ORIGINAL ARTICLE

SOCIAL AND OBSTETRIC PROFILE OF PREGNANT ADOLESCENT WOMEN[1]

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ABSTRACT
Adolescence is the stage of life between childhood and adulthood, marked by complex processes of biopsychosocial growth and development. In this period, the early onset of sexarch, associated with lack of knowledge in terms of contraceptive methods and low schooling, results in an increase in sexually transmitted diseases and unwanted pregnancy. The objective of the study was to identify the social and obstetric characteristics of pregnant adolescent women. This is a descriptive, retrospective, cross-sectional and quantitative study, developed with data from 2011, 2012 and the first half of 2013, involving 309 pregnant adolescent women aged between 10 and 19 years. Data were collected through a form, in the Prenatal and Puerperium Attention and Monitoring System and Local Ambulatory Information System, as well as physical and electronic records of 32 family health units of a city in the Midwestern region of the state of São Paulo. For data analysis, descriptive statistics and association tests were used. It was found that 36% of pregnant women attended six or more prenatal visits. The prevalent age range was 16 to 19 years. Adolescents' health education, as an attempt to reduce gestation in adolescence, is essential in order to improve the quality of life of the mother-baby binomial.

Keywords: Adolescence. Teenage pregnancy. Health education.

INTRODUCTION

Adolescence, delimited between 10 and 19 years by the World Health Organization (WHO)[1], is a transition stage between childhood and adulthood. It is marked by a complex process of biopsychosocial growth and development and by profound changes and transformations that require attention, which may or may not result in future problems[2].

The beginning of sexual activity of young people is considered a milestone, since, besides being an important factor in the transition to adult life, it includes a group at risk for the onset of sexually transmitted diseases (STDs), unplanned pregnancies, gestational and labor complications, as well as abortions[3].

In the world scenario, the theme of adolescent pregnancy has presented itself with increasing importance, and it was considered a public health problem in many countries. Adolescents aged 10 to 19 years account for 11% of worldwide births and 23% of the global burden of illness (Disability-adjusted life years) due to pregnancy and childbirth[4,5].

At present, the numerous transformations in the most diverse fields, political, economic and social, lead the excess of information and freedom transmitted to the adolescents to greater participation in diverse types of subjects, including sex. In addition, the characteristic impulsivity of this phase, low self-esteem, aspiration to maturity and the fact that pregnancy is often part of the adolescent's life project in an attempt to achieve economic and emotional autonomy, end up interfering with the increase in the incidence of desired and undesired pregnancy in adolescence[2].

In this perspective, health promotion presupposes the recovery of community participation, which

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should be encouraged, recognizing people as capable of promoting self-care. This is why it is important to stimulate the formation of group dynamics in the communities assisted by the *Rede de Atenção à Saúde* (RAS - Health Care Network), since, in addition to contributing to the health promotion of these individuals, they can become partners in addressing the main problems of the community, especially with regard to primary health care. The educational actions in health face the challenge of innovating, recovering the social spaces existing in the neighborhood, creating networks of support to the community and acting interdisciplinarily[6].

Thus, considering the multiplicity of factors resulting from gestation in adolescents' lives and the fact that intersectoriality, multiprofessionality and professional training are strategies that can contribute to the improvement of their prevention, this study is justified by the need to increase knowledge regarding the scenario of teenage pregnancy, responding to the objective of identifying social and obstetric characteristics of adolescent pregnant women.

This research was supported by the Ministry of Health (MoH) through the *Programa de Educação pelo Trabalho em Saúde (*PET-Saúde - Health Work Education Program) and was developed in partnership with the *Faculdade de Medicina de Marília* (FAMEMA - Medical School of Marília) and the *Secretaria Municipal de Saúde* (SMS - Municipal Health Secretariat) of a city in the midwest region of the state of São Paulo.

METHODOLOGY

This is an exploratory, descriptive, cross-sectional, and retrospective study that used a quantitative approach, carried out in a city in the Midwest region of the state of São Paulo.

The pregnant women participating in the study were selected based on a survey carried out in the *Sistema de Monitoramento e Avaliação da Atenção ao Pré-natal e Puerpério* (Pre-natal SIS - Prenatal and Puerperium Monitoring and Evaluation System) and the Sistema de Informação Ambulatorial Local (SIAL - Local Ambulatory Information System), including those registered in the years of 2011, 2012, and first half of 2013, aged between 10 and 19 years.

