse them. I tell you this because that happened to a friend of mine. She went to a party, and she met a boy..., and afterwards we heard that she had been sexually abused by this boy” (No. 2, 18 years old)

Two categories belonged to individual experiences: ‘facing such an overwhelming responsibility alone’, and ‘becoming a mother: the joy of having a baby but the end of childhood’. The first category stressed the feelings of anguish and sadness that surrounded the recognition of pregnancy. It was a solitary moment, one in which participants were faced with the reality of being the only ones who were unable to escape from the pregnancy:

“My niece went with me... [to perform a pregnancy test]... When I knew the result, I took this test and went home crying. I mean, I didn’t know what to do[...] Then he [her partner] told me..., well the first thing he told me was that I shouldn’t have that baby..., and.... Well.... I start crying again, “But what do you mean that I shouldn’t have it? And what am I going to do to avoid having it?” [...] And then afterwards I told my mother [that she was pregnant]... I was afraid that she might beat me, but she didn’t beat me. Just with her words she told me everything... she felt that I betrayed her” (No. 2, 18 years old)

The second category referred to the feelings raised by the prospect of being a mother. They were much more positive. The baby gave rise to positive feelings and encouraged them to go ahead. However, they also expressed that being a mother entailed increased responsibility and the sacrificing of leisure activities and contact with people their own age.

“Well... this..., to be at home, feed her, take care of the baby. I can’t go out like when I was single, go out with other girls, have fun ... it’s not like that anymore. Now I have become... completely..., well... now I don’t go like that anymore... going out with friends, in the street... I stay at home, watch my daughter. Sometimes I visit my auntie, stay there for a while, and afterwards come back home [...] When he comes [her partner] we go out” (No. 6, 18 years old)

Categories that referred to external factors included two: ‘misinformation and other barriers to pregnancy prevention’, and ‘girl’s mother as central pillar’. Misinformation regarding sexuality and contraceptive use was found. Even if participants acknowledged having received sex education and advice it seemed that these had been provided in a hierarchical way, minimizing the possibility of discussion and appropriation of the information. Mothers were very important for those girls. They were perceived as the most supportive figure and the one that was always there. Motherhood was idealized, while at the same time there was not much expectation placed on the fathers, who were conceptualized as absent or marginal to their lives, and who sometimes caused emotions of rage in the girls.

Finally, participants expressed their belief in the importance of education as a means for getting better-paid jobs. Economic independence was perceived as important for women, since men were unreliable as life-long supporters for them and their babies.

“My dream now is to continue studying, studying to have..., well afterwards ...., afterwards then..., to have a good job... to be able to support myself and my baby as well. To study in
order to live more relaxed. I mean, it’s not just that since I got like that [pregnant] I will have to leave school and stay behind. I mean I have to struggle to keep on going” (No. 4, 15 years old)

However, schools did not encourage their continued education, but served as places where condemnation was common.

The latent content of the interviews was condensed by the theme: ‘gender structures constraining girls’ agency’. Gender relations affected girls’ capability to make decisions regarding sexuality and reproduction. Those relations took place at the individual level, when girls related to their partners, their mothers, or other people that criticized them. They also took place at the institutional level (school, marriage, and family), mainly constraining girls’ freedom and agency. At a higher level, gender structures configured women as submissive and men as violent and abusive. Those structures also idealized motherhood for women, while at the same time they demonized sexuality. Resistance to those structures emerged from girls’ recognition of the need to be economically independent from men, and their defiance towards external criticism and patronizing attitudes regarding their pregnancy and motherhood.

“Well, yes, many times people are just hypocrites. Since they are friends with my mother..., then they don’t speak what they really think in front of you, but behind your back they will say, “Oh look, what a shame!... she has become pregnant!.... poor girl”.... behind you they will say “poor girl!!!”... […]” (No. 4, 15 years old)

Image 11. Young girl showing how to put on a condom during a workshop.
Table 4. Categories and a selection of codes and meaning units from the interviews (Paper III).

<table>
<thead>
<tr>
<th>Category</th>
<th>Fatalism</th>
<th>Modest girls and unreliable men</th>
<th>Misinformation and other barriers for pregnancy prevention</th>
<th>Facing such an overwhelming responsibility alone</th>
<th>Becoming a mother: the joy of having a baby but the end of childhood.</th>
<th>Girl’s mother as central pillar</th>
<th>The importance of education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes</td>
<td>Things occur outside her</td>
<td>Disempowered</td>
<td>Dangers looking for girls</td>
<td>Resignation</td>
<td>Lack of knowledge</td>
<td>Incorrect information</td>
<td>Advice</td>
</tr>
<tr>
<td>Meaning units</td>
<td>“... those are life things that just happen like that” (No 1)</td>
<td>“I don’t know, I don’t know how my life will be still... if I will return with him at least for a while... if there will be somebody else in my life” (No 4)</td>
<td>“He is already an adult but he continues being like a child who does not think about things well” (No 2)</td>
<td>“He has changed a lot..., he used to be womanizer, alcohol abuser, violent” (No 3)</td>
<td>“When you let a man call you..., you are done” (No 4)</td>
<td>“Women who stay at home with the mother, they are appreciated” (No 5)</td>
<td>“I got a kind of infection when I had sex with a condom” (No 2)</td>
</tr>
</tbody>
</table>
Discourses on adolescent pregnancies: providers’ and policy makers’ perspectives (Paper IV)

Four interpretative repertoires emerged from the analysis: ‘sex is not for fun’, ‘gendered sexuality and parenthood’, ‘professionalizing adolescent pregnancies’, and ‘idealization of traditional family’.

The ‘sex is not for fun’ repertoire constructed a moralistic approach to adolescent sexuality. Risks associated with sexual intercourse, such as HIV infection or unwanted pregnancy, were perceived not as the main problem to be prevented but more as a means for discouraging girls’ sexual activity. Adolescence was considered to be a period of underdevelopment, incompatible with the maturity needed for engaging in sexual intercourse. Consequently the messages delivered to adolescents regarding contraceptives were ambiguous and did not strongly encourage safe sex.

"[When asking what might happen if contraceptives were made available at secondary schools] Wow!, that will be a scandal!... that will be complete chaos!... I mean when the teacher at my daughter’s school asked the students to make a table with all the contraceptives available... well, at the next parents’ meeting... well... everybody complained! The parents argued that they should not be teaching those things at school, because they were opening the students’ eyes..., that if they teach those issues at school students will know how to protect themselves and they will go out and have sex with everybody” (teacher, woman, FG teachers)

For single girls, pregnancy was seen as the proof of being sexually active ("the body of the crime") and thus subject to criticism. This posed special challenges at school, where pregnancy among students occurred. The way schools dealt with it had changed rapidly because of the legal prohibition to expel pregnant students, and within this changing scenario normative criticisms and actions to “hide” pregnant adolescents coexisted with very supportive attitudes.

