

**Sexual and contraceptive knowledge, habits and attitudes among first-year students at the University of Buenos Aires' medical programs.**

*Medical student research project, 2014-2015*

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## Abstract

Sexual and contraceptive habits, attitudes and knowledge are factors that are tightly intertwined with some of the most important challenges in global health today. They are central both to the fight against HIV/AIDS, family planning and the improvement of maternal health, which are specifically manifested in the UN Millennium Development Goals.

This paper deals with such issues among a specific study population, namely 505 first-year students at the programs of the Faculty of Medicine at the University of Buenos Aires, aged 19 to 24. Such a population is an interesting study object not merely because these are people about to enter into medical careers, but also because of several negative developments in Argentina, for example when it comes to contraceptive use and the incidence of HIV among the young. The data are based on an anonymous survey including a total of 67 different questions, conducted as part of the forthcoming PhD project of Provenzano Castro, M.D., and selecting the relevant questions for the purpose at hand here. Throughout the paper, the results are compared with earlier literature both in Argentina and outside – on young populations that are not specifically students on such programs in Buenos Aires.

The main findings are that (1) the students report a higher age of sexual debut than what has generally been found in Argentina among the young in general; (2) apart from contraceptive pills, the male condom, 'the emergency pill' and IUDs, the students have a relatively low knowledge of other forms of contraception, with no other form being known by more than 60 percent; (3) there are clear gender differences when it comes to knowledge, with males much less familiar with several forms of contraception, and more often answering erroneous ways of protecting themselves or the partner against HIV-transmission; (4) condom-use is reported as high at first intercourse (93.2%), higher among the males, and higher than in earlier studies in Argentina; (5) the respondents generally demonstrate positive attitudes towards condoms, but with the males being clearly more negative than the females; and (6) there is a large discrepancy between the *actual* and the *wished for* sources of sexual/contraceptive information, with parents, teachers and health-care professionals playing a lesser role than the students would have wanted.

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# 1. Introduction

Several of the most important challenges in global health today intersect at the topic of sexual habits, attitudes and knowledge – perhaps most specifically at the use of and attitudes towards condoms. Not only is the fight against HIV transmission dependent on condoms as a form of contraception; the knowledge and use of contraception in general is crucial to preventing unwanted pregnancies and thereby securing maternal health. Altogether, this is clearly manifested in two of the eight UN Millennium Development Goals (MDGs), namely (1) reducing the maternal mortality rate by two thirds, and (2) halting and beginning to reverse the spread of HIV/AIDS and malaria, while achieving universal access to HIV/AIDS treatment for those in need (Millennium Project 2006).<sup>1</sup>

This paper realizes the importance of such issues and sheds light on them from a country-based perspective. It probes the sexual attitudes, knowledge and habits of Argentinian first-year students at the Faculty of Medicine in Buenos Aires, aged 19 to 24, with the relevance to HIV/AIDS and maternal health clearly in mind. While giving due attention to condom use specifically, it also recognizes Green and Ruark's (2011) argument that the work against HIV/AIDS must not become too condom-centered, forgetting the 'culturally imbedded *behaviors* that spread HIV' (ibid.: 70). The paper therefore looks at factors such as *attitudes* towards condoms and *knowledge* of

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<sup>1</sup> The third of these goals is reducing the mortality rate for children under five years by two thirds.

contraception and sexually transmitted diseases (STIs), rather than merely the specific use of contraception.

Many similar studies have already been conducted – also in Argentina specifically. The difference in this study is that the respondents are all part of a specific group, being first-year students at the various programs at the Faculty of Medicine at the University of Buenos Aires. The rationale behind such a selection is twofold: Firstly, besides affecting these students' own lives, their attitudes and knowledge should also affect their future practice as health-professionals, including their ability to offer adequate information to patients. Discussing Argentina, Kamenetzky (2004: 22) argues that efforts towards HIV and AIDS require a 'paradigmatic change in beliefs and behavior'. Any such effort would need to include the actual workers within the health-care system themselves, and studying their beliefs and habits as they enter their study programs is one contribution in such a direction.

Secondly, earlier studies have shown an alarming level of stigmatization and discrimination from health care facilities, 'with people living with HIV experiencing judgemental [sic] attitudes from providers and refusal of services' (UNAIDS 2013: 84). This is most certainly a problem also in Argentina: Between 2008 and 2013, 16 percent of Argentines surveyed by UNAIDS reported having been denied health and/or dental services due to their HIV status, while a stunning 45 percent reported having been denied family planning services – the highest number in the UNAIDS list besides Rwanda (*ibid.*: 85). UNAIDS has stated clearly that 'intensified efforts are needed to reduce stigmatizing attitudes and behaviours among health care workers' (*ibid.*: x). Though the present study does not specifically look at stigmatization, it deals with central features of the students' knowledge-levels, which is inextricably connected to stigmatization/discrimination (NAT 2010: 19).

## 1.1 Design and methods

The findings here are based on the responses to a survey conducted in 2011 as part of the forthcoming PhD project of Belén Provenzano Castro, M.D., including a total of 658 respondents at the Faculty of Medicine at the University of Buenos Aires. About 4,900 students are admitted yearly to the Faculty. One first year class in every field of study. On average, about 4900 students are admitted yearly to the Faculty. Multi-stage random probability sampling was applied to choose one first-year class from each study field, while the participants were selected by non-probability sampling. The sample was then modified for gender and study program based on Faculty statistics of

distribution<sup>2</sup> Data were recorded anonymously. IBM SPSS v20 and Epidat 3.1 were used to analyse data. Out of the total of the 658 respondents, 103 were 25 years or older and have been filtered out of the findings reported here. There are two reasons for this decision: Firstly, the age-range of 19 to 24 corresponds well with earlier studies on young people’s sexual habits, and attitudes, knowledge and use of contraception - both domestically and internationally. This makes the data more relevant and translatable. Secondly, in this age group the ratio of medicine students was significantly higher with respect to other programs such as technical radiology and nutritional science, which can be considered more peripheral to the issues discussed here.

The total of 505 students between 19 and 24 years of age were 72.6 percent female and 27.4 percent male. Almost everyone (99.2 percent) was (formally) single. 1.9 percent of the females and 0.6 percent of the males had children at the time the study was conducted. The students were distributed across study programs as illustrated in table 1.1. Here we can see that looking specifically at those 24 years or younger changes the study program and gender distribution somewhat in comparison with the statistical distribution mentioned above. As shown by the table, the bulk of the students from both genders were taken from the medicine program – with 59.7 percent in total and 78.1 percent for males.<sup>3</sup>

Study program	Gender			Total
	Female	Male		
Medicine	52.8%	78.1%		59.7%
Nursing	9.3%	6.3%		8.5%
Obstetrics*	3.5%	0%		2.6%
Phono-audiology*	2.0%	0%		1.4%
Radiology**	12.7%	3.9%		10.3%
Nutritional science	11.0%	2.7%		8.7%
Chinesology and physiatry*	8.6%	9.1%		8.7%
Other	0%	0%		0%
TOTAL	100%	100%		100%

**Table 1.1 Distribution between study programs**

\*) Licence programs

\*\*) Technical program

The data reported here are based on a selection of questions from a questionnaire consisting of 67 different questions concerning sexual health,

<sup>2</sup> This statistical distribution was 54% medicine, 2% midwifery, 15% nursing, 10% radiology, 9% nutrition, 1% speech therapy and 8% physiotherapy. On the gender side it was 74% women, 26% men.

<sup>3</sup> One part of the findings, the knowledge of contraceptive forms reported in section 4.2, is based on a larger sample of respondents (617), from a later extension of the project.

habits and knowledge Participation was voluntary, with all respondents participating giving informed consent to this. Students were informed that the information in the study would remain strictly anonymous, with the data protected and remain covered by statistical confidentiality as is enshrined in Law 17.622, Article 10. This was considered ethically sufficient by the University of Buenos Aires, and no additional ethical clearance was sought (Brodahl & Hovind 2012: 14-15; 18). Those who were away from the University at the time of the survey did not have the chance to participate.

Furthermore, the paper is part of a cooperative project between the University of Buenos Aires and the University of Oslo. It emanates from an initiative by the Centro de Capacitación en Programas de Salud (CEPAPS), with contribution from the Asociación Médica Argentina de Anticoncepción (AMADA) and the Sociedad Argentina de Ginecología Infanto Juvenil, contributing primarily through promotion of sexual health and the prevention of transmittable disease among young students. The activities of CEPAPS are based on voluntary activity by students from various careers at the Faculty of Medicine. The specific objectives of this project are (1) to identify and describe among the first-year students at the Faculty of Medicine knowledge, attitudes and practices regarding sexuality; (2) to design and implement prevention and promotion strategies within sexual and reproductive health, directed towards university students; (3) to cooperate with both governmental and non-governmental organizations in order to strengthen inter-disciplinary and inter-institutional work; and (4) to develop a way to include students of medical sciences themselves in investigative activities (Brodahl & Hovind 2012: 14-15). As can be seen, the paper at hand contributes to the first two of these goals; the first directly, the other indirectly.

## 1.2 Thematic structure

The paper begins with a thematic background, discussing the topics of contraception, maternal health and HIV/AIDS – and the relation between them – through the perspective of the Millennium Development Goals (MDGs) of the United Nations. I discuss the progress of these goals from an Argentinian perspective, noting that many positive developments on a global level have not been as marked in Argentina. Furthermore, I argue specifically for the importance of probing sexual habits and knowledge-levels, as they are both internally related, and related to levels of stigmatization and discrimination.

In chapter 3 I give a broader literature review of the results of similar studies as the one at hand, having asked many of the same questions to study

populations that were similar on many (but not all) respects. While focusing primarily on Argentinian studies, I also include Spanish studies and one British study in order to have a European point of comparison, which also gives an impression of whether nationality is a more decisive factor than, for example, center-periphery, age or educational level. Together, this gives a rich point of reference for reading the results of the study.

Chapter 4 goes through the findings of this study specifically, beginning with age of sexual debut, continuing with knowledge of contraception and protection against HIV, contraceptive habits, attitudes towards condoms and finally sources of sexual/contraceptive information. I discuss the findings and relate them to the literature review as I go, as I find this to be a much more dynamic way of constructing arguments.

Chapter 5 summarizes the paper and gives concluding thoughts about the results and the topics at hand.