Data collection took place between July 2013 and March 2014, and was based on the evaluation of physical and electronic medical records of all 32 *unidades de saúde da família* (USF - family health

units) of the municipality, and the registration in the information systems mentioned above. To do so, it was used an instrument developed by the researchers and validated by five specialists in the subject, composed of the following variables: number of prenatal consultations, age of pregnant women, schooling, abortion incidence, pregnancy planning, number of pregnancies and marital status. All the available databases were included, seeking the coverage of all the pregnant women in the selected territory.

Data were collected by the students of the PET-Saúde Project, who were divided into random pairs and were responsible, on average, for collecting data from six to seven USF. Previously, a telephone contact was made with the trio manager of the health units to schedule the collection (doctor, nurse and/or dentist).

The data were organized and stored in Microsoft Excel® 2007 spreadsheet and were analyzed in the SPSS® 21.0 statistical tool. Due to the nature of the variables under study, the data summary used tables, number of individuals in each group, mean and standard deviation. For the verification of associations between the qualitative variables, the Pearson's Chi-square test was used and, when necessary, the G test by theoretical restriction, with approximation of the p-value calculation by the Willians' method or Fisher's Exact Test (FET) when indicated, with the calculation of the p value obtained with the Monte Carlo approximation. For the associations that presented significant Chi-square test, G-test or Fisher's exact test, the z-test was used for proportions, considering values above 1.96 in absolute value[7].

In the analysis of the data, the pregnant women, for whom there was no information on the variables under analysis, were excluded. The initial sample size of the study was 309, with possible variation in the tables of the results arranged, as a function of the variables under analysis. The significance level of 5.0% of probability for rejection of the null hypothesis was adopted in all tests.

The research complied with the ethical and legal precepts as determined by Resolution 466/12 of the National Health Council and was approved by the *Conselho Municipal de Avaliação em Pesquisa* (COMAP - Municipal Council for Research Evaluation) of the SMS of the city scenario of this study and by the Research Ethics Committee (REC) of the Faculty of Medicine of Marília, under CAAE No. 16335613.2.00005413 and Opinion No. 302 956.

RESULTS AND DISCUSSION

Prenatal care is universally recognized as a strategy for establishing a health surveillance process. The focus of this process is on the factors that determine the normal evolution of pregnancy, aiming at reducing maternal and infant morbidity and mortality[8]. In Brazil, the Ministry of Health recommends its start early in the first trimester of pregnancy, with at least six consultations among health professionals: doctors and nurses[9].

As shown in Table 1, the chi-square test result was non-significant ($X2 = 0.231$; g.l. = 3; $p = 0.972$), which allows to state that there is no association between age and number of visits, not observing significant differences between the observed and expected values in the general sample. There were similarities between the proportions of the number of consultations observed: five or less (5.6%, 21.0%, 35.7%, 37.8%) and six or more (5.3%, 27.0%; 36.3%, 35.4%), for the ages of 11 to 13 years, 14 and 15 years, 16 and 17 years, and 18 and 19 years, respectively. This result does not differ statistically from the marginal proportions observed in the general sample (5.5%, 21.9%, 35.9%, 36.7%).

Table 1. Relationship between age and frequency of follow-up to consultations during the Prenatal program of the Ministry of Health, involving 309 pregnant adolescent women in the period of 2011, 2012 and the first semester of 2013, Marília, SP, Brazil, 2014.

Age		Consultation No.[1]		Total
		Five or less	Six and up	
11to13 years	Score	8_a	6_a	14
	Expected Score	7,8	6,2	14,0
	% of Consultation No.	5,6%	5,3%	5,5%
	Adjusted residues	,1	-,1	
14 and 15 years	Score	30_a	26_a	56
	Expected Score	31,3	24,7	56,0
	% of Consultation No.	21,0%	23,0%	21,9%
	Adjusted residues	-,4	,4	
16 and 17 years	Score	51_a	41_a	92
	Expected Score	51,4	40,6	92,0
	% of Consultation No.	35,7%	36,3%	35,9%
	Adjusted residues	-,1	,1	
18 and 19 years	Score	54_a	40_a	94
	Expected Score	52,5	41,5	94,0
	% of Consultation No.	37,8%	35,4%	36,7%
	Adjusted residues	,4	-,4	
Total	Score	143	113	256
	Expected Score	143,0	113,0	256,0
	% of Consultation No.	100,0%	100,0%	100,0%
	% of the Total	55,9%	44,1%	100,0%9

$$X^2 = 0,231; g.l.= 3; p = 0,972$$

[1]Each subscribed letter indicates a subset of Consultation No.; equal letters indicate categories whose column proportions do not differ significantly from each other at the 0.05 level, by means of the z-test for proportions.