"People say that adolescent pregnancy has increased, but... this is false. I mean, what has happened is that nowadays girls and boys are starting to know their rights and ask for them..., they know that they can remain in school [if they are pregnant]..., I mean, they know that there is a law that prevents schools from expelling pregnant students... So, nowadays pregnant students exercise this right and they remain at school... and that’s why it seems that adolescent pregnancy is increasing. Because previously the school used to send the pregnant student home, or allow her to continue education from home, banning her from showing up at the school... […] But there are a lot of teachers who still believe that giving too many rights [to students], empowering adolescents regarding their rights will be harmful... some of us teachers are changing, but it’s very hard... (Head of provincial sex education programs, man)

From the ‘gendered sexuality and parenthood’ repertoire, women and men were constructed in opposite ways, both regarding sexuality and parenthood. Regarding sexuality, men were constructed as sexually driven, aggressive, and unconcerned about the consequences of sexual intercourse.
Women were constructed as sexually uninterested, understanding sex as linked with love, and menaced by men’s sexual drives.

“For example the issue that when a girl loses her virginity then she is no longer chaste and pure and she becomes a... she is no longer... they don’t see her as a worthy woman anymore..., they see her as ... as a whore... a woman that any man can use... she is no longer.... No longer worthy to get married... and that has a great influence..., has a great influence on girls... Somehow... the girl can’t make her own decisions... and many men... maybe because of their power... power to convince girls... they go along with girls... and in that way those girls lose their chastity ... and... dignity...” (Youth representative, Andean Committee for Adolescent Pregnancy Prevention, woman)

Men were not trusted to take responsibility for pregnancy prevention, and thus sexual and reproductive programs did not tackle them. Regarding parenthood, men were constructed as unreliable and not engaged, while women were responsible and had to make sacrifices. Men were absent from the repertoires and not expected to comply with their role as fathers. Girls were expected to take responsibility and endure the pregnancy, independently of the risks associated with it or their own feelings. Abortion was not regarded as an option.

The repertoire of ‘professionalizing adolescent pregnancy’ referred to the process of transforming adolescent pregnancy from being seen as a common event dealt with within families, to a health and social problem that should be managed in a professional way; this led to the production of “professional” tools and concepts such as policies, plans, statistics, and adolescent-friendly services.

Providers were interested in helping adolescent girls, but they maintained a distance from them. The adult professionals remained the only ones whose knowledge was relevant, while the adolescents were constructed as lacking this knowledge and thus engaging in premature sexual relations that had led to, among other negative outcomes, adolescent pregnancy. Professionals’ attempts to be close, could also be regarded as patronizing and disrespecting adolescents’ right to confidentiality and autonomy.

“I think that all the people working at those institutions [working in AP prevention in Orellana] even if they are making great efforts..., they still have a lot of taboos... all the information provided and services are full with taboos... and thus if a girl goes to the hospital for counseling, well..., she will have to surpass lots of barriers... like queuing, disclosing her needs in front of everybody, fearing of the staff spreading all what she is talking about...and the criticism... I think she will never return to such a service...” (Youth representative Andean Committee for Adolescent Pregnancy Prevention, woman)

Amongst the professionals, hierarchies were also present, and the medical profession was considered as being expert on adolescents’ sexual and reproductive health and adolescent pregnancy. The relevance of youth participation and other expertise, such as that from professionals working with violence against women, was underestimated. As a consequence, issues related to gender-power relations and violence remained secondary or absent on local plans and programs regarding adolescents’ sexual and reproductive health and pregnancy.
The last repertoire, ‘idealization of traditional family’, constructed the nuclear heterosexual family as the ideal environment for both adequately raising adolescents and reproducing Ecuadorian traditional values, which were seen as having become endangered by foreign influences and other factors such as migration and increased sexual freedom. At the same time, participants acknowledged that violence and abuse were common practice within families in this setting, and that many times the apparently ‘ideal’ nuclear heterosexual family could in fact be where adolescent girls were subject to sexual abuse and exploitation.

“We were at one school talking about the prevention of sexual abuse and we were saying to the children that nobody had the right to touch their bodies, Ok?... And we were working through drawings...And then this little girl came to me and told me that her father used to touch her, and that the only thing she enjoyed doing was crying... Well. There are too many cases like that... and many times the mothers [of the sexually abused children] do not help at all” (Head of NGO working with gender based violence, woman.)
DISCUSSION

The framework described in this thesis assumes that adolescent pregnancies need to be understood within the wide array of adolescents’ sexual and reproductive health and rights. Those rights are conceptualized not as mere legal regulations and norms, but as adolescents’ actual capability to exercise them, to be in control of their sexuality and reproductive capacity. Girls exercise their sexual and reproductive rights in relation to others at the individual, institutional and social levels, and those relations are highly influenced by gender structures.

The discussion section aims to highlight how these findings may contribute to a better understanding of issues related to girls’ agency-freedom, their entitlement to a system of sexual and reproductive health protection, and the effect of the gender regimes of institutions and gender order on girls’ sexual and reproductive rights, as well as on the phenomenon of adolescent pregnancies in general.

Agency-freedom

Adolescent pregnancy could be a free choice, an expression of a young girl’s right to be sexually active and a mother. In fact, a number of studies from other settings present adolescent pregnancy as a way of rebelling towards norms that criticize girls’ sexual activity and motherhood (Garcia Dias & Gornes, 2000; Mccallum & Reis, 2005). Our findings, however, do not support the conceptualization of adolescent pregnancy as a consequence of increased girls’ agency and freedom, but more as a reflection of a constrained capability for exercising their sexual and reproductive rights. The fact, for example, that unwanted pregnancies accounted for half of all pregnancies among adolescent girls suggests a limited freedom to decide when to become pregnant. However, it has to be pointed out that the percentage of unwanted pregnancy among adolescents was the lowest, when compared with other age groups. Instead of perceiving this as a sign of increased agency among adolescents, it is most likely a reflection of the powerful effect of symbolic constructions of motherhood and femininity in influencing girls’ decisions regarding sexuality and reproduction.

A great deal of research on adolescent pregnancies takes the risk perspective, constructing it as a consequence of “unsafe” sexual practices carried out by individual girls. As a consequence, the focus is put on “changing” girls’ sexual behavior, as if everything were under the individual girl’s control. This individualistic approach has been challenged by some authors (Breheny & Stephens, 2007; DiClemente et al., 2005; Elfenbein & Felice, 2003; Florez, 2005; Heilborn et al., 2007; Schutt-Aine & Maddaleno, 2003; UNFPA, 2005a), and this thesis also shows that the majority of factors that increase the risk of adolescent pregnancy in Orellana remain far beyond the individual adolescents’ control. Factors such as poverty, suffering sexual abuse, and parental absence belonged to the structural level and adolescent girls were unable to effect change in any of them. The two factors, ‘early sexual debut’ and ‘use of contraceptives during first sexual intercourse’, remained more under the adolescents’ control. However, girls’ capability to make decisions regarding sexual intercourse and condom use is not just a matter of being aware of sexual and reproductive rights.
This study highlights a number of issues that limit girls’ control of their sexuality and reproductive lives; for example, the way gender interplays in the relationships they have with their partners, and the quality of the information they receive regarding sexuality and contraceptive use, limit girls’ sexual autonomy. Gender relations with partners did not enhance girls’ sexual agency, and the secrecy and contradictions regarding contraceptive information and access further constrain girls’ capability to engage in safe sex.