## 2. Background

This chapter thematically sets the stage for both the literature review and the results of the study. Individuals' sexual habits, knowledge and attitudes cannot be understood in a vacuum; they are part of a larger socio-cultural fabric along with factors such as STIs and maternal health. Especially the latter is a very prominent issue in Argentina due to a persistently high number of unsafe abortions, related to strict legislation (IWHC 2014; Brodahl & Hovind 2012). I begin by presenting the UN Millennium Development Goals as a framework for understanding HIV/AIDS, contraception and maternal health as intertwined phenomena. I then move more specifically to looking at numerical developments in Argentina from a MDG perspective. I end the chapter by discussing the importance of attitudes and knowledge as part of this picture.

The eight Millennium Development Goals (MDGs) were formulated at the Millennium Summit of the United Nations in 2000, with all member countries as well as many international organizations committing to them. Three of these – number four, five and six – are directly concerned with questions of health: reducing the mortality rate for children under five by two thirds from the 1990 rate; reducing the maternal mortality rates by two thirds from the 1990 rate, while securing universal access to reproductive health; and halting and beginning to reverse the spread of HIV/AIDS and malaria, while securing access to treatment for HIV/AIDS for all those in need (Millennium Project 2006).

The MDGs were to be met by 2015 – the year this paper is being written. We know now that though much has been achieved, the goals relevant to the topic in this paper have not been reached in full, neither for maternal mortality

nor the spread and treatment of HIV/AIDS. Opinions on whether or not one should be satisfied notwithstanding, such discussions are based on developments on a *global* level – often with focus on sub-Saharan Africa. There is a lot to be learned by also looking at regional and national developments, in this case Latin America and Argentina. Before going further into such developments, I will discuss some of the general aspects of maternal health, contraception and the spread of HIV/AIDS – and the relation between them.

## **2.1 HIV/AIDS, contraception and maternal health through the perspective of the Millennium Development Goals**

Maternal health and the spread of HIV/AIDS are not completely separate phenomena, but interwoven both with each other and with several other factors, such as opportunities for family planning and the use of condoms. The World Health Organization (WHO) stresses that family planning has a direct role in the prevention of both HIV/AIDS and unwanted abortions, naming condoms a ‘dual protection’ in this sense, while also stating that family planning ‘is essential to securing the well-being and autonomy of women, while supporting the health and development of communities’ (WHO 2015). The positive consequences for *infant* mortality is also a central factor here, with family planning reducing adolescent pregnancies with higher incidences of pre-term birth, as well as preventing child-birth in socio-economically or even psychologically unviable situations.

Additionally, family planning stabilizes population growth and can give women increased chances of pursuing educations or careers, which again has broader socio-economic consequences relevant for the spread of HIV/AIDS (ibid.). It must be remembered that due to low economic, social and cultural status in many countries, women are also at a disadvantage when it comes to the *decisions* regarding safe sex, in addition to often lacking HIV-related information and services. Women can find it culturally hard to argue for condom use, and may also tie a lot of their identity to motherhood in cultural settings where they face relative sexual inequality (Bond & Dover 1997: 389). According to UNAIDS (2013: 7), ‘[g]ender inequalities and harmful gender norms continue to contribute to HIV-related vulnerability’, with women suffering from intimate partner violence being 50 percent more likely to be living with HIV.

Latin America and Argentina are not exempt from such factors. Argentina does indeed have a history of significant public and political female participation, perhaps most clearly manifested by the Eva Perón of old and the Cristina Kirchner of today. The literacy rate and income rate for women are also

almost equal to that of men. However, there is another side to this. The Foundation for Sustainable Development points succinctly to this by arguing that women in Argentina ‘are still shadowed by the historically traditional, Catholic influence, and “machismo” culture’, noting that this is most apparent in the *lack of access to reproductive rights and health care* (FSD, n.d.). As further argued by the English-language newspaper and website Argentina Independent (2013), though Argentina ‘has come a long way’, there is still a significant disparity between what has formally been accomplished on the one hand, and actual practices on the other, especially at the social margins.

Especially the question of abortion is highly relevant to Argentina, where there is a high amount of unsafe abortions being performed every year. This is tightly related to strict legislation, where abortions are outlawed in almost all situations through articles 85-88 of the 1922 Penal Code. Since 1922, the exemptions from the law have gone through some modifications as part of political and ideological conjunctures, and today there are only two exemptions: (1) the pregnant woman’s life stands at risk, or (2) the pregnancy is the result of sexual assault. Until a Supreme Court decision in 2012, the latter of these only applied to “a mentally deficient or insane woman” (LOC 2012).<sup>4</sup> Abortion is nonetheless widespread, with about 500,000 being done every year, approximately 40 percent of all pregnancies (Brodahl & Hovind 2012: 2). Most of these are thus performed illegally, often under unsafe conditions. According to Human Rights Watch (HRW 2009), about 30 percent of maternal mortality could be attributed to this in 2004, making it the leading factor behind the mortality rate. As the rate has actually gone *up* since then, to 69/100,000 live births in 2013 (WHO 2013), we have few reasons for believing the situation has changed significantly.

## 2.2 The MDGs in an Argentinian perspective

Having today reached 2015, we know that the MDGs relevant for this paper will not be fully reached. Projections indicate that global maternal mortality has been reduced by only 45 percent, with contraceptive prevalence increased from 55 to only 64 percent worldwide (United Nations 2015: 6). With a 40 percent decline, Latin America is the region with the second-to-*least* decline in maternal mortality, behind only the Caribbean. Most strikingly, however, the *Argentinian* reduction since 1990 has been miniscule, from 71/100,000 in 1990 to 69/100,000 in 2013 (United Nations 2013).

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<sup>4</sup> The Catholic Church in Argentina – Catholicism being the main religion of the country - has been strictly opposed to this decision, stating that rape is no justification for abortion (LOC 2012).

Historically, contraceptives have not been heavily distributed or subsidized by the Argentinian government, 'except for the army draftees who were given condoms for prophylactic reasons rather than population concerns' (Kamenetzky 2004: 17). Though such efforts have clearly increased in later years, the United Nations estimates that there is still an unmet need for family planning for 11 percent of women aged 15-49 in Latin America; the number being 17 percent in 1990. Again, Argentina comes out negatively, with the use of any form of contraception for women aged 15-49 being *reduced* from 65.3% in 2001 to 55.4% in 2012, having peaked in 2005. The use of condoms has seemingly been *halved* between 2005 and 2012 (United Nations 2013). Latin America and the Caribbean is also still the region with the second highest birth-rate for women aged 15-19, with 73/1,000 being ranked only after Sub-Saharan Africa (United Nations 2015: 39-42). In Argentina, the rate has actually marginally *increased* since 1990 (United Nations 2013).

For the situation with HIV/AIDS, the interpretation of numbers is somewhat more difficult. This is because increasing amounts receiving treatment tends to increase prevalence of infection, as less die from disease (Bastien 2009: 1). When keeping in mind also that high prevalence rates will lead more easily to increased absolute numbers of infections, which can 'conceal' positive developments, one can today argue that parts of the sixth MDG have indeed been reached. The worldwide annual incidence has been reduced from 3.5 million in 2000 to 2.1 million in 2013. Especially the increase in people receiving anti-retroviral therapy (ART) has been marked, with a swift increase leading to 13.6 million being treated with ART for HIV infection by June 2014, seemingly reaching the goal of 15 million by this year (United Nations 2015: 45-46).

However, this is largely based on Sub-Saharan Africa, which is the by far most severely affected region. Latin America in general and Argentina specifically have had relatively low prevalence and incidence rates, but the rate has in fact *increased* in Argentina since 1990, from 0.03 percent to 0.04 percent in 2013. Prevalence has increased significantly, as have deaths from AIDS, the latter which has doubled. Again, the latter factors must be interpreted in light of the consequences of treatment on prevalence, and the consequences of prevalence on spread. However, it is alarming that the numbers for people receiving ART have here actually gone *down* marginally, rather than up, with condom use also going markedly down (United Nations 2013). There have also been few positive developments in the amount receiving a late diagnosis of HIV, with numbers rising somewhat for males, while falling somewhat for women, since the turn of the millennium, in total staying more or less on the same level (DSETS 2013: 30-31).

As of December 2013, about 110,000 persons were living with HIV in Argentina, 30 percent of which did not know about their situation. About 5,000 new infections occur every year, with unprotected sex as the reason for 96 percent of women and 98 percent of men. There are significant differences *within* Argentina as a country. While annual incidence in Buenos Aires has fallen from 40.6/100,000 in 2001 to 23.9/100,000 in 2011, it has risen sharply in other regions, being practically doubled for example in the region of Cuyo (DSETS 2013: 13). This is consistent with patterns found in the use of contraceptive methods, often being much less widespread in rural areas, due both to accessibility and to cultural differences (Kamenetzsky 2004).

19 percent of new infections occur among those less than 24 years old (DSETS 2013: 4-6). *Among males aged 19-24, the incidence of infection has risen from 11.3/100,000 in 2001 to 15.7/100,000, while it has gone strongly down in the age group 25-44. Interestingly, while this development was also present for women until 2004, it has afterwards turned, with the 2011 levels the same as in 2001. The ratio of men to women was 50 percent higher in 2011 than in 2001.* It is interesting, therefore, to look at whether such differences are consistent with attitude/knowledge differences in our study. In any case, this also suggests reasons for looking specifically at younger populations, as in this study.

It should be mentioned that there have been many positive developments in Argentina in the later years. Mortality from AIDS has gone down, albeit slowly; transmission from sharing material during drug use has gone down rapidly, as have the cases of vertical transmission; the distribution of condoms has tripled since 2006, to mention some factors (DSETS 2013: 25-52). There are also good intentions to turn negative developments. This is manifested especially in the Strategic Plan for 2013-2017 (Plan Estratégico Nacional), developed by the Directorate for AIDS and Sexually Transmitted Diseases (DSETS) under the auspices of the Ministry of Health. Among others, the goals include reducing the mortality from AIDS from 3.3/100,000 to 2.9/100,000; increasing the amount of centers for prevention, advice and testing for HIV by about 60%; reducing the amount receiving a late diagnosis; and vastly increasing infrastructure to fight discrimination, as well as the amount of satisfied users consulting centers for such reasons, holding the reduction of stigmatization/discrimination as one of its four main goals (DSETS 2013 [1]: 48-49; DSETS 2013 [2]: 4; 13).