It is known that teenage pregnancy is considered high risk and it is related to the higher occurrence of preterm birth, low birth weight and inadequate prenatal care, which implies a lower number of visits, a later onset and a low number of complementary exams. Other related factors are the lack of information on the benefits of prenatal care and the shame of adolescents in seeking health care, especially among low-income people[12].

In Table 2, the result of the chi-square test was not significant ($X2 = 6.209$; g.l. = 3; $p = 0.102$), allowing to state that there is no association between schooling and the number of consultations, and there were no significant differences between the values observed in the general sample.

There were similarities between the proportions of the number of consultations observed, five or less (18.7%, 28.6%, 20.9%, 31.9%) and six or more (20.0%, 18.6%; 37.1%, 24.3%), for the ages of 11 to 13 years, 14 and 15 years, 16 and 17 years and, 18 and 19 years, respectively, and there was no statistical difference of the marginal proportions considered in the general sample (19.3%, 24.2%, 28.0%, 28.6%).

Despite the non-significant difference between the association of schooling and the number of consultations, there is evidence that gestation in

adolescence has repercussions on school dropout rates, both in the period before childbirth and later, impacting the mothers' level of education and decreasing their opportunities in society[10].

Table 2. Relationship between schooling and the frequency of follow-up to consultations during the prenatal program of the Ministry of Health, involving 309 adolescent pregnant women during the period 2011, 2012 and the first semester of 2013, Marília, SP, Brazil, 2014.

Schooling[2]		Consultation No.[1]		Total
		Five or less	Six and up	
EFF	Score	17[a]	14[a]	**31**
	Expected Score	17,5	13,5	**31,0**
	% of Consultation No.	18,7%	20,0%	**19,3%**
	% of the Total	10,6%	8,7%	**19,3%**
	Adjusted residues	-,2	,2	
CES	Score	26[a]	13[a]	**39**
	Expected Score	22,0	17,0	**39,0**
	% of Consultation No.	28,6%	18,6%	**24,2%**
	% of the Total	16,1%	8,1%	**24,2%**
	Adjusted residues	1,5	-1,5	
EMP	Score	19[a]	26[b]	**45**
	Expected Score	25,4	19,6	**45,0**
	% of Consultation No.	20,9%	37,1%	**28,0%**
	% of the Total	11,8%	16,1%	**28,0%**
	Adjusted residues	-2,3	2,3	
CHS	Score	29[a]	17[a]	**46**
	Expected Score	26,0	20,0	**46,0**
	% of Consultation No.	31,9%	24,3%	**28,6%**
	% of the Total	18,0%	10,6%	**28,6%**
	Adjusted residues	1,1	-1,1	
Total	Score	91	70	**161**
	Expected Score	91,0	70,0	**161,0**
	% of Consultation No.	100,0%	100,0%	**100,0%**
	% of the Total	56,5%	43,5%	**100,0%**
	$X^2 = 6,209; g.l.= 3; p = 0,102$			

[1] Each subscribed letter indicates a subset of Consultation No.; equal letters indicate categories whose column proportions do not differ significantly from each other at the 0.05 level, by means of the z-test for proportions; IES2 Incomplete Elementary School. CES3 Completed Elementary School (nine years). IHS4 Incomplete High School. CHS5 Completed High School (three years).

In a study carried out in the city of Curitiba-PR, it was found that, although the adolescents performed the prenatal consultations and all the exams adequately, they indicated a loss of educational opportunities due to pregnancy. Such situation is one of the main negative effects related to gestation in adolescence. It is clear that future plans and education itself is a frequent concern of young mothers[10].