Our findings agree with other studies that state that a high proportion of adolescent pregnancy in Latin American countries takes place within formal unions and marriages (Bruce & Mensch, 1999; Clark et al., 2006; Guzman et al., 2001). Our findings also support the conceptualization of marriage as a situation that might further complicate girls’ sexual agency, especially regarding girls’ capability to practice safe and consensual sex, and thus prevent unwanted pregnancy, sexually transmitted infections, and sexual abuse. Marriage was claimed to be a reason for dropping-out from school for pregnant adolescents and adolescent mothers. Since girls who had experienced pregnancy highly valued education as a way of gaining economic independence from men, marriage may curtail this mechanism of resistance.

Such a fatalistic view of life constrained girls’ agency and reinforced their resignation to existing arrangements. Gender configurations of women and men constructed a way of teaching girls sexuality based largely on falsehood and fear; not enhancing their capability to exercise their sexual and reproductive rights, but trying to keep them away from potential risks. Since other authors evidence that this form of sex education does not result in safer sexual practices and lower prevalence of adolescent pregnancy (Metcalf, 2004; Schutt-Aine & Maddaleno, 2003), it should be challenged.

Finally, the encounter with providers has been shown to be an opportunity for enhancing girls’ autonomy and capability to exercise their sexual and reproductive rights (Brubaker, 2007; Dickey & Deatrick, 2000; Gijsbers van Wijk et al., 1996; Metcalfe, 2004; Pinto, 2004). However, in this setting those encounters were characterized by taboos, poor confidentiality mechanisms, moralistic and patronizing advice, and low respect for adolescents’ autonomy. Thus, instead of strengthening girls’ capability to exercise sexual and reproductive rights, the encounter with providers may contribute to girls’ further disempowerment and self-blame.

Entitlements

The rights approach acknowledges that to enable individuals to exercise their sexual and reproductive rights, they should be entitled to a system of sexual and reproductive health protection in which the state takes responsibility for both the implementation of a network of sexual and reproductive health services and the elimination of social inequities that might place certain individuals or groups at higher risk of ill sexual and reproductive health (Braveman & Gruskin, 2003; Hunt & Bueno de Mesquita, 2006; London, 2008; UNHCHR & WHO, 2008).

This study highlights that despite the existence in Ecuador of policies and programs regarding sexual and reproductive health, their implementation remains weak in Orellana. Comparing the
reproductive health situation of women in this province with the national situation, inequities in access to services were marked. Moreover, within the province, inequities were also prominent: indigenous women living in rural areas had the lowest access to reproductive health services. Reasons for those inequities were not explored in depth but might refer to geographical inequities in the distribution of resources, placing health services distant to the areas where the indigenous communities were located. Other reasons might be related to the acceptability of the services on offer that still did not take into account users’ criteria of quality, and were not ethically sensitive. Gender issues related to women’s subordination towards men’s decision-making might have further constrained women’s access to services, especially when those services related to issues of sexuality and reproduction.

Sexual and reproductive health implementation in Orellana - and most likely in other similar isolated areas - faces also the problem of being inadequately represented by national statistics that underestimated the problem and disregarded inequities. National data were showing a less dismal situation for the province and were unable to point out which were the women living in situations of highest vulnerability regarding the exercise of their sexual and reproductive rights: indigenous women living in rural areas. Moreover, accountability mechanisms remained inefficient, thus turning difficult the implementation of the well intended national policies and programs.

Focusing on adolescents’ sexual and reproductive health, policies and programs also existed in Ecuador (CNE, 1998b; MSP, 1995; MSP, 2005; MSP, 2007b). As in other Latin American countries (UNFPA, 2005a), the majority of those programs were implemented through the ministries of health, and thus focused on issues that could be dealt by the medical profession. In this way, adolescent pregnancy and adolescents’ sexual and reproductive health have become an area of medical research and, more recently, of medical practice. This orientation had implications on the array of services that were perceived as being within the state’s responsibility, and the ones that remained as “private issues” (the responsibility of the girls and/or their families). Girls were entitled to sex education and adolescent-friendly services, as means to preventing adolescent pregnancy, and to maternal services when they got pregnant. However, this study highlights that there are other issues that need to be taken into account for ensuring girls’ capability for exercising sexual and reproductive rights, whether pregnant or not. Some of those issues refer to the development of a relevant array of services that includes medical services and sex education but which also supports services for allowing adolescent mothers to remain at school or get a job, economic support, abortion services, and services for dealing with violence and sexual abuse (which were highly prevalent among adolescent girls, especially when pregnant).

This research also highlights some weaknesses in the existing array of services. Girls were entitled to a limited network of services that might not fulfill all their needs and the services they were entitled to were not delivered in a way that enhanced their capability for exercising their sexual and reproductive rights. Adolescents acknowledged receiving sex education but seemed not to have applied it, and it was not a factor that decreased the likelihood of experiencing adolescent pregnancy. The fact that there were already some providers questioning the quality of the sex education provided, and the hypocrisy of some schools that stigmatized adolescent pregnancy, is an encouraging sign that the situation could improve. Other means for ensuring that services are relevant to adolescents’ needs is adolescent participation, and this issue was felt as important by
service providers. However, barriers to meaningful participation still existed, especially in relation to providers’ adult-centric attitudes that devaluated adolescents’ opinions and initiatives.

Other issues that also influenced girls’ capability to exercise their sexual and reproductive rights referred to the so-called ‘social determinants of sexual and reproductive health’, such as socioeconomic situation, education enrolment, and gender relations and their impact on girls’ agency. Poverty and parental absence, risk factors for adolescent pregnancy in Orellana, have also been associated with adolescent pregnancy in other settings (Dias & Aquino, 2006; Florez, 2005; Flórez & Soto, 2008; Gigante et al., 2008; Guijarro et al., 1999; Guzman et al., 2001; Peres et al., 2008) and they could be labeled as social determinants of health. Sexual abuse is connected with gender-power relations and it has been claimed to be not only a way of exercising violence but also of maintaining women’s subordination and men’s control of their sexuality (Connell, 1987). This study highlights how gender-power relations limit girls’ capability for exercising their sexual and reproductive rights. Consequently, gender subordination could also be labeled as a social determinant of sexual and reproductive health, as could marital status and education enrolment; the three are interconnected, being in a formal union limited girls’ capability to practice safe sex through gender relations that placed girls in a subordinated position, and through the negative effect of marriage upon girls’ enrolment in education. It remains a question as to how the health system might be able to appropriately deal with the issue of adolescent pregnancy when the majority of social determinants of adolescent pregnancy and adolescents’ sexual and reproductive health that emerged from this study, remains far beyond the scope of this sector.