Many of the important elements are also manifested in legal documents, such as Law 25.673 of 2002. Among others, this sets as objectives working towards the 'highest possible level of sexual health and responsible procreation', so that the population can 'adopt decisions free of discrimination, coercion or violence'; decreasing maternal and child mortality and morbidity;

preventing unwanted pregnancies; contributing to the early detection of STIs, and maximizing female participation in decision-making related to sexual health. Additionally, article 5 of the same law states clearly the obligations of the Health, Education and Social Ministries of working towards higher knowledge levels and identifying risk-behavior. A decree added to the law in 2003 states further the necessity of offering the whole population access to information and counseling on sexuality and contraception; prevention, diagnosis and treatment of STIs; and also the prevention of abortion (MSAL 2003). All of this notwithstanding, it is clear from the above that the current situation in Argentina – and the numerical developments – are far from being completely line with intentions put down in law.

### **2.3 The importance of habits and education**

Access to family planning, to health-care facilities and to contraception is one factor, thoughts and habits another; it is of paramount importance to not forget the ‘culturally imbedded *behaviors* that spread HIV’ (Green & Ruark 2011: 70). In several areas of the world there has in later years been a worrying decline in the use of condoms. Above I referred to the reduction in the use of condoms and contraception in Argentina, showing that the country is by no means exempt from this. This of course adds further to the importance of probing attitudes and habits of young people, including of students entering medical professions, as in this study. While it most certainly has consequences for the amount of abortions, and thus for the maternal mortality rate, it also has consequences for the spread of HIV/AIDS. Positive attitudes towards condoms ensure their increased use (Teva et al. 2014: 128).

However, it needs to be kept in mind that focusing too narrowly on condom use – especially when done in a practical, numerical, rather than cultural sense – can be a significant pitfall. Green and Ruark (2011: 14-16) argue strongly that one of the central deficits of the global work against the HIV epidemic is that it has been *too* condom-centered. According to the authors, it defies evidence-based principles to work towards consistent and correct use of condoms for people who have multiple and concurrent sexual relationships; it is rather the amount of relationships and the lack of mutual fidelity between partners that should be the target of future efforts; we know that the risk of HIV infection is correlated with the number of sexual partners, especially when these partners overlap over time. In short, they call for working for risk *avoidance* rather than risk *reduction*. An exclusive focus on the sexual form of transmission can also eschew other efforts towards for example blood-borne transfusion, or cultural practices such as circumcision (Bastien 2009: 3).

The present study does not go into detail about sexual behavior outside of contraceptive use, but acknowledges very clearly that efforts against HIV/AIDS – or maternal health for that matter – cannot merely be understood as phenomena of availability; they must be considered also in their sociological context. It also takes such concerns seriously by considering *knowledge-levels*. While variations in the spread of HIV can be partly explained by *zeitgeist* – by cultural tendencies and the role attributed to condoms and contraception within adolescent circles - it is also tightly related to knowledge about HIV and contraception. There are many indicators that such knowledge, including the dispelling of common myths, is important to the spread of disease. In the global report for 2013, UNAIDS (2013: 18) writes that efforts to protect young people from HIV infection is being undermined by ‘[i]nadequate access to comprehensive sex education’, which has shown itself ‘effective in delaying sexual debut and increasing condom use among young people who are sexually active’. A nationwide study among adolescents in Argentina of 2004 found that 33 percent of those who did not use contraception during their sexual debut related this decision to a lack of information. In addition, 15 percent justified their decision by stating that the sexual debut does not cause pregnancy, suggesting a wider lack of knowledge (Oizerovich et al. 2004). There are generally few data about ‘comprehensive correct knowledge’ in Argentina, the United Nations only having data from 2012 for women specifically. These show a proportion having such knowledge at 40.3 percent, not much higher than in Sub-Saharan Africa, with 30 and 37 percent for women and men respectively (United Nations 2013). All of this motivates for probing the knowledge-levels of the students in the study at hand, with the added factor that they are also future health-care personnel themselves.

Knowledge is also inherently cultural and is related – inversely – to levels of stigmatization and discrimination (NAT 2010: 19). Such stigma are associated with delayed testing, non-disclosure to one’s partner about HIV-status, and a low degree of interaction with HIV-related health services (UNAIDS 2013). Using an index to measure the level of discrimination towards persons with an HIV diagnosis based on five questions, a 2008 study in Buenos Aires (Jorrot et al 2008: 45-47) found a ‘high’ level among 35 percent of the respondents in the youngest age group (under 25), and 28 percent in those between 25 and 44 years.<sup>5</sup> The numbers were more than twice as high among

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<sup>5</sup> The five questions were as follows: (1) Would you share a meal with a person you suspected or knew had HIV/AIDS?; (2) Would you drink from the same glass as a person you suspected or knew had HIV/AIDS?; (3) If a teacher has AIDS, do you think he/she should be allowed to go on teaching at school?; (4) If you became aware that a fruit or vegetable vendor had AIDS, would you go on buying?; (5) If a family member of yours had AIDS, would you prefer it be kept a secret?. Two or more negative answers (positive for the last question) were considered a ‘high’ level of discrimination; one negative answer as an intermediate level.

those with low education compared to those with higher education, which is consistent with the educational pattern discussed repeatedly in the literature review. Wang et al. (2011: 27) used this very same index, finding here that 40 percent of adolescents received a 'high' level. The proportion was higher among those with lower ages, among males, among those from middle or low socioeconomic levels, and among those from the interior of the country. In both these studies, only three out of four thought that a teacher with AIDS should not be allowed to go on teaching. 41 percent in the latter study would not share a glass with a HIV-positive person.

This corresponds quite well with a UK study by the National Aids Trust (NAT), where 73 percent agreed that people with HIV can work like anyone else, and where 74 percent believed that HIV-positive deserve the same amount of respect as those with cancer (NAT 2010: 20-21). Numbers from Spain are even more unsettling, with one out of three confirming that they would not work or study with a HIV-positive person (INE 2004), though with a younger age group (only up to 49) than for example the British study. Stigmatization is clearly not a phenomenon peculiar to Argentina.

Having now gone through many of the central statistical, historical and sociological aspects underlying the present study, I will move to considering data from similar studies undertaken both inside and outside of Argentina. This offers an important reference point for reading the results of the present study - both in terms of similarities and differences.



### 3. Literature review

This section reviews earlier literature, studying research that has already been conducted on similar topics as here, in order to create a reference point for interpreting our data, and for comparing the students in this study with young populations more generally. It makes use of the findings of Jorrat et al. (2008) from Buenos Aires, Wang et al. (2011), Oizerovich et al. (2004) and Kamenetzky (2004) nationally in Argentina, as well as data collected by UNAIDS (2014) from various Argentinian sources. I also use two Spanish studies (INE 2004; Teva et al. 2014) and a British study (NAT 2010) in order to have a European reference point for the data.<sup>6</sup>

The section is divided in findings on (1) sexual debut; (2) contraceptive habits; (3) knowledge of contraception and HIV/AIDS; and (4) the respondents' sources of sexual/contraceptive information.

#### 3.1 Sexual debut

In a 2008 study from Greater Buenos Aires, Jorrat et al. (2008: 26-27) found an average sexual debut of 16 years. Wang et al. (2011: 13) studied a younger population (14-19), but of the roughly 60 percent of the study who had already had their sexual debut, the average age was 15 years. Oizerovich et al. (2004),

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<sup>6</sup> For clarity, I do not use decimals in the percentages in this chapter, but round up or down to the nearest whole percentage point.

studying youth between 10 and 20 years, found a national average age of 15.6 years. Comparing these to the numbers from Spain (INE 2004), the average sexual debut seems to be generally lower in Argentina, with the Spanish study reporting 18.1 years for men and 19.1 years for women. These Spanish numbers correspond well to those reported by Chartsbin (2009) based on two global reports, giving 19.2 for the genders combined. This suggests a potentially large cultural difference across the two countries.

In the Jorrat et al. (2008) study, debut was earlier among manual workers, among those with lower income, of lower age, with less education – and among males; more than four times as many males as females had their sexual debut before they turned 15 years. A finding by Kamenetzky (2004: 8) is interesting in this regard, based on a series of 1993 interviews with Argentine youth between 18-24 years (the same as in our selection). Many males reported having had their sexual initiation in warehouses together with their fathers, understood by them as ‘an obligation to fulfill in order to affirm their virility’. Importantly, this often happened *without* an intimate talk with the respective parent about expectations and disease prevention, which could have lessened anxiety, which should be kept in mind for the findings on sources of sexual/contraceptive information in section 4.5.

### **3.2 Contraceptive habits and attitudes**

Jorrat et al. (2008: 28) found that 83 percent among those between 15 and 24 years used a condom during their first sexual relation. The numbers were *much* higher in this age group than those between 25 and 44 years, where it was only 35 percent, which clearly suggests age/period as an important factor. Studying a younger population of 1100 adolescents aged 14-19, Wang et al. (2011: 13) found the number to be 89 percent. Surprisingly, Oizerovich et al. (2004) found a much lower number (54 percent), with as many as 34 percent not using any form of protection during first sexual relation. This large discrepancy could perhaps be attributed to a bias arising from the latter study finding its population among even younger persons (10-20 years), or by using youth attending obstetric/gynecological services. The two Spanish studies reinforce the impression that the Oizerovich et al. (2004) study represents an outlier. In the former (INE 2004), 80 percent of those under 30 years had used a condom; in the latter, studying 4,612 Spanish adolescents, 84 percent of females and 86 percent of males used this (quoted in Teva et al. 2014: 128). *Most of these studies thus report findings around the high- to mid-80 mark.*

According to a 2014 data summary from Argentina by UNAIDS (2014), 83 percent of the respondents between 15 and 49 years who had had intercourse

with more than one person during the last twelve months had used a condom *during the last intercourse*. Jorrat et al. (2008: 30) found this to be 86 percent among those under 25 years, with 79 percent reporting condom use at every sexual relation with an occasional partner. This latter number was 71 percent in the sample of Wang et al. (2011: 21), with 80 percent of the males and 63 percent of the females. Again we see a significant gender difference; I discuss this further in the results chapter. In most studies, higher socio-economic and educational levels were associated with an increased use of contraception. The Argentinian numbers reported here are quite a lot higher than those from Spain (INE 2004), where only 59 percent answered that they always use a condom – though here it was specifically asked about the prevention of STIs, which must be kept in mind.

The INE findings are especially interesting as a reference point because they include questions about *attitudes* towards condoms that are identical to the ones used in this study. Their findings are therefore reproduced in the below table.

	Women	Men
They are safe	80.5	84.1
You enjoy more because of the security they offer	57.2	45.0
They hinder feeling the body of the other	23.4	36.7
They lessen the sexual desire of the man	22.7	27.7
They lessen the sexual desire of the woman	13.9	16.9
They are complicated to use	13.9	15.9
They create lack of confidence	11.6	13.9

Table X.X The image of condoms for men and women – affirmative answers, percentage points (INE 2004).