Regarding the data that did not present significant, it is assumed that they may be related to the inadequate filling of medical records, since it was noticed that many of them were incomplete. This fact stems from the health professional's failure to record all data, either by forgetting, by considering the information irrelevant, due to lack of time for registration, or by the lack of training of employees. The results found in the physical records, and in agreement with the reality of the Sistema Único de Saúde (SUS - Unified Health System), show low or regular filling quality, although they are one of the data sources most used by the health system. Despite the importance of the medical record, it has been observed, in cases of judicial expertise, that this document is often incomplete, with illegible handwriting and data conflicting with those of nursing, or even absent[11].

This information reinforces the need for a targeted work so that professionals and academics are aware of the importance of correct registration of information, since the inadequate completion of records or lack of data weakens the trust relationship between health professionals and patients, resulting in loss of credibility, empathy and complications in the diagnoses, as well as consequent treatment impairment. Medical record is a rightful document of patients and its correct fulfillment contributes to the improvement of health professionals/patients relationship, as well as to the planning of health care, implementation of care, treatment and evaluation of the assistance results, besides acting as a useful tool for consultation, improvement of the health system and for supporting scientific research.

Table 3 shows an association between the marital status and the number of pregnancies, given the value of the Fisher's exact test (FET), which resulted in p=0.007.

Table 3. Relationship between marital status and the frequency of the number of pregnancies during the Prenatal program of the Ministry of Health, involving 309 pregnant women during the period 2011, 2012 and the first half of 2013, Marília, SP, Brazil, 2014.

Marital Status		No. Pregnancies[1]		
		Two and up[2]	One	Total
Married	Score	7_a	32_a	**39**
	Expected Score	8,7	30,3	**39,0**
	% of Consultation No.	16,3%	21,5%	**20,3%**
	% of the Total	3,6%	16,7%	**20,3%**
	Adjusted residues	-,7	,7	
Single	Score	11_a	72_b	**83**
	Expected Score	18,6	64,4	**83,0**
	% of Consultation No.	25,6%	48,3%	**43,2%**
	% of the Total	5,7%	37,5%	**43,2%**
	Adjusted residues	-2,7	2,7	
Stable union	Score	24_a	42_b	**66**
	Expected Score	14,8	51,2	**66,0**
	% of Consultation No.	55,8%	28,2%	**34,4%**
	% of the Total	12,5%	21,9%	**34,4%**
	Adjusted residues	3,4	-3,4	
Others	Score	1_a	3_a	**4**
	Expected Score	,9	3,1	**4,0**
	% of Consultation No.	2,3%	2,0%	**2,1%**
	% of the Total	0,5%	1,6%	**2,1%**
	Adjusted residues	,1	-,1	
Total	Score	43	149	**192**
	Expected Score	43,0	149,0	**192,0**
	% of Gestation No.	100,0%	100,0%	**100,0%**
	% of the Total	22,4%	77,6%	**100,0%**
	Fisher's Exact Test (F.E.T.): p = 0,007			

[1] Each subscribed letter indicates a subset of number of gestations; equal letters indicate categories whose column proportions do not differ significantly from each other at the 0.05 level, by means of the z-test for proportions; 2 Including a pregnant teenager with five pregnancies and eight with three pregnancies.

In the population of single people, the number of adolescents with two or more pregnancies was smaller than expected in the sample and there was one adolescent with gestation greater than expected. There was a significant difference between the proportions of pregnant adolescents: 48.3% with one gestation and 25.6% with two or more pregnancies. It was also observed that the proportion of pregnant adolescents differed statistically from one another. In fact, the proportion of adolescents with two or more pregnancies (25.6%) was lower than the general sample (43.2%), which is similar to the proportion of adolescents with gestation (48.3%).

In the stable union, the number of adolescents with two or more pregnancies was higher than expected in the sample, while the number of adolescents with one pregnancy was lower than expected; there was a significant difference between the proportions of pregnant adolescents, and the number of those with one gestation (28.2%) was lower than the quantity of those who had two or more pregnancies (55.8%). There was also a significant

difference between the proportions of adolescents with two or more pregnancies (55.8%), which was higher than that of the general sample (34.4%), which is almost similar to the proportion of adolescents with one gestation (28.2%).

Statistically similar results were identified, taking into account the z-test of proportions and the adjusted residuals for the marital status of married pregnant women. In these cases, the proportions of the number of pregnancies - two or more (16.3%) and one gestation (21.5%) were similar and did not present significant differences in the number of visits in the general sample (20,3%). In the item others, the proportions of the number of pregnancies - two or more (2.3%) and one gestation (2.0%) were similar among themselves and did not present significant differences in relation to the number of visits in the general sample (2 ,1%).