Within the wider picture of women’s sexual and reproductive health in Orellana, ageism could also be seen as a social determinant of health. Ageism in this context means that adolescent girls’ access to reproductive health services is limited by the fact that they are young. In that sense, contraceptive use was lower when compared with their adult counterparts, while access to skilled delivery care was higher. Thus, it seems that when gender norms intersect with age norms, access to services related to maternity increases, while access to services related to sexuality is curtailed. This may reinforce the contradictory message that sexual intercourse should not be encouraged for girls, while motherhood should be endured, fitting with the machismo-marianismo system’s impossible ideal of womanhood, simultaneously combining sexual chastity and motherhood (Berglund et al., 1997; Lagarde, 1990; Montecino, 1991).

According to the rights approach to health, states are responsible for ensuring that measures are taken with due diligence to address the social determinants of health (Braveman & Gruskin, 2003; Gruskin et al., 2007; UNHCHR & WHO, 2008; Yamin, 2008). However, providers’ discourses placed the main responsibility for pregnancy prevention on girls’ sexual behavior and not on the state in terms of its responsibility to provide an adequate network of sexual health services. Other factors that could be considered as social determinants of adolescent pregnancy and adolescents’ sexual and reproductive health –such as poverty alleviation- were even less viewed as the state’s responsibility.
Gender regimes

Gender regimes refer to the gender arrangements within institutions such as schools, companies, health services, or families. By acknowledging the existence of gender regimes, institutions did not constitute neutral spaces with certain practical objectives, but were places where gender-power relations were produced and reproduced (Connell, 1987; Connell, 2002). In the context of Orellana, gender regimes were embedded within the machismo-marianismo system and thus were influenced by the configuration of adolescent girls as subordinated, sacrificed and sexually menaced while adult men were configured either as protectors or predators (Andrade & Herrera, 2001; Berglund, 2008; Berglund et al., 1997; Herrera, 2002; Miles, 2000; Stobbe, 2005).

The present study highlights a number of influential institutions in the area of adolescents’ sexual and reproductive health. At the more intimate level, the institution of marriage is a powerful one. Marriage is still viewed as a place of safety, especially regarding women’s reputations. Sexual intercourse and pregnancy within marriage are sanctioned for women, and this poses a challenge for adolescent pregnancy prevention since the majority of adolescent pregnancies in Orellana take place within formal relationships. Marriage does not seem to be such a safe place for girls as intimate partner violence within marriage was common and marriage was associated with premature exit from education. Formal partners of adolescent girls were mainly adult men with the obvious potential for power misbalance associated with large age gaps. The special vulnerability of married adolescents and young women to reproductive hazards such as HIV and sexually transmitted infections, violence and unwanted pregnancy has also been highlighted by other authors and
The “nuclear heterosexual family” is another key institution. It is interesting that what is idealized is not the extended family, which is the traditional family model in this setting, but the modernized version of father, mother and children. Families are perceived as the core of society and are seen as having greater influence and responsibility for educating children and adolescents about sexuality. The presence of at least one parent during the adolescent girl’s life protected them from early pregnancy, and mothers were seen as very important in the lives of adolescents who got pregnant or who were already mothers. Contradicting this perception of families as safe places, sexual abuse and sexual exploitation were cited as being mainly inflicted by family members, and many times with the complicity of the wider family. Thus, the protective effect of the family may not lay in any particular structure - such as the nuclear heterosexual family - but in its ability to provide an emotional attachment with a caring adult who remains supportive to the girl.

Even if the nuclear heterosexual family is considered as the ideal, it is also apparent that it is far from the norm since households headed by single females are common in this area. Ironically, the reality of many families being headed by single mothers further reinforces the orthodoxy of women as sacrificed mothers and men as unreliable as fathers; while the fact that those families did not comply with the ideal structure of the “nuclear heterosexual family” constructs them as defective, and charges the female heading the family with the responsibility for her daughter’s sexual behavior.

Another important institution is the school. Here, gender regimes become clear in the way schools approach pregnant or mothering students. Attitudes are changing but still a schoolgirl’s pregnancy is seen as a sign of illicit sexual intercourse, and consequently mechanisms for hiding this “body of the crime” remain in place. Responsibility is placed only on the girl who becomes pregnant and little attention is given to the man or boy who made her pregnant. Married pregnant girls enjoyed a higher status, but it seems that usually the students who get pregnant are not married, and this could be a reflection of the concept of pregnant girls as single, or the effect of marriage on rates of school dropout. Individual teachers with strong attitudes supporting pregnant students’ education may lead to a change in particular schools’ gender regimes. However, in other schools patronizing attitudes disrespecting girls’ right to privacy and confidentiality may lead to increased rates of drop-out. Arrangements to ensure that students who get pregnant or who have children remain at school were not perceived as important. Pregnant adolescents and adolescent mothers expressed strong interest in getting more education in order to be able to get better jobs and thus become economically independent from men. For ensuring that the educational system responds to these needs, those gender regimes that stigmatize adolescent pregnancy need to be challenged first.

Finally, health services also display gender regimes. Gender regimes within the health system establish what the state’s responsibility is and thus the object of policies and programs, and what is
not. What gets included and what remains excluded from public policies and programs resembles the public-private dichotomy: issues that could be dealt by the medical and educational professionals get included, while issues that are perceived as women’s tasks or family business - such as child care or dealing with intimate partner violence - remain excluded. The way encounters between providers and girls take place also bears patriarchal characteristics of producing and reinforcing men’s and adults’ domination and women’s and adolescents’ subordination (Connell, 1987; Connell, 2002). That curtails the interaction between providers and adolescent users of services, and also has an effect on the way youth participation is approached; it becomes downgraded or instrumentalized, since young peoples’ opinions are not perceived as being as relevant as those of adults, especially professional adults.

Girls “do gender” in relation with their partners, families, teachers, classmates, and health providers (Fenstermaker & West, 2002). These encounters take place within structures and rules that have being framed within a gender order, for example the nuclear heterosexual family and marriage are consequences of normative heterosexuality. Each of those encounters contributes to the constraining of girls’ sexual agency through their subordination to men, adults, professionals, and authoritative figures. Resistance remains possible, and could be enhanced when some of those more powerful figures challenge gender regimes - for example, when a teacher within a school openly criticized the school authorities’ discriminatory attitudes towards pregnant students.
Gender order

Gender relations influence the way girls express their sexuality and the decisions they make. As has been pointed out earlier, those gender relations are part of a wider structure that Connell names “the gender order of a society” (Connell, 1987; Connell, 2002). Even if this study does not focus on uncovering this gender order, some of its features came out when exploring gender relations.

This gender order is produced and reproduced through power relations, where men exercise power over women. Violence, sexual abuse, and forced unwanted pregnancy are means to exercise this power and control over women’s sexuality. Economic dependence on men is also a strong way for maintaining subordination. In fact, girls in this study recognized economic dependence as a powerful reason for being in a union, and attempted to resist it through education. In Orellana, gender regimes at schools, welfare policies and programs, and the job market do not facilitate women’s access to well-paid jobs.