We see that the Spanish youth responding to these statements were generally quite positive to condoms, although with about one out of five disagreeing that they are safe, and about one out of four thinking that they lessen sexual desire on the male part. However, the most conspicuous element is that men are clearly more negative than women, especially when it comes to enjoyment due to security and the degree of feeling the body of the other. This pattern is consistent with our results, but the Spanish numbers are overall *more negative* than those from the Argentinian students (see section 4.4).

### 3.3 Knowledge of contraception and HIV/AIDS

According to Jorrat et al. (2008), 91 percent of the respondents knew that ‘sexual relations’ was a way of transmitting HIV.<sup>7</sup> When asked five questions regarding

<sup>7</sup> However, only 16 percent referred explicitly to sex without the use of a condom.

how HIV can be transmitted, only 15 percent got all five answers right, while 25 percent got as few as either zero, one or two correct answers. For all these findings, those living centrally in the capital presented higher knowledge than in the outskirts of greater Buenos Aires (Jorrat et al. 2008: 22).<sup>8</sup> Wang et al. (2011: 19) found that 90 percent mentioned sexual relations as a way of transmitting HIV, but they note clear signs of respondents lacking information with for example only 30 percent mentioning sharing syringes, and only 4 percent vertical transmission (ibid.: 39). On the other hand, condoms were mentioned as a way of avoiding HIV infection by 95 percent, with only 5 percent erroneously answering contraceptive pills.

These Argentinian numbers are higher than those of the National Aids Trust (NAT) in the United Kingdom, which – asking 1,944 adults aged 16 or more – found that 80 percent knew that HIV was transmitted by sex without a condom (NAT 2010: 4). However, 30 percent could identify all ways of transmitting HIV. This is quite similar to UNAIDS (2014) numbers from Argentina, where 24 percent of those between 15 and 24 years – the same age range as in our study – identified all these ways correctly without at the same time mentioning an erroneous way, somewhat higher for males than for females. The results from Spain seem to suggest a somewhat higher level of knowledge there, with 96 percent identifying sexual relations and 86 percent blood-borne transmission (INE 2004).

The Argentinian data showed that knowledge was generally found to be lower among those with low education and from lower socioeconomic strata. For example, Jorrat et al. (2008: 22) saw that fewer correct answers about HIV among those in the periphery of Greater Buenos Aires was associated with lower educational levels. This being a recurrent impression should be kept in mind when considering the findings in this paper, as the respondents are at the beginning of studies of considerable length – at a university in the capital, and most likely from socio-economically well-off strata of society.

### **3.4 Sources of information about sexual topics**

Jorrat et al. (2008: 53) found that the clearly most important source of information about HIV/AIDS reported by the respondents was television, mentioned by 83 percent, followed by graphic media (28 percent) and radio (24 percent). It is interesting that family, partner and friends were only mentioned by *altogether* 40 percent of these respondents, with health-care workers at 10

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<sup>8</sup> The questions were based on asking whether the following methods could transmit HIV: mosquito bites, sharing of toilets, vertical transmission, transmission during pregnancy and through breast-feeding.

percent. While the latter were mentioned more by women, television was mentioned more by men. This pattern is quite consistent with our findings (see section 4.5). The numbers are here not divided by age, but the authors do note that the family, partner and friends combined was more important in the younger age-group, as well as those living in the capital; both of which are resonant with our sample in this study.

Wang et al. (2011: 33), studying a much younger sample, looked at the same topic somewhat differently, asking not specifically about HIV/AIDS, but about sexual health in general. Here, family alone was answered by 56 percent of the total (slightly higher for females than males, and higher for those from higher socioeconomic strata). Contrary to the study above, television here played a marginal part, with only 10 percent mentioning it. Among 'non-personal sources' the internet was the most popular. When asking the youth about their sources for information about the use of contraception (Wang et al. 2011: 15), 39 percent answered family, followed by school and friends. 13 percent answered 'no one'. Television was practically not mentioned.

This could suggest that general sexual information is more readily accessed by family and friends than information about HIV/AIDS. However, there is also the age difference; considering the very young age range of the latter study (15-19) compared with that of Jorrat et al. (2008), it could be that older generations have used family and friends less, perhaps due to increased social stigma. This is supported by the INE (2004) study in Spain: While 38 percent declared having had *no* communication about such topics with parents – consistent with the findings above – this was much less the case for those under 30 years, with about one out of four (INE 2004).

## 4. Results

This section presents the results of the study. I discuss these throughout the chapter, pointing repeatedly back to the literature review. For clarity and visualization, the most central findings are summed up in charts or tables. I divide the chapter into similar sections as above, focusing here on (1) sexual debut; (2) knowledge about contraception, transmission of HIV and protection against infection; (3) condom use; (4) attitudes towards condoms; and (5) sources of information.

### 4.1 Sexual debut

Of the respondents in this study, 83 percent reported having already had their sexual debut, with 80.4 percent of the females and 89.9 percent of the males. The average age of debut was 17 years for both genders. This is much higher than the findings from other Argentinian studies reviewed in section 3.1, which lie around the 15 – 15.5 year mark – both those with wide and narrow age ranges. This finding must be kept in mind when considering the other results. Though it cannot be considered more than a speculation, the higher debut age in our selection could suggest more conservative sexual habits, possibly related to socioeconomic/educational factors, as this study includes students of specific study programs – in the capital. Such differences are by no means unknown; though in a clearly different cultural setting, Daniyam et al. (2010: 152) found that the medical students from their study in Nigeria reported a much later sexual debut than the average suggested by secondary school data from other

parts of the country.<sup>9</sup> In Canada, Langille et al. (2005) found that lower socio-economic status in the form of lower parental educational levels was related to earlier sexual debut for females, which goes further to suggest such a dynamic, due to the consistency of educational levels across generations within families.

#### 4.2 Knowledge about contraception and protection against HIV

Out of a series of mentioned contraceptive forms, the respondents were asked to check the ones they were familiar with. The results, divided by gender, are presented in the below table.

	Female	Male	Total
Natural methods*	48.3%	41.2%	46.4%
Coitus interruptus	35.7%	30.4%	34.3%
IUD	84.7%	71.4%	81.2%
Vaginal rings	21.0%	26.5%	22.5%
Sexual relations during menstruation	13.7%	22.3%	16.0%
Contraceptive pills	97.4%	96.0%	97.1%
Hormonal injections	32.4%	21.3%	29.5%
“Emergency pill”	83.1%	79.2%	82.1%
Contraceptive patch	29.8%	12.8%	25.3%
Male condom	93.1%	91.0%	92.6%
Female condom	59.9%	55.9%	58.9%
Diaphragm	37.5%	25.8%	34.4%
Tubal ligation	49.7%	35.7%	46.0%
Vasectomy	48.1%	43.2%	46.8%

**Table 4.1 Knowledge of various forms of contraception, by gender**

We see that by far the most known contraceptive forms are the contraceptive pill and the male condom, followed by ‘emergency pills’ and IUDs. After this, no other form of contraception was marked by more than 60 percent, and most by less than half the sample. The gender differences are equally interesting: The males report less knowledge of all of these forms of contraception than the females, except for two – one of which is having sex during menstruation (the other being vaginal rings). Five of the contraceptive types are marked by more

<sup>9</sup> While 72 percent of the medical students had their debut after 17 years of age, sexual debut was reportedly between 11 and 15 in these earlier findings.

than 10 percent fewer males than females, including IUDs. While the contraceptive patch is known by about 30 percent of the girls, only 13 percent of the males have marked it. Together, this clearly suggests a discrepancy in knowledge. Though it can be partly explained by the females being the gender to wear or take most of these forms, the difference is still strong, and the male condom is in fact mentioned by more females than males as well (almost 10 percent of the males do not mark that they know it, which by itself is striking).<sup>10</sup>

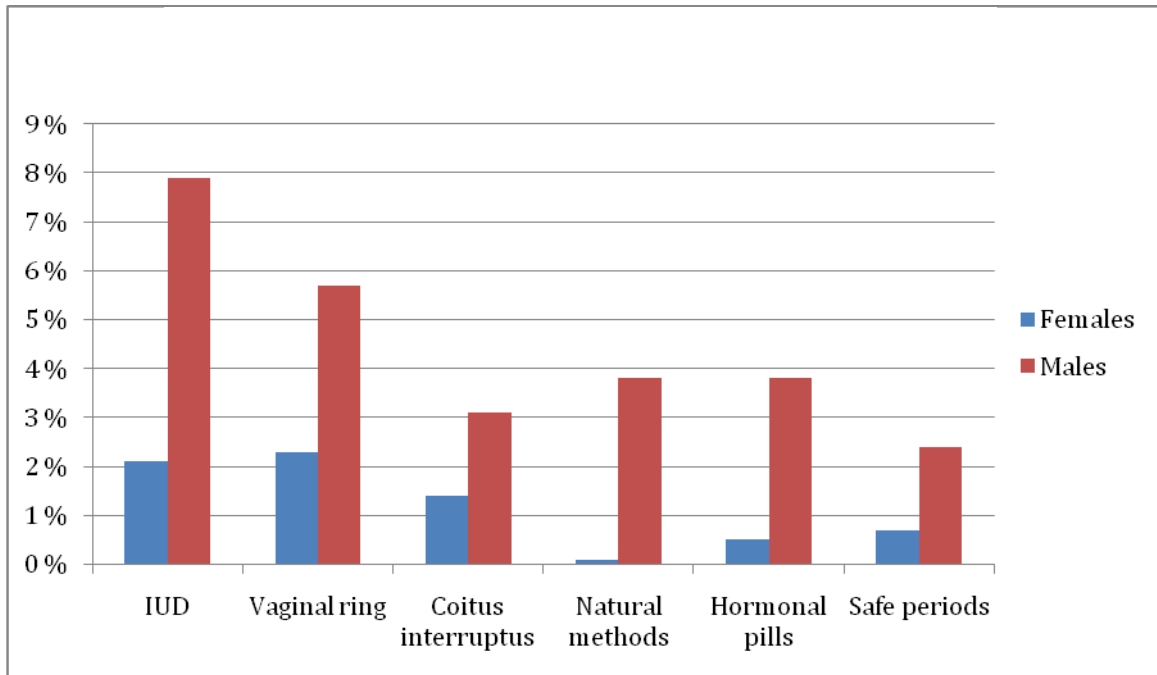
The respondents were also confronted with a series of either true or untrue ways of transmitting HIV, with the purpose of marking those they considered correct. 98.6 percent marked sexual relations without protection. 89.6 percent correctly marked receiving blood transfusion, while 94.9 percent correctly marked the sharing of syringes. Fewer marked transmission during pregnancy and unprotected oral sex; 47.1 and 64.3 percent respectively. More males than females correctly marked unprotected oral sex; apart from this, there were insignificant gender differences here. On the other hand, 14.3 percent incorrectly marked 'sharing personal articles', and as many as 42.7 percent giving a blood donation. Even sharing a public bath was marked by 4.4 percent – 22 of the students. The males were somewhat more likely to choose these incorrect alternatives than the females.