Considering the number of pregnancies and the marital status, it is noticed that the recidivism of the pregnancy in the adolescence, that is, two or more pregnancies, is greater when the conjugal situation is the stable union.

The stability of the relationship and the confidence acquired in the partner causes the adolescent not to be prevented properly. There is low adherence to family planning, lack of orientation regarding contraceptive methods, lack of use or inadequate use, and difficulty in terms of accessing contraceptive methods. It is emphasized that the fact that adolescents do not have adequate contraceptive methods means that they do not use these methods and get pregnant without planning, and do not prevent STDs[12].

Corroborating this situation regarding the stability of marital relationship, a study carried out in the state of Piauí observed a greater recurrence of pregnancy up to two years after the end of a gestation in adolescence, with a greater predominance of married pregnant women[13].

Another study, carried out in Natal-RN, shows that this factor is related to the repetition of pregnancy, as well as the low level of schooling, the inconsistent use of contraceptive methods and, mainly, the desire to be a mother as a life project for adolescents[16]. These data are reinforced by the WHO estimate and, according to it, 40% of adolescents who become pregnant will have a second pregnancy in the next three years[14].

The consequences of repeated pregnancies may result in family disorganization, school drop-out, social and labor market withdrawal, aggravation of emotional issues, which play an important role in this new phase, as well as contradictory family reactions such as feelings of revolt, abandonment and the acceptance or rejection of pregnancy and embarrassment. Many families come to radical attitudes, such as expelling the adolescent from home, inducing or forcing abortion and imposing responsibilities, requiring marriage or stable union[15].

As identified in Table 4, it was observed that, among adolescents (n=29; 100%) who planned gestation, 2 (6.9%) presented an abortion; and among those who did not undergo gestational planning (n=84, 100%), 4 (4.7%) had an abortion. Disregarding the forms that did not contain all the data, it stands out that only 26% of the adolescents planned.

In a study in which 201 adolescents who had abortions were analyzed, the result pointed to 73 (36.3%) adolescents who had planned their pregnancy and aborted and 128 (63.3%) who had not planned it and had abortions. It is worth mentioning that, in this same study, the absence of information in the medical records was related to nonconformities found in the relationship of abortions and gestational planning. Still, it is reiterated that most of the adolescents did not perform pregnancy planning, corroborating the data of the present study[16].

In the literature, there is the importance of the performance of primary health care in partnership with schools in order to work articulately the comprehensive evaluation of the adolescent. It is necessary to carry out actions that allow access to public policies for sexual and reproductive health care by adolescents[17].

Table 4. Relationship between planning and number of abortions of the adolescents of the family health units in the years 2011, 2012 and the first half of 2013, Marília, SP, Brazil, 2014.

Number of Abortions	Pregnancy Planning							
	Yes	%	No	%	No Information	%	Total	%
None	26	89,65	79	94,04	162	82,65	267	86,41
One	1	3,45	4	4,77	14	7,14	19	6,15
Two	1	3,45	-	-	1	0,52	2	0,65
No Information	1	3,45	1	1,19	19	9,69	21	6,79
Total	29	100,00	84	100,00	196	100,00	309	100,00

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The partnerships between teaching and practice, bringing the academy closer to health services, strengthen the units of the Family Health Strategy as a space for the production of scientific knowledge in order to rethink health practices, providing the incorporation of innovative proposals aimed at training adolescents to conscious choices, aimed to promote their autonomy. The use of problematizing methodologies has proved to be a challenge, because it is necessary to work prejudices and respect the other, in order to recognize the other as a source of knowledge, providing opportunities for personal and professional exchanges and growth[17].

FINAL CONSIDERATIONS

The present study had the objective of tracing the social and obstetric profile of adolescent pregnant women from a city of the state of São Paulo, Brazil, in order to provide knowledge in terms of better care of these patients by USF and the public health sector.

There was no significant relationship between the age of the pregnant women and the number of prenatal visits attended, nor was there a statistical significance between schooling and the number of visits. The age range of 16 to 19 years presented a higher rate of pregnant women, corresponding to 223 (72.1%) of the total number of adolescents participating in the study. It was found that the recidivism of pregnancy in adolescence is greater when the marital situation is a stable union and also that most of the adolescents did not carry out pregnancy planning.