Symbolic relations that construct women as passive and economically dependent on men further contribute to the justification for maintaining this dependence. Symbolic relations configure “good girls” as submissive, obedient, and sexually uninterested, while men are configured as naturally sexually driven. Motherhood is idealized, and men are configured as unreliable and absent. As a consequence, the expectation placed on men regarding their responsibility on issues of sexuality and reproduction is lessened, while girls are held responsible for the same issues and are criticized when failing. At the same time, results from this study show that the majority of partners of adolescent mothers are economically supporting their children. This could become an opportunity for a more optimistic configuration of men and thus for advocating their greater involvement in sexual and reproductive issues and fatherhood.

Finally, emotional relations play an important role. The romantic love ideal, the search for intimacy and affection, the need to show commitment, to express love and to be attached, play a powerful role in girls’ decision making on sexuality and pregnancy. Girls’ relations with their mothers are highly affective, and this connection could be a good opportunity for enhancing their sexual agency. Also, relations with providers bore emotional connotations; on the one hand they could enhance closeness, but on the other hand it could turn into paternalism and reinforce age discrimination.

Methodological considerations

Combining methods

For this project quantitative and qualitative methods were combined in a situational approach, in an attempt to answer each of the four questions through the most appropriate methodology (Dahlgren et al., 2004). Quantitative methods were used first, followed by the two qualitative studies, but both methodologies held the same relevance and complemented one other.

The combination of different approaches highlighted some difficulties when merging diverse theoretical traditions. The two quantitative studies looked for prevalence and risk factors, while the two qualitative studies focused more on individuals’ accounts. The two qualitative approaches were
also different from each other; while content analysis approached individuals’ accounts as interpreting reality, discourse analysis approached them as constructing reality. However, as pointed out in other studies, the combination of methods can be an adequate approach to explore the complexity of health issues (Barbour, 1998; Dahlgren et al., 2004; Morgan, 1998).

Challenges and measures for enhancing trustworthiness

Several measures were taken in order to enhance the research’s trustworthiness, both regarding quantitative and qualitative criteria. This section explores the measures taken, and the aspects that could have limited trustworthiness according Lincoln and Guba’s criteria of truth value, applicability, consistency, and neutrality (Dahlgren et al., 2004; Lincoln & Guba, 1985):

Truth value refers to the ability of the study to measure what it aimed to measure. According to quantitative standards it is defined as “internal validity” and relates to avoiding bias (Bonita et al., 2006; Hennekens & Buring, 1987). Selection bias could have occurred in the prevalence study, for instance, because the lack of accurate registers in the province might have led to the exclusion of some isolated communities. In the case-control study, selection bias could have occurred in the selection of controls, since cases who had undergone an abortion might have decided not to disclose it, and thus were wrongly classified as controls. In this study the matching criteria for cases and controls also limited the possibility to include ethnic differences as a potential risk factor.

Regarding qualitative standards, truth value is defined as “credibility” and refers to how well the findings had captured the reality being explored (Lincoln & Guba, 1985). In the two qualitative studies, since I was living in the area where the research was going on, credibility was enhanced by prolonged engagement in the area and persistent observation. The risk of naivety was minimized by discussion with the other researchers who were not familiar with the area. Other measures to enhance credibility included informal debriefing with colleagues and referent checking. Referent checking was done through informal interviews with young people who were not participants in the studies, and through two workshops where preliminary results were presented. The first workshop was held with young leaders, and the second one with service providers and policy makers. Both allowed us to see the reactions to our preliminary findings, and for us to refine them as a way of returning results. Triangulation was also used to enhance credibility. Triangulation of researchers, as I mentioned before, enabled the insider and outsider perspective. Triangulation of methods allowed noticing parallels, such as the relevance of gender issues. Triangulation of participants was done by involving both adolescents and service providers as participants. In order to stay closer to the text, the original Spanish version was used for coding, and translation into English only took place when categories and repertoires emerged.

Applicability is important in public health research since it refers to what extent results can be generalized to other settings. Quantitative studies seek external validity by appropriate sample procedures (Bonita et al., 2006; Hennekens & Buring, 1987). In our case, in both the prevalence study and the case-control study, we ensured that communities and participants were randomly selected, thus enhancing their likelihood of representing the real situation in Orellana. However, the absence of accurate local information for calculating the sample size in both studies could also have had an impact. The extent of analytical generalizability is arguable; however looking at the context, our results might reflect the situation of adolescent pregnancies and adolescents’ sexual and
reproductive health and rights in other Amazon provinces of Ecuador and neighboring countries in a better way than results of studies carried out in large cities of the same countries.

Qualitative studies seek transferability, since generalization from those studies is analytical and not statistical (Lincoln & Guba, 1985). In both our qualitative studies, transferability was enhanced by purposely selecting participants based on their ability to contribute to the study question. We also made an effort to contextualize the results in order to help readers evaluate to what extent our results were applicable in other settings.

Research consistency, according to quantitative criteria, is defined as “reliability” and refers to the likelihood of getting the same results if the study is repeated (Bonita et al., 2006). For enhancing reliability the prevalence and case-control studies used questionnaires that had already been validated in a similar setting, and they were piloted prior to application. The use of the ACE questionnaire for investigating adverse events during childhood could be perceived as inadequate for this setting, however a better instrument was not available and during piloting it became clear that it was understandable and meaningful for participants. Interviewers were well trained and supervised, and they came from a similar background to that of the participants (female, young, living in Orellana, Spanish as mother tongue for two and Kichwa [indigenous language] as mother tongue for one).

In qualitative research, consistency has a different meaning and it is defined as “dependability” or the ability to respond to issues emerging from the data (Lincoln & Guba, 1985). In both our qualitative studies we followed an emergent design, and responded to constant change even if that implied modifications on the planned schedule. The interview guides allowed the incorporation of issues emerging from previous interviews, and we used preliminary emerging results to refine the design of the following studies.

The final dimension of trustworthiness refers to neutrality (Dahlgren et al., 2004; Lincoln & Guba, 1985). Quantitative studies claim neutrality and objectivity by maintaining distance from the observed phenomenon, while qualitative studies deny the possibility of researcher’s neutrality and seek neutrality in the data (confirmability). In this aspect our research followed the qualitative criteria of confirmability even when approaching the quantitative studies. We, as researchers, were not neutral. From the moment we selected the research question, the methods, and the approach, we were already orienting the results. However, that did not mean that our research was just showing what we wanted to argue from the start. To enhance data neutrality, we put our preunderstanding into “brackets” (Husserl, 1973). That meant in the quantitative studies, looking for all the results and not hiding the ones that did not support our working hypothesis. In the qualitative studies, that meant not going in-depth into existing theories until findings were analyzed, and not excluding contradictory findings. As a way of enhancing confirmability we recognized and stated our position as researchers, not as neutral observers but as exploring the results from a rights and gender perspective. Finally, we also tried to detail the methodology to show how we reached the results, so readers could follow our arguments and audit the process.