The students were thereafter asked to either mark or not mark a series of potential ways of protecting themselves against HIV transmission. 98.3 percent correctly identified the (male) condom, but this was higher among the females (99.6 percent) than the males (95.0 percent). The female condom was identified by much fewer, 66.1 percent of the females and 63.0 percent of the males, again with a gender difference. This pattern is also reproduced for other forms of contraception: The males were significantly more likely to answer (incorrectly) that both IUDs, vaginal rings, coitus interruptus, natural methods, and hormonal pills were protective, as well as having intercourse when the woman was not menstruating. The differences are quite striking and are illustrated in the below chart.

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10 The results discussed in this paragraph are based on a larger sample of respondents (617) than the others in this article, due to a later extension of the total sample, with additional interviews.



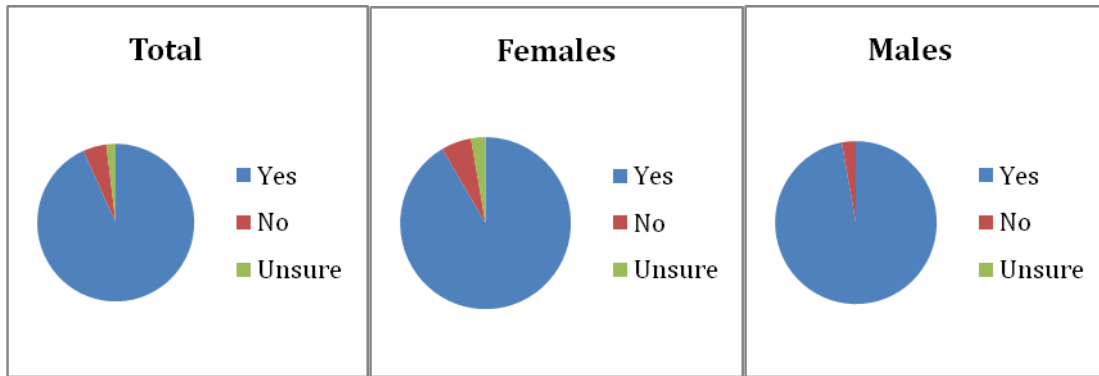


**Chart 4.1 Gender differences in marking incorrect ways of protecting oneself against HIV-transmission, by percentage of students answering a given form.**

Though the percentages are never very high, and though the knowledge is generally higher than for example that reported by Jorrat et al. (2008), it is nonetheless unsettling that there are such clear gender differences. It suggests that in some way or other, young females are receiving more or better education with respect to such transmission, which resonates with the findings on knowledge of contraceptive forms above. Considering the development in HIV infection over the later years in Argentina, where incidence has risen among males aged 19-24, while going strongly down in the age group 25-44 (DSETS 2013: 4-6), there is great reason to take such a finding seriously.

### 4.3 Condom use

Those of the respondents who reported having initiated sexual relations (82.9 percent, with 80.4 percent of the females and 89.8 percent of the males) were asked whether or not they used a condom during this first relation. 93.2 percent answered positively – 97.2 percent of the males and 91.5 percent of the females.

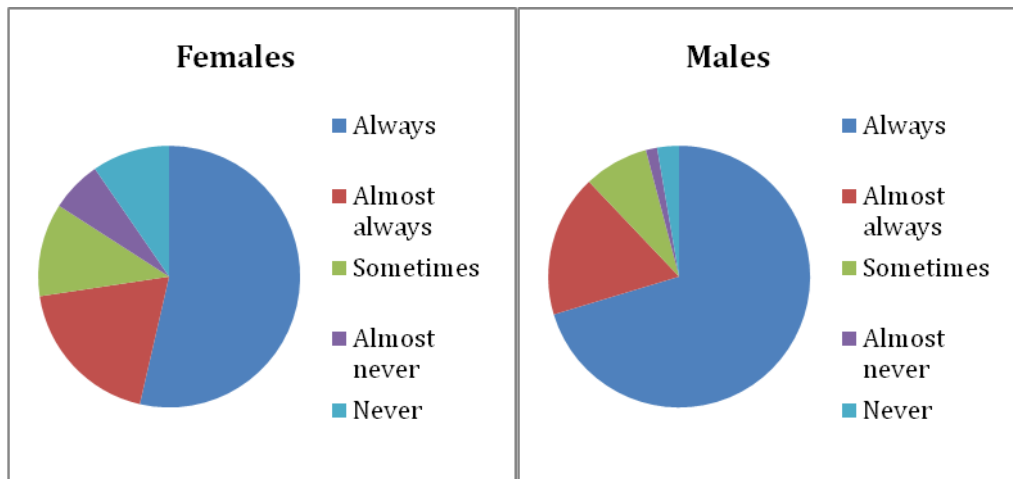


Charts 4.2-4.4 Proportion of respondents having used a condom during first sexual relation

Comparing this with the literature review, we see that condoms were used more by our respondents than in the findings of Jorrat et al. (2008) and Wang et al. (2011) from Argentina, and much more than Oizerovich et al. (2004). Our numbers are also higher than the highest of the Spanish studies (quoted in Teva et al. 2014), where the numbers were 83.8 percent and 86.1 percent for females and males respectively. One cannot from this perspective pin down any exact explanation(s) for such differences. However, it likely has to do with socioeconomic factors; a pattern of both increased knowledge and use of contraception among those with higher education and from higher socioeconomic strata has been found in other studies (ex. Jorrat et al. 2008: 28). Developments in Argentina since the years of the other studies could potentially be a factor as well, but as I show in section 2.2 there are few signs that the developments point in such a direction.

Furthermore, 58.5 percent of the respondents report 'always' using a condom in stable relationships, with 18.6 percent reporting 'almost always', making for a total of 77.1 percent. These are significantly higher than those of Jorrat et al. (2008), where 36 percent of those between 15-24 years (the same range as in our study) reported always using it. While they are actually *lower* than in Wang et al. (2011), where – as shown in section 3.2 – they were 69 and 20 percent, respectively, it must be kept in mind that the age range was lower in this study. Our numbers intersect quite well with the Spanish numbers of the INE (2004), where 59 percent reported always using a condom.

There are clear gender differences when it comes to condom use. As seen above, almost ten percent more males than females reported use during first sexual relation. 70.4 percent of the males report *always* using a condom, compared to 53.6 percent of the females. 10 percent of the females 'never' use a condom, compared to only 3 percent of the males. The same gender pattern is shown when the respondents were asked to mark what sorts of contraception they 'regularly' use: Here, 86.7 percent of the males compared to 66.6 percent of the females mark the (male) condom.



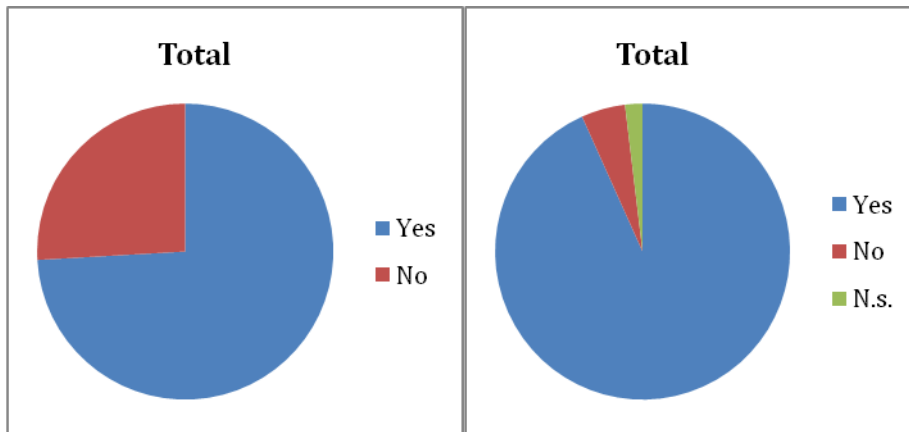
Charts 4.5-4.6 Frequency of condom use among both genders

It is likely that such clear differences can be explained partly by recall bias, with the gender actually wearing the condom – and most likely carrying it more often – remembering it the best. This is made even more likely by noticing the pattern in regular use of contraceptive pills in a partnership. 60.9 percent of the females report regular use of these, compared to only 26.6 percent of the males.<sup>11</sup> When asked what form of contraception was used during the sexual debut, 11.7 percent of the females answer contraceptive pills, but only 5.9 percent of the males. Taking the pill yourself gives a higher degree of control, and likely a better position to remember its regular use. However, it must be noted that in both Jorrat et al. (2008) and Wang et al. (2011), these gender differences when it comes to condoms are more inconclusive, though also these point slightly towards males reporting higher use.

When asked about condom use during the respondents' *last* sexual relation the positive answers are significantly fewer, with 69.1 percent of the women and 86.1 percent of the males – reflecting again the same gender pattern and making a total of 74.1 percent. This reduction from first to last sexual relation is consistent with other studies, but it is larger here than in these studies. Jorrat et al. (2008: 31) found a rate for those 15-24 years at 86 percent, and Wang et al. (2011: 20) at 89 percent. One should, however, be careful with making conclusions about this, as the wording in our study asks for 'the person with whom you maintained sexual relations', as opposed to 'occasional partners' in both the other studies; the former thus suggesting stable relationships to a larger extent. Our study is also female-dominated, which – considering the gender differences above – should have an effect on the total. Finally, the Wang et al. (2011) study includes younger respondents, which

<sup>11</sup> After this, no other method of contraception is mentioned by more than 5 percent of any of the genders.

again should be expected to heighten condom use. This last factor is supported by looking at the respondents *25 years or older* in our data material. Only 75.5 percent of them answer that they used a condom during their first sexual relation, compared to the 93.2 percent of the lower age group. While 77.1 percent of those under 25 always or almost always use a condom, this is only 61.3 percent for those 25 or older. Such conclusions notwithstanding, there is a clear drop in condom use from first to last intercourse, especially among females.