As shown in other studies, there is a direct and important relationship between schooling or the level of information that adolescents receive and their pregnancy, and it is clear that, the more educated, the lower the percentage of preterm or recidivant pregnancies, and, if pregnant, the better the quality of life of mothers and babies.

Based on the "column profile" contingency analysis, there was a high number of non-responses in the analyzed variables, which resulted in inconsistent statistics in some tables, contrary to the associations observed in other studies. It means that, inadequate completion of medical records, probably exerted influence in the absence of associations between some analyzed variables. Thus, the importance of the development of strategies that promote the adequate practice of recording information in medical records is emphasized.

In addition, it is verified that health education processes with adolescents, involving the family environment, is essential for the reduction of pregnancies, both unplanned and planned, in order to improve their and their children's quality of life. Only education, not just awareness, leads young women to better job opportunities and pregnancy retardation in search of a better working life perspective. It is necessary to take into account the particularities of adolescents and respect the autonomy of the subjects.

Above all, the education of health professionals to correctly record medical records is of paramount importance in order to provide a tool capable of generating theoretical and scientific knowledge and better quality of care in terms of the relationship between health professionals and patients.

PERFIL SOCIAL E OBSTÉTRICO DE GESTANTES ADOLESCENTES

RESUMO

A adolescência é a etapa da vida compreendida entre a infância e a fase adulta, marcada por complexos processos de crescimento e desenvolvimento biopsicossocial. Nesse período, o início precoce da sexarca, associado à falta de conhecimento sobre métodos contraceptivos e baixa escolaridade, resulta no aumento de doenças sexualmente transmissíveis e gravidez indesejada. O objetivo do estudo foi identificar as características sociais e obstétricas de gestantes adolescentes. Trata-se de estudo descritivo, retrospectivo, transversal e quantitativo, desenvolvido com dados de 2011, 2012 e primeiro semestre de 2013, de 309 adolescentes de 10 a 19 anos, gestantes, coletados mediante formulário, no Sistema de Monitoramento e Avaliação da Atenção ao Pré-Natal e Puerpério e Sistema de Informação Ambulatorial Local, além de prontuários físicos e eletrônicos de 32 unidades de saúde da família de um município do centro-oeste do estado de São Paulo. Para análise dos dados, utilizou-se a estatística descritiva e testes de associação. Identificou-se que 36% das gestantes frequentaram seis ou mais consultas do pré-natal. A faixa etária prevalente foi a de 16 a 19 anos. Constatou-se que a educação em saúde das adolescentes é primordial como tentativa para a diminuição da gestação na adolescência, a fim de melhorar a qualidade de vida do binômio mãe-bebê.

Palavras-chave: Adolescência. Gravidez na adolescência. Educação em saúde.

PERFIL SOCIAL Y OBSTÉTRICO DE GESTANTES ADOLESCENTES

RESUMEN

La adolescencia es la fase de la vida comprendida entre la infancia y la fase adulta, señalada por complejos procesos de crecimiento y desarrollo biopsicosocial. En este período, el inicio precoz de la relación sexual, asociado a la falta de conocimiento sobre métodos contraceptivos y baja escolaridad, resulta en el aumento de enfermedades sexualmente transmisibles y embarazo indeseado. El objetivo del estudio fue identificar las características sociales y obstétricas de gestantes adolescentes. Se trata de un estudio descriptivo, retrospectivo, transversal y cuantitativo, desarrollado con datos de 2011, 2012 y del primer semestre de 2013, de 309 adolescentes de 10 a 19 años, gestantes, recolectados mediante formulario, en el Sistema de Monitorización y Evaluación de la Atención al Prenatal y Puerperio y Sistema de Información Ambulatoria Local, además de registros médicos físicos y electrónicos de 32 unidades de salud de la familia de un municipio del centro-oeste del estado de São Paulo-Brasil. Para el análisis de los datos, se utilizaron estadística descriptiva y pruebas de asociación. Fue identificado que 36% de las gestantes frecuentaron seis o más consultas del prenatal. La franja de edad prevalente fue entre 16 y 19 años. Se constató que la educación en salud de las adolescentes es primordial como un intento para la disminución de la gestación en la adolescencia, a fin de mejorar la calidad de vida del binomio madre-bebé.

Palabras clave: Adolescencia. Embarazo en la adolescencia. Educación en salud.

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