Table 5 summarizes the main limitations of each of the papers and of the overall study.
Table 5. Summary of main limitations of Papers I-IV.

| Paper I | Isolated communities might have been left out because of inadequate registration procedures in the province.  
 | Desirability bias might have influenced some responses, such as under representing the prevalence of unwanted pregnancy.  
 | Recall bias could have affected data regarding the dates of birth.  
 | Evaluation of women’s reproductive health situation left out issues such as sexually transmitted infections, HIV, sexuality, or violence, and thus led to narrow view of reproductive health.  
 | Indicators used in the local study and in the national survey sometimes differed, making comparisons more difficult.  
 | Lack of information regarding policy implementation limited the application of the HeRWAI instrument. |
| Paper II | Sample-size calculated with estimates from other settings since information from Orellana or anywhere else in Ecuador was not available.  
 | Selection bias could have occurred when classifying cases and controls; for example single mothers underrepresented or girls who had had an abortion could have been misclassified as controls.  
 | Since parental permission was sought, girls suffering from sexual abuse within family might have been prevented from participating.  
 | Control-group included both sexually active and non-sexually active girls, thus with completely different probability of getting pregnant.  
 | The adequacy of the ACE questionnaire can be questioned (developed for USA), but no other instrument was available.  
 | Social-desirability bias might have lead to under-reporting of events such as intimate partner violence or contraceptive use among single girls.  
 | Matching criteria did not allow to analyze the effect of ethnicity on adolescent pregnancy.  
 | Regarding some variables information on timing was not collected, making it impossible to determine whether they were cause or consequence of early pregnancy. |
| Paper III | Social desirability bias could have occurred.  
 | The position of the interviewer (adult, European, professional) might have affected the answers of the participants.  
 | Analyzing both pregnancy and motherhood, raised different feelings that many times conflicted.  
 | The first author’s long residence in the area and involvement in the field of sexual and reproductive health might have influenced the results, despite the effort to bracket any possible pre-understandings.  
 | The translation into English might have distorted the true meanings of the results.  
 | Theoretical framework of gender-power might have hide girls’ voices.  
 | Diversity of experiences of being pregnant as an adolescent was not explored, since focus was put on commonalities. |
| Paper IV | The study did not explore differences between discourses of different providers (e.g. men and women, or health providers versus other disciplines).  
 | The fact that anonymity was not achievable in the focus groups might have affected the results. |
| General | Sexuality was not explored in depth.  
 | Heterosexuality was neither explored nor problematised.  
 | Adolescence as a social construction was not problematised.  
 | Difficult to balance respecting the integrity of girls’ decisions with condemning the conditions that might force them to make particular choices. Mechanisms of resistance and challenge might not have been adequately highlighted.  
 | Ethnic and cultural issues were not explored in-depth.  
 | Men’s and boy’s perspective on fatherhood were not explored.  
 | The variety of methods and issues explored –pregnancy prevention, but also pregnancy and maternal care for adolescents, rights, gender, etc.- might have complicated the picture and lead to shallowness. |
Reflecting on my role: insider-outsider

This research was initiated while I was still working in a sexual and reproductive health project in Orellana, so I have been both an insider (through my daily work) and outsider (through my role as a researcher). Being recognized as an insider was an advantage when looking for participants for the interviews, and it facilitated access to service providers and policy makers. It also gave me the opportunity to share some of the preliminary results and get comments. On the other side, I cannot claim to be neutral or blind. My theoretical and empirical background and orientation towards rights and gender equity influenced the research topic, the approach to it, and the interpretation of the results. Another person in the same setting could have looked at the same issue in a different way, and could have ended-up with different conclusions. However, as already said before, I tried to put my preunderstanding in “brackets” while doing the analysis, and let the statistical data and the participants’ words to speak for themselves (Creswell, 1998; Dahlgren et al., 2004; Husserl, 1973).

Another issue that has to be acknowledged is that I was not a truly an “insider”, and that could as well have had implications. I lived in the area, I was familiar with adolescent pregnancies, but I was also a European, an adult, and a medical doctor. All those labels separated me from the participants in the study. I bore in mind the risk of an ethnocentric and adult-centric approach, and hope that this awareness helped to avoid patronizing and biased attitudes.
CONCLUSIONS

To be pregnant as an adolescent girl in Orellana was a reflection of the general neglect that the population of this region suffers in terms of socioeconomic development compared to other parts of the country. The close link between structural factors such as poverty and adolescent pregnancy was evidenced once more in this study. The implementation of women’s sexual and reproductive health policies and programs was also neglected in this area. Limited access to appropriate and integrated sexual and reproductive health services translated into low levels of modern contraceptive use and high levels of unwanted pregnancy, especially among indigenous women. Services were medicalized, oriented towards married women, patronizing, and did not adequately respond to adolescents’ needs. Access to such services was not encouraged for adolescent girls, thus leading to low levels of contraceptive use, and high prevalence of adolescent pregnancy.

However, high prevalence of adolescent pregnancy was not only a reflection of limited access to sexual and reproductive health services. Gender-power relations modulated girls’ sexual agency and their decision-making regarding sexuality and reproduction. Gender relations operated through intimate relationships, family, gender regimes of schools and health services, and the gender order. Power, production, emotional and symbolic relations contributed to girls’ subordination towards men, adults and professionals. They operated subtly through symbolism that idealized the sacrificed-mother and the submissive and chaste girl, or violently through sexual violence and exploitation. Thus, girls’ decisions regarding sexuality and pregnancy in Orellana were constrained by the general dismal situation of the province that limited their access to services and opportunities, and by the disadvantaged position they faced within gender and generational relations.
IMPLICATIONS FOR PRACTICE AND FURTHER RESEARCH

Implications for practice

The implementation of the National Policy of Sexual and Reproductive Health and Rights

- Accurate information sets the basis for relevant policy and practice. This study points out that: first, national data did not represent the true situation in Orellana (and most likely in other remote areas of the country), and secondly, it is possible to gather and analyze data locally. Therefore, it might be worthwhile to establish mechanisms for the production of information locally. Those mechanisms will need to ensure the quality of the information collected, strengthen the local capacity for data analysis and information-based policy-making, and take into account issues such as the comparability of information between different regions.

- Reproductive and health interventions in the province of Orellana need to focus on the groups that have suffered from the lowest access to services, namely rural indigenous women. Interventions need to be implemented in a way that is acceptable for them.

- There is a need to discuss mechanisms for ensuring the implementation of the National Policy of Sexual and Reproductive Health and Rights through concrete programs that reach the local level. Mechanisms for ensuring the proper monitoring and evaluation of those programs also need to be discussed, alongside ways to enable users to channel their opinions and suggestions in such a way that influences decision making and practice.

- Two issues are still not strongly addressed in the National Policy which are relevant for the exercise of adolescents’ sexual and reproductive health and rights: sexual abuse and legal abortion. It seems that an open debate regarding these issues is urgently needed, alongside their effect on the exercise of adolescents’ sexual and reproductive rights, and suggestions for modifying the legislation.