Charts 4.7-4.8 Rate of condom use at last intercourse with person with whom the respondents maintained sexual relations (left), compared to condom use at first intercourse (right). N.s. = not sure.

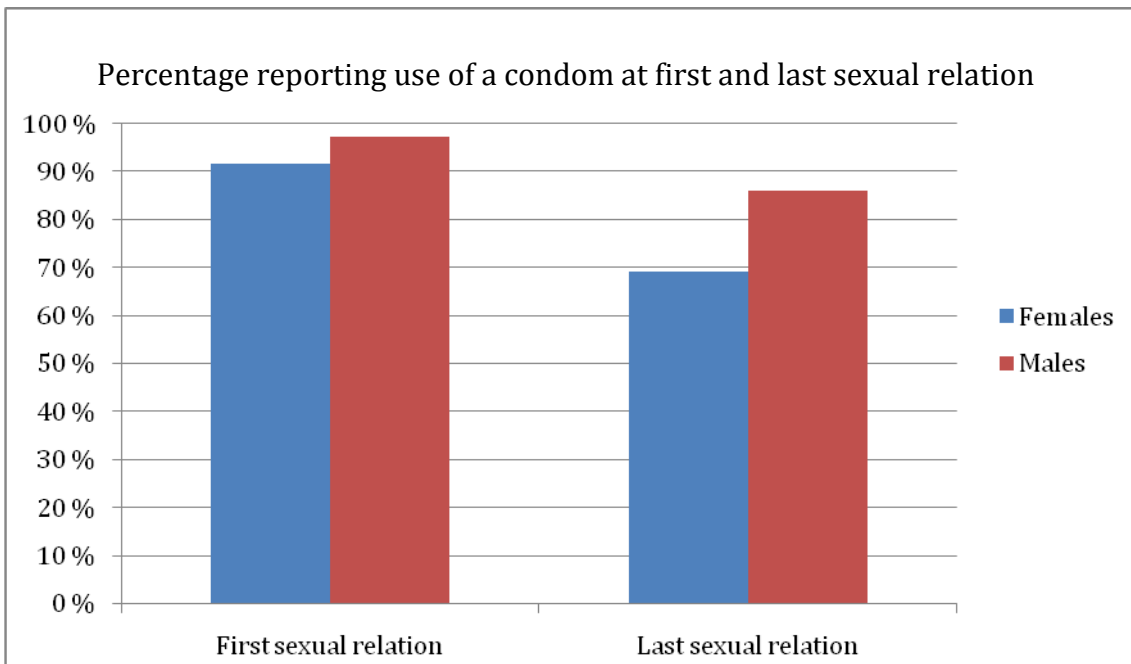


Chart 4.9. Rate of condom use at last intercourse with person with whom the respondents maintained sexual relations, gender-specific.

#### 4.4 Attitudes towards condoms

Our study confronted the respondents with seven statements about condoms, asking them either to totally agree, quite agree, agree somewhat or disagree.<sup>12</sup> The seven statements were that condoms (1) are complicated to use; (2) create lack of confidence in the couple; (3) lessen the desire of the woman; (4) lessen the desire of the man; (5) hinder feeling the body of the other; (6) allow for more enjoyment because of the security they offer; and (7) are secure. The results are shown in charts 4.10-4.16. For presentation purposes, the column for ‘disagree’ is not shown, as it is generally significantly higher than the others, thus masking details. It makes up the rest of the total for each statement.

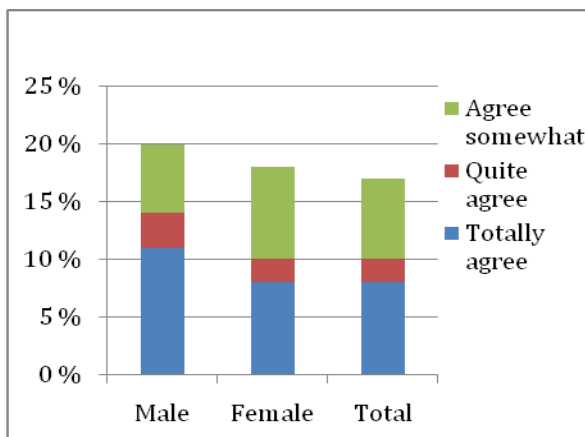


Chart 4.10 "Condoms are complicated to use"

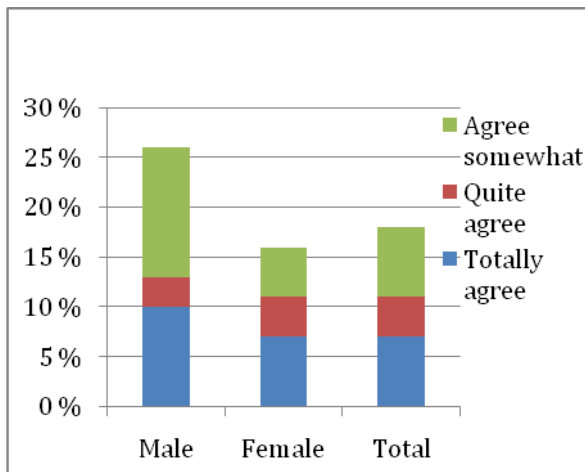
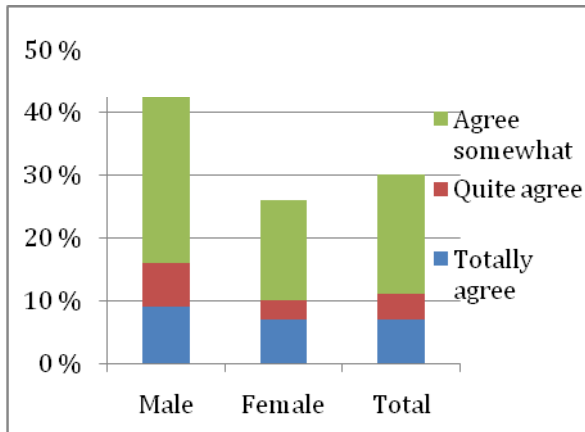


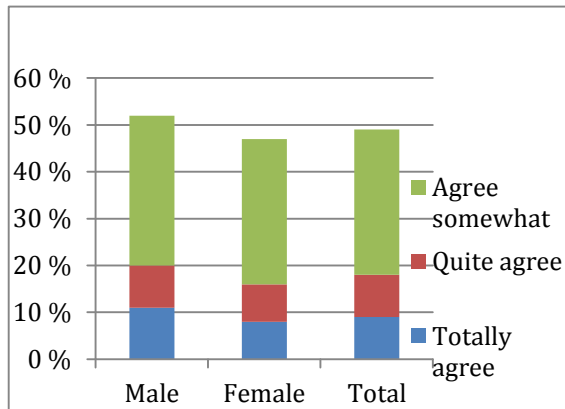
Chart 4.11 "Condoms create lack of confidence between the couple"

The most apparent overall finding here is that the males are clearly more negative towards condoms than females. Whether one sets the cut-off at ‘quite agree’ or ‘agree somewhat’, more males think condoms are complicated to use, create lack of confidence, lessen the desire of both genders, and hinder feeling the body of the other. For example, 15 percent more of the males than the females either fully or quite think condoms hinder feeling the body of the other. While slightly fewer males than females disagree completely that condoms allow for more enjoyment because of security, almost 10 percent fewer males *totally* agree with this, adding further to the overall impression. The only statement where the males are more positive in total is the security of condoms.

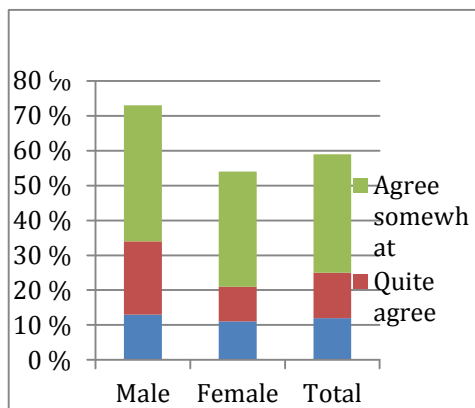
<sup>12</sup> The wording in Spanish was ‘totalmente de acuerdo’, ‘bastante de acuerdo’, ‘algo de acuerdo’ and ‘nada de acuerdo’.



**Chart 4.12 “Condoms lessen the desire of the woman”**



**Chart 4.13 “Condoms lessen the desire of the man”**

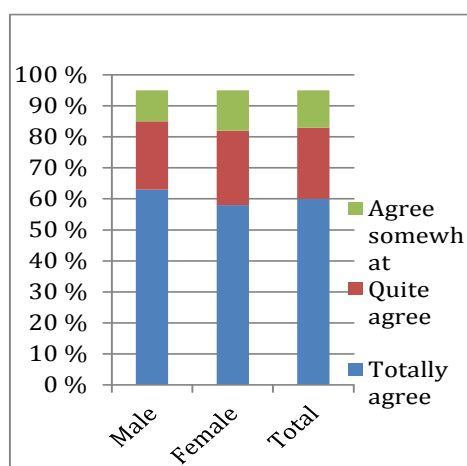
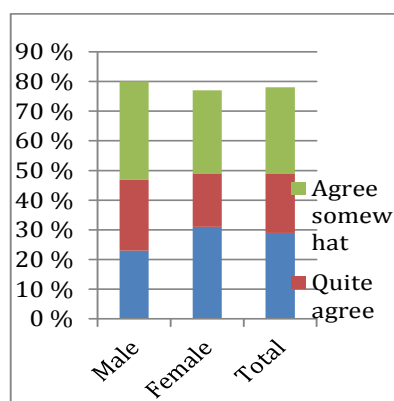


**Chart 4.14 “Condoms hinder feeling the body of the other”**

In section 3.2 I discussed similar data from a Spanish study by INE (2004). Here, the respondents agreed or disagreed to the exact same statements as in our study, which makes for an interesting reference point. An important difference is that our study has nuanced agreement into three categories. I solve this by grouping ‘totally agree’ and ‘quite agree’ together and comparing them to the Spanish numbers for agreement. This comparison is presented in table 4.1, numbers in percentages. Though the numbers are quite similar overall – including the gender differences – the general tendency is that the Argentinian students studied here have a *more positive* image of condoms than the respondents in the Spanish study. Except for enjoyment because of added security, they agree less with the negative statements and more with the statement about safety. However, the differences between the two groups must here be remembered: While INE (2004) asked men and women between 18 and 49 years, we have included here only students of 24 and below.

There is also an important educational and/or socioeconomic difference here, as we have specifically selected a university population of studies within

health-care, while the Spanish study has a general approach. The differences in results could thus be due to age, education or cultural differences – or all three. It nonetheless suggests that the first-year students in Buenos Aires have a *relatively* positive view of condoms, though with more negative attitudes amongst the males.



Charts 4.15-4.16. "Condoms allow for more enjoyment because of the security they offer" (left) and "Condoms are secure" (right)

	Our study		INE (2004)	
	Women	Men	Women	Men
They are safe	81.9	84.8	80.5	84.1
You enjoy more because of the security they offer	49.3	46.4	57.2	45.0
They hinder feeling the body of the other	20.5	34.6	23.4	36.7
They lessen the sexual desire of the man	16.8	19.7	22.7	27.7
They lessen the sexual desire of the woman	9.4	15.9	13.9	16.9
They are complicated to use	9.4	14.0	13.9	15.9
They create lack of confidence	10.4	12.9	11.6	13.9

Table 4.2 Percentages agreeing with statements about condoms, comparison between our study and INE (2004).

#### 4.5 Sources of information

The students were also asked about their sources of information about sexual topics – both their actual sources and the sources they optimally would have wanted. These showed striking differences, as is illustrated by the below charts.

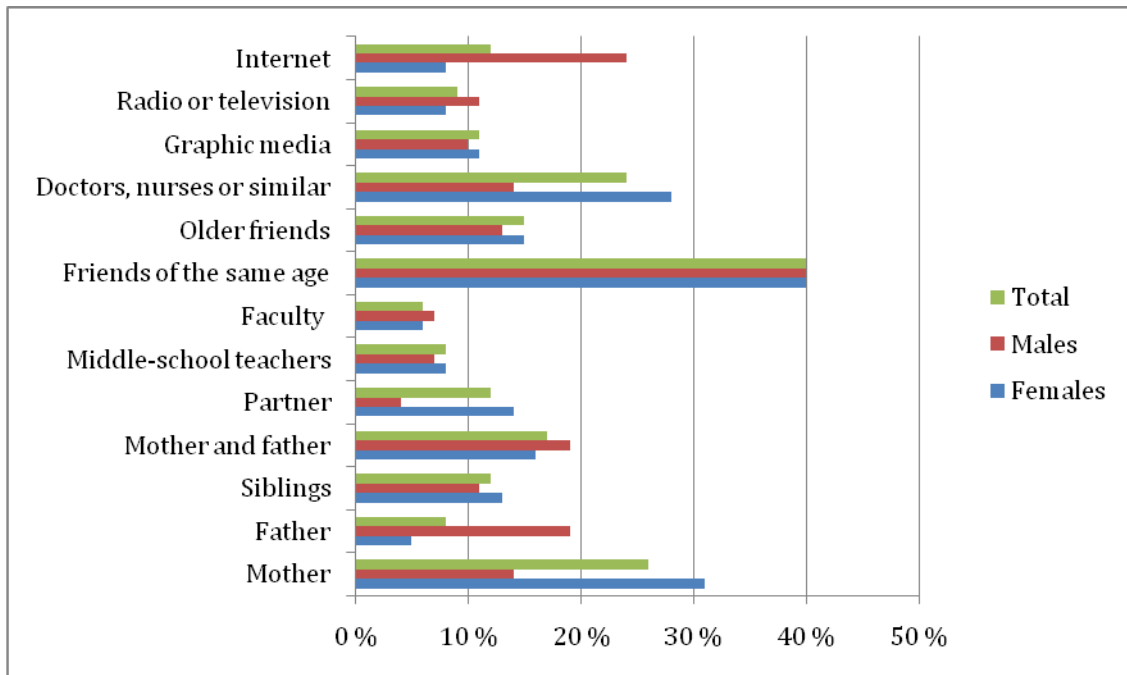
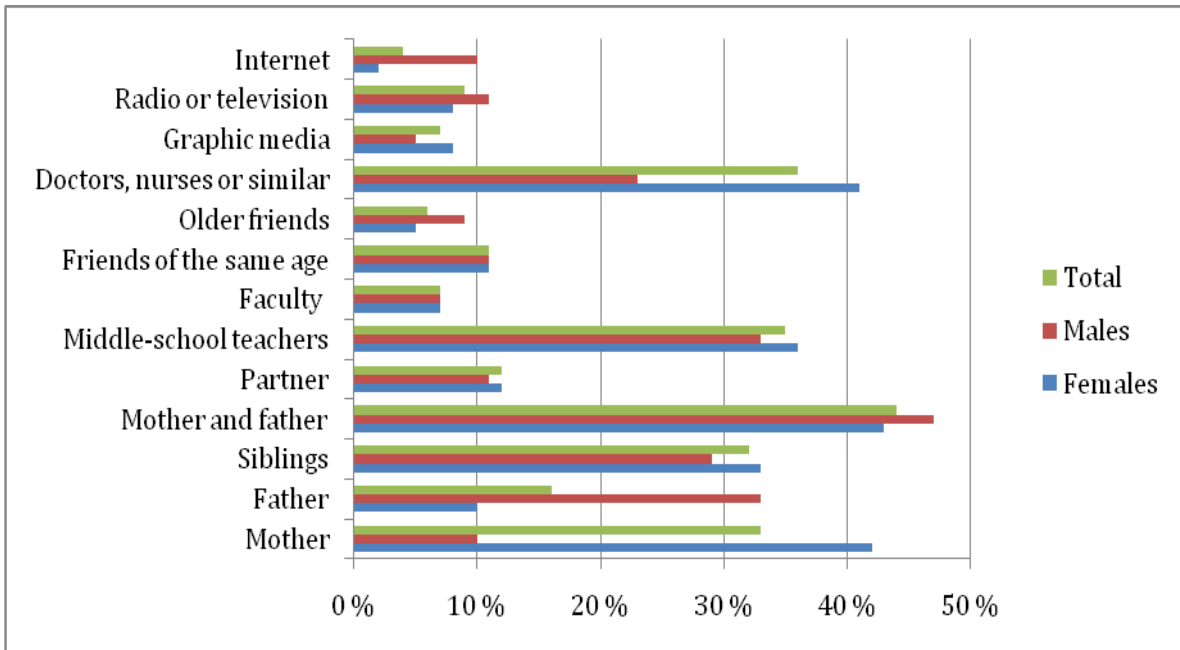


Chart 4.17. Sources of information about sexual topics as checked by the respondents

Many interesting findings are revealed by this chart. Firstly, we see that the clearly most used single source of information – equal for both genders – is friends of the same age. Following this are mother and father, which are chosen predominantly by females and males respectively; even fewer males get information from their mother than females from their father, suggesting that the father is a much more peripheral figure in general. For the males, the internet is actually a more used source than both parents, in contrast to the females, who use it more than three times less than the males. Health-care workers are mentioned almost twice as much by the females. Teachers, partners and siblings play more marginal roles than these other factors when disregarding gender.

However, the perhaps most interesting findings appear when we compare the above to what the respondents *would wish* were their main sources of information. This is illustrated in the below chart.





**Chart 4.18. Sources of information about sexual topics as the respondents would have wished if they could choose themselves.**

While friends play the clearly largest role as sources in practice – especially those of similar age – *this factor almost disappears in the above chart*. What takes over this position is *grown-ups in these young people’s lives* – parents, teachers and health-care workers. While this shows us that very many of these respondents feel they have gotten less information from both parents than they would have wanted, as well as from teachers, which were marginal in the first chart, we also see that they have received less information from the health-care system than they would have wanted, which suggests there is still work to be done in reaching out to young people – even those from higher socioeconomic and educational strata. Both graphic media, radio and television, and especially the internet play larger roles than the respondents would have wanted. This problematic seems especially marked for males, who use the internet much more than they would wish for.

The studies in the literature review have unfortunately not examined what the respondents would want hypothetically, but we can compare the data to the first of the charts above. These are quite ambiguous, but we see that there are several signs of ‘non-personal’ sources playing a central part also there, with Jorrat et al. (2008: 53) finding television as the most important source, with family, partner and friends combined being mentioned *less than television alone*; health-care workers also being marginal.<sup>13</sup> In the INE (2004) from Spain, about one out of four of those under 30 years reported having had no communication

<sup>13</sup> Note, again, that the authors here asked about HIV/AIDS-related information specifically, not sexual topics in general.

with parents at all. Only 54 percent of those 18-29 years are satisfied with the communication with their parents. This study also shows very clearly that the percentage that is satisfied with the information from their parents is much lower in higher than in lower age groups. Though 'personal' sources of information were more important among the respondents of Wang et al. (2011: 33), 13 percent answered 'no one' when asked about sources for information about contraception, and only four out of ten referred to the family.

## 5. Summary and conclusions

This paper has presented the results of a survey of the sexual habits, knowledge and attitudes among first-year students at Faculty of Medicine of the University of Buenos Aires, aged 19-24 years. Throughout the paper I have repeatedly emphasized the tight relation between such factors on the one hand, and improving maternal health and fighting HIV/AIDS on the one hand – as manifested in two of the Millennium Development Goals. Studying the former thus has relevance for the latter. This is especially important at a time when several developments in Argentina are negative and often opposite the general trend worldwide, for example in the reduction of condom use or the increase in HIV-infection among those aged 19-24. Looking specifically at such students in no way offer results that are generalizable to the overall population, but it does give an important impression of the habits, knowledge and attitudes of those entering medical professions, which is both valuable in itself while offering a source of comparison with studies already conducted on young people more generally.

Firstly, our study has shown that the respondents overall report *a significantly later age of sexual debut* than what has been found in other Argentinian studies, lying at 17 years for both genders, 1,5-2 years later than the trend in the literature review. This already suggests our sample of respondents as differing from young people more generally, which could possibly be due to socioeconomic and educational factors.

Secondly, we see that *apart from contraceptive pills, the male condom, 'emergency pills' and IUDs, the students have a generally low familiarity with other forms of contraception*, with no other form being answered by more than 60 percent. The males are clearly less familiar with most forms than the females, often with differences between 10 and 15 percent, which is striking, especially with the underlying knowledge that HIV-infection in Argentina has been rising more among young males than females, with the rate of men to women being 50 percent higher in 2011 than in 2001 in this age group (DSETS 2013: 4-6). However, *the students tend towards a higher knowledge of routes of HIV transmission and methods of protecting oneself against HIV than what has been found in other studies*. For example, while Wang et al. (2011: 19) found that only 30 percent of the respondents mentioned sharing syringes as a form of transmission, this was 95 percent in our study.<sup>14</sup> Still, more than 40 percent believed *giving* a blood donation could cause infection, and 14 percent the sharing over personal articles. The most striking is the gender differences in erroneous answers. There is clearly a *higher amount of erroneous answer among the males*. Though not high in absolute numbers, the males were several times more likely to incorrectly mark f.ex. IUDs and hormonal pills as protective against HIV. This adds further to the impression of contraceptive knowledge being more lacking among the males.