The provision of adolescents’ sexual and reproductive health services

- Mechanisms to strengthen adolescent-friendly services might benefit from an open discussion where providers would be able to hear different opinions, actualize their knowledge, and question their own attitudes and approaches towards adolescents’ sexual and reproductive health and rights.

- Providers working with adolescents should receive a proper training including not only practical clinical knowledge, but also theoretical knowledge related to gender, rights and sexuality.

- Since contraceptive use prevents adolescent pregnancy (alongside other problems such as sexually transmitted infections in the case of condoms) improved access to contraception for adolescents should be strongly encouraged. This seems to be not just a matter of availability,
but also of challenging the attitudes of providers, teachers and parents towards a less moralistic and more realistic approach towards adolescents’ sexual and reproductive needs.

- Programs need to evaluate their approach in order to avoid “mother-nization” of services for girls or patronizing attitudes. They should also explore ways for addressing men’s and boys’ reproductive and sexual health needs and to involve them in the process of their partner’s pregnancy and childbirth.

- It is important to take into account in the provision of services, the connection between adolescent pregnancy and sexual abuse. Services for pregnant adolescents should investigate past and ongoing sexual abuse and establish links with institutions and organizations with expertise in managing that problem; while institutions and organizations dealing with child sexual abuse should take into account the increased risk of adolescent pregnancy among sexually abused girls.

- Since sexual abuse seemed to be a common phenomenon, all institutions and organizations working with adolescents and children need to be familiar with the correct protocol to adequately manage those cases, including a reference system and universal access to emergency contraception.

- For adolescent girls who get pregnant or already have children, efforts should be made in the educational system to make it possible for them to remain at school. Welfare measures to enable them to be autonomous seem appropriate.

- In Orellana there are a number of different actors with diverse expertise, and this variety of knowledge should be taken advantage of in order to develop a network for both sharing knowledge, and providing comprehensive reproductive and sexual health services for adolescents.

- The stereotype of the adolescent girl as single, and the view of marriage as a place of safety should be questioned. Providers in Orellana should recognize that the majority of adolescent pregnancy takes place within “formal” unions and be aware of the risks that “married” adolescent girls might face regarding their sexual and reproductive health.

**Empowerment**

- Programs and policies for adolescent pregnancy prevention should not attribute blame to the individual girl by viewing adolescent pregnancy as girl’s failure to engage in “safe-sex”. Programs need also to take into account the important role of structural factors such as poverty or parental absence and find ways to ameliorate the impact of such factors on adolescents’ sexual and reproductive health.

- Empowering women of all ages regarding their sexual and reproductive health and rights, and facilitating an open debate and interaction between different generations of women, might lead to mothers giving better information to their daughters and also contributing to enhancing young girls’, and their own, agency.
Strengthening adolescents’ participation in policy-making and service implementation is a cornerstone for ensuring the relevance of services, and might also serve as a way of empowering young girls and boys in exercising their rights.

Since gender inequity and girls’ subordination strongly curtailed girls’ capability for exercising their rights, measures to enhance gender and generational equity are needed for a sustained improvement in the sexual and reproductive health of girls in Orellana.

Implications for further research

- This study points out inequities in the exercise of sexual and reproductive rights, and it would be interesting to further investigate what lies behind those inequities and how they could be overcome; for example, to explore the rationale behind indigenous women’s strikingly low access to skilled delivery care and modern contraceptive use.

- This study highlights some factors that increased the risk for adolescent pregnancy. However, further research is needed to determine the characteristics of the connections between adolescent pregnancy, dropping-out of school, and early marriage. It would also be interesting to explore the consequences of early marriage for young girls’ sexual and reproductive health.

- The perceived high prevalence of sexual abuse during childhood and adolescence deserves further research. Exploring the magnitude of sexual abuse in Orellana might be challenging but could be a good way of putting this problem on the local policy makers’ agenda.

- More in-depth research on the role of education as a mechanism for girls’ empowerment and the response of the educational system to this aspiration would be interesting.

- This study highlights the need for adequate information, counseling and services for adolescents, and the need to improve their delivery. Therefore, it would be interesting to explore more deeply which are the best ways to implement adolescent-friendly services.

- Another relevant aspect was the importance given to young people’s participation. Since the conceptualizations of participation varied widely, it would be interesting to explore more deeply the meanings assigned to participation from the points of view of the different actors, and the potential impact of young people’s participation on the sexual and reproductive health of young people.

- This study only focused on the girls not exploring boys’ and men’s perceptions as partners, fathers or users of services. It would be useful for strengthening policies and services to explore the perspectives of young men regarding issues such as access to services, and their perception of reproductive and sexual health and rights, gender relations and fatherhood.

- Another aspect of pregnancy prevention that this study obviated was pregnancy termination. It would be pertinent to explore the experiences of girls who decided to undergo abortion and the
role that safe abortion could have in the prevention of adolescent pregnancy and the exercise of girls’ sexual and reproductive rights in this setting.

- Finally, it would be interesting to explore the usefulness of the framework of gender and rights to approach other issues related to sexual and reproductive health, such as HIV, infertility, contraception, maternal health, cervical cancer, gender based violence or sexual abuse.
BRIEF REFLECTIONS FOUR YEARS LATER

I started this research project with the aim of understanding better the situation of sexual and reproductive health of adolescent girls in order to strengthen the work we were doing in Orellana. After four years of struggling with numbers and words, I ended up with contradictory feelings. On the one hand I realized that the activities UNFPA was developing in the area constituted an integral approach and had enabled the people involved (young leaders, teachers, health and social providers, among others) to share different perspectives and question their own prejudices regarding adolescents’ sexual and reproductive rights. On the other hand, I realized that there were no magic bullets. The factors that influence girls’ capability to make choices regarding sexuality and pregnancy are so deeply rooted and have so many political implications -such as poverty alleviation, the investment on social services or gender equality- that it will take a long time to eradicate them. Nevertheless, I think that this thesis also points out some issues that could be addressed in a shorter time, such as the provision of adolescent-friendly services, the construction of networks of expertise, or the implementation of protocols for adequately managing sexually abused girls.

The challenge is now how to ensure that the issues highlighted by this research project could be taken into account in local, and maybe even national, policies and interventions. In Orellana, the scenario is now different from four years ago: reproductive and sexual health has become relevant to the work of local organizations and institutions such as the provincial departments of health and education; UNFPA’s leading role has become less prominent, thus leaving room for a greater involvement of the public institutions; also youth and adolescents’ networks have become stronger and young people have gained access to certain levels of policy-making; and through the National Plan for Adolescent Pregnancy Prevention, adolescent-friendly services had started to be provided through existing public health services in Orellana. Within the actual scenario, the implications for the practice described before could be useful to strengthen the ongoing interventions, and there is a network of organizations, institutions and persons that may be interested in taking them into account. The workshops held in April 2009 have become the first step in making these results accessible in Orellana. During those workshops, participants mainly agreed with our findings and suggested some issues that may deserve further research. It was also felt that young people’s voices are still perceived as secondary to professionals’ voices, and ignored when they contradict the views of already existing plans and programs. Moreover, the workshops showed that communicating results to young people requires a different approach from communicating them to policy makers and service providers. The first step has been taken: we have some insights from four years of living, working, and researching in the area, thus maintaining the connection between research and practice. Several more steps need to be taken; such as the translation of this thesis, not only into Spanish but also into Spanish-friendly versions for young people and for policy makers. Moreover, disseminating results does not end with producing and distributing documents but also entails ensuring spaces for presenting and discussing them, using research as a means to strengthen the relevance of policies and programs.
It has been a long journey, but it should not end with a document which is mainly for the consumption of the academic community. Four years later, and writing the final words of this “kappa”, I hope that this work will also become a new beginning.

Image 15. Women and girls participating in a reproductive health workshop in a rural community of Orellana.
ACKNOWLEDGEMENTS

A large number of people have contributed to this small piece of research; some of whom I already knew well before I started and many others who have become important to me during this journey. To all of them I want to send a huge thank you!

I owe much gratitude to my three supervisors: Marianne Wulff, Miguel San Sebastian and Ann Öhman. I would never have expected that my first meeting with my main supervisor, Marianne Wulff, would be a family dinner at her house!!! And her kindness has endured to this day. I am really grateful to her for providing sound advice, encouragement, much fun, and support not only on the technical and logistical aspects of the thesis, but also on making me feel warmly welcomed. I have to give thanks as well to Steen and Maria, for all the lovely dinners, “fikas”, excursions, and even for taking care of Peio while I went out for dinner!

To Miguel San Sebastian, I feel deeply in debt to him. I found out about Umeå because he happened to be working there and he was the one who suggested the possibility of starting a PhD; so I think that if he had not been here I would not have written this book (maybe he regrets having been here now!!). During the process he has been an endless source of guidance and support, quickly replying to so many drafts and even fighting with journal editors on my behalf!!! I am grateful as well to Miguel’s family, Anna-Karin, Emil and Sisa for all the warm welcomes, gatherings and invitations, and for such nice details (like sharing your toys with Peio!!!).

It has also been a pleasure to work with Ann Öhman. She was responsible for making me almost crazy trying to read all those books about gender theory and feminism that made me realize how ignorant I was (I still am…) on gender issues. It has been a privilege to be supported by such an expert on gender studies and I really appreciate not only her sound comments but also her never forgetting to let me know when and what I was doing well.

On this side of the ocean, I also have to thank all the staff and students at the Division of Epidemiology and Global Health and also at the Division of Gynecology and Obstetrics. I am especially grateful to Birgitta Åström and Anna-Lena Johansson, who always helped with the logistical arrangements and always ensured things go smoothly. I am also very grateful to Lena Mustonen who helped with all the printing arrangements and with the layout of figures, tables and so on. It has been such a pleasure and joy to meet people from so many different places in the world, and from so many disciplines. I have learnt a lot from many of them and from attending so many diverse research presentations (that also gave me credits!!!). I am especially grateful to the “Latina girls”: Lorena, Cynthia, Erika, Alison and the “adopted” YienLing… it has been great relief to be able to chat and make jokes in my own language!!!

I am also very grateful to Ulf Högberg, Aina Tollefsen and Maria Emmelin for their many comments and suggestions during the midterm seminar; they were very useful and oriented many of the decisions I made afterwards. I am also grateful to Anna-Karin Hurtig and Maria Wiklund, for reading the whole thesis and giving their comments to improve the final version. I am also grateful to Anna-Britt Coe for her support and wise comments on Paper I and to Marianne Winther Jørgensen for introducing me into the world of “interpretative repertoires” and kindly advising me on their use in Paper IV.
ACKNOWLEDGEMENTS

I am really grateful to all the staff at Solskenet Day Care Center, specially to Maria, Pernilla, Anika, Charlotte, Malin, Linda, Majvor and Emily, for taking care of Peio while I was “i skolan”, working on this thesis.

In Ecuador, I am very grateful to all the staff at Fundación Salud Amazónica and UNFPA Ecuador for allowing me to combine this research with my work. I am especially in debt with Alba Aguirre, who was my boss when I started this research project and strongly encouraged me to get on with it. I am also grateful to Mercedes, Marcia Elena and all the other colleagues at the UNFPA office in Quito and in Manabí and Riobamba. I am also grateful to Family Care International, especially to Martha, Cristina, Maria, Maritza and Alexia, for giving me the opportunity to participate in an interesting project with indigenous women while at the same time continuing with my thesis. In Coca, I am grateful to my former boss Fabiola, and all the staff at FUSA headquarters: Hugo, Nabor, Guillermo, Edy, Norma and Johana. I am especially in debt to my closest colleagues with whom I have worked since 2001 in the FUSA-UNFPA Sexual and Reproductive Health and Rights project in Coca: Manoli, Amaia, Pati, Alba, Leito, Leti, Papo, Rocio, Franklin, and Maritza and Marcela, in Lago Agrio. I learnt so much from all of them. I had so much fun and they have been the best (and most crazy) working team I could ever have dreamt of. I am also grateful to all the young leaders who helped me with the data collection and with informally commenting on the preliminary results. In the Provincial Ministry of Health Office I am highly indebted to Rosa Japón, and in the Provincial Ministry of Education to Alberto Mayalica; both always helped with arranging workshops, getting signatures and permits, and even locating potential participants for the focus group discussions. I am also very grateful to all the staff at the Health Department of the County Council, especially to Juan Balseca, Jimena Freire and Alba Peralta, who always supported this research. Finally I wish to thank the Consejo Provincial de Orellana and especially all the staff that worked in the data collection of the Demographic, Health and Environment Study in Orellana: Gaby, Johana, Doris, Rosaura, Hernán, and Augusto.

Above all, I am grateful to all of the women and girls who participated in the surveys, to all the girls who shared their experiences with me in the individual interviews and with all the providers and policy makers that participated in the focus group discussions. Without their first-hand knowledge, this book would have not been produced.

Thank you Marcela for taking care of Peio with such love and tenderness while I was dedicated to this research. And finally I wish to give a special mention to my family, both in Spain- aita, ama, Fran, Aran, Mikkel, tía Isabel- and Ecuador- Delfín and Peio. My parents have always encouraged me and this time has been no exception. Without their help taking care of Peio (and cooking us delicious meals!!!) while we settled down in Umeå and he got accustomed to the Swedish dagis, things would have been too hard for us. Being such a long time away from Delfín has make me realize how much nicer things are when we are together; I am grateful for his encouragement and support on all the decisions I take, and for such a nice summer in Umeå keeping me company while I was writing the Kappa. I was six months pregnant with Peio when I presented my research proposal and now he is three-and-a-half years old, and he has been my closest collaborator during this journey. I am so grateful for his company, and for making me closer to the participants in my study.
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