Thirdly, *condom use at first sexual relation is more widespread in our sample* than what has been found in earlier studies reviewed here, both the Argentinian ones and the INE (2004) study from Spain. 93.3 percent of the respondents answer that they did use a condom the first time. When asked about their last intercourse with whom they maintained sexual relations, there is a sharp reduction to 74.1 percent. This reduction is consistent with findings in other studies, though it is more marked here. However, there is all along a gender difference here, with males overall reporting a higher use of condoms than the females. When asked about contraceptive pills, however, the pattern is turned clearly on its head. I have theorized that this may to a large extent be due to recall bias by the person wearing/taking and often possessing the form of contraception.

Fourthly, the respondents have a *generally positive view of condoms*, though only 60 percent agree completely that they are secure, and only 30 percent that they allow for more enjoyment because of added security. More than 10 percent either agree or quite agree that they create lack of confidence within the couple. *The answers are also more positive than in the INE (2004) study from Spain*, which asked the exact same questions. Again, there is an interesting gender difference, with males being more negative than females on almost all accounts. Interestingly, males were much more likely to agree that condoms

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14 In the Wang et al. study the students had to come up with the alternatives themselves rather than simply marking them, which must be expected to account for some of the difference.

lessen the desire of the woman than the women themselves, though this was especially marked for 'agree somewhat'.

Fifthly, there is a *clear discrepancy between the actual sources of information of sexual topics among the respondents, and what they actually would have wanted*. Parents, teachers and health-care workers play a marginal role, especially among the males, where internet is a more mentioned source than all of these, and friends of the same age the top source for both genders. *When asked what they would have wished, however, mother and father rise to the top among both genders, with health-care workers and teacher also rising strongly. At the same time, 'friends of the same age' goes down sharply*. The sample used here is special because it only includes students of such programs in the capital, but there is little reason not to see this as suggesting clear room for improvement in the roles responsible grown-ups play in the sexual and contraceptive education of young people – especially among the males, who here demonstrate lower levels of knowledge and are part of a group which has developed negatively – epidemiologically speaking – the later years.

Considering findings in the studies discussed in the literature review, and their contrast to the study at hand, there is also a need to explore further the quality of sexual education received by especially adolescents from lower socio-economic strata of society, both in school or at home. The general pattern is that the lack of knowledge is especially marked among these. Note, however, that there are signs that the proportion of HIV infected males and females among those with *higher* education has been rising since the turn of the millennium (DSETS 2013: 22-23).<sup>15</sup> This – along with the negative developments in Argentina discussed in chapter 2 – could potentially have something to do with more fundamental cultural views on sexuality. For example, as Green and Ruark (2011: 72) argue, '[t]he AIDS epidemic has taken place within the context of an increasingly "sex positive" culture in the countries of the West'; cultural traits that may diffuse more strongly towards Argentina, which has generally been a quite 'Western'-oriented Latin American country due to its history. The media are clearly part of this as well. As stated succinctly by Abraham et al. (2002: 28), it is of little surprise 'that teenagers seek romantic and sexual involvement in a media-permeated culture in which the commercialization of sexual semiotics is commonplace, even in media designed for teenage consumption'.

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<sup>15</sup> Interestingly, this is especially marked among homosexuals, where there has been as much as a ten percent rise in proportion in this period, from 23 to 33 percent having tertiary education or higher (DSETS 2013: 22-23).

## 5.1 Strength and weaknesses of the paper and study

I have mentioned throughout this paper several of what I consider to be its strengths. First and foremost, it deals with very central issues in global health today, manifested clearly in two of the three Millennium Development Goals that deal with health specifically. It does this by looking at a country where several developments in relation to HIV/AIDS and maternal health have not been as positive as in many other countries, and it does this by studying a young population in a country where exactly this age group has come to suffer from a larger part of the overall HIV/AIDS-burden in recent years. It looks specifically at students entering various medical professions – mostly medicine and nursing – in a country where there is still significant discrimination and stigmatization related to HIV/AIDS status, both from people in general and from health-care services. Additionally, it looks specifically at attitudes towards and the use of condoms and other forms of contraception, with the underlying knowledge that such use has tended to go down in recent years.

One of the weaknesses of the study is that some of the questions have ready-made alternatives, where the respondents can check off for example various ways of transmitting HIV, which is perhaps a less secure way of testing knowledge than making the respondents come up with these alternatives themselves, while also making comparison with earlier data more difficult. One could also wish for more complex correlations, seeing for example how negative attitudes towards condoms relate to condom use, and again to knowledge. Such correlations have not been discussed or studied here. Finally, one could perhaps also argue that it would be specifically interesting to look at students as they are *finished* with their studies, rather than when they enter them, as this could say something about the effects of going through the study program, as well as the attitudes of those entering the professions. However, this merely adds to the amount of potential studies for the future, complementing the one at hand.

## 8. Literature

- Abraham, Charles, Daniel Wight and Sue Scott (2002). 'Encouraging Safer-Sex Behaviours: Development of the Share Sex Education Programme'. In Derek Rutter & Lyn Quite (eds.) *Changing Health Behaviour*, pp. 28-48. Buckingham, UK: Open University Press.
- Argentina Independent (2013). 'A Century of Struggles: Gender Equality in Argentina'. Buenos Aires, Argentina: The Argentina Independent. Retrieved 28.09.2015, at <http://www.argentinaindependent.com/socialissues/a-century-of-struggles-gender-equality-in-argentina/>
- Bastien, Sheri. *HIV prevention among young people in- and out-of-school in Kilimanjaro, Tanzania*. Ph.D. dissertation. Oslo: The University of Oslo, Faculty of Education, Institute for Educational Research.
- Bond, Virginia & Paul Dover (1997). 'Men, women and the trouble with condoms: problems associated with condom use by migrant workers in rural Zambia'. *Health Transition Review*, supplement to vol. 7, 377-391.
- Brodahl, Andrea & Magrit Jarlsdatter Hovind (2012). Knowledge and attitudes towards abortion among the first year medical students at the University of Buenos Aires, Argentina. Oslo: The Faculty of Medicine, The University of Oslo. Retrived 19.08, 2015, from <https://www.duo.uio.no/bitstream/handle/10852/29014/ProsjektoppgaveArgentina.pdf?sequence=3&isAllowed=y>
- Chartsbin (2009). 'Average age at first sex by country'. Windsor Gardens, Australia: Chartsbin.com. Retrieved 29.09.2015, from <http://chartsbin.com/view/xxj>
- Daniyam, C.A., P.A. Agaba & E.I. Agaba (2010). 'Sexual behavior of medical students: A single institutional survey'. *African Health Sciences*, 10(2), 150-153.
- DSETS (2013). 'Boletín sobre el VIH-sida e ITS en la Argentina'. No. 30, December 2013. Buenos Aires, Argentina: Dirección de Sida y Enfermedades de Transmisión Sexual.
- FSD (n.d.). 'Gender Equity Issues in Argentina'. San Francisco, CA: Foundation for Sustainable Development. Retrieved 20.08.2015, from <http://www.fsdinternational.org/country/argentina/weissues>
- Green, Edward C. & Allison H. Ruark (2011). *Aids, Behavior, and Culture. Understanding Evidence-Based Prevention*. Walnut Creek, CA: Left Coast Press.
- HRW (2009). 'Abortion'. New York, NY: Human Rights Watch. Retrieved 20.08.2015, from <https://www.hrw.org/news/2009/03/31/abortion#Argentina>
- INE (2004). 'Salud y hábitos sexuales. Las conductas sexuales desde la perspectiva del sida'. Boletín no. 4, 2004. Madrid, Spain: Instituto Nacional de Estadística.
- IWHC (2014). 'Thosands March for Changes to Abortion Law in Argentina'. New York, NY: International Women's Health Coalition. Retrieved 28.09.2015, from <http://iwhc.org/2014/10/thousands-march-changes-abortion-law-argentina/>
- Jorrat, Jorge R., Paula Barletta, María J. Chacón & Manuel E. Riveiro (2008). 'Información, actitudes y conductas en relación con el VIH-sida'. Buenos Aires, Argentina: Centro de Estudios de Opinión Pública, Universidad de Buenos Aires.
- Kamenetzky, Sofia (2004). 'Argentina', in Robert T. Franceour & Raymond J. Noonan (eds.), *The Continuum Complete International Encyclopedia of Sexuality*, pp. 1-26. New York, NY: The Continuum International Publishing Group.
- Langille, Donald B., Jean Hughes, Gail T. Murphy & Janet A. Rigby (2005). 'Socio-economic Factors and Adolescent Sexual Activity and Behaviour in Nova Scotia'. *Canadian Journal of Public Health*, 96(4), 313-318.
- LOC (2012). 'Argentina: Supreme Court Decision on Abortion'. Washington D.C.: Library of Congress. Retrieved 20.08.2015, from [http://www.loc.gov/lawweb/servlet/lloc\\_news?disp2\\_l205403029\\_text](http://www.loc.gov/lawweb/servlet/lloc_news?disp2_l205403029_text)
- Millennium Project (2006). 'About MDGs – What they are'. Retrieved 19.08.2015, from

- <http://www.unmillenniumproject.org/goals/index.htm>.
- Oizerovich, Silvia, Dora Daldevich, Miriam Salvo, Alicia Schulman, Sandra Vázquez & Hilda Santos (2004). 'Investigación exploratoria sobre características de crecimiento, desarrollo y cuidados de la salud esexual y reproductiva en población adolescente'. *La Revista de la Sociedad Argentina de Ginecología Infanto Juvenil* 11(3), 219-230.
- MSAL (2003). 'Ley 25.673'. Buenos Aires, Argentina: Programa Nacional de Salud Sexual y Procreación Responsable. Retrieved 24.08.2015, from <http://www.msal.gov.ar/saludsexual/ley.php>
- NAT (2010). 'HIV Public Knowledge and Attitudes, 2010'. London, UK: The National AIDS Trust. Retrieved 24.08.2015, from <http://www.nat.org.uk/media/files/publications/jan-2011-hiv-public-knowledge-and-attitudes.pdf>
- Teva, Inmaculada, María P. Bermúdez & María T. Ramiro (2014). 'Satisfacción sexual y actitudes hacia el uso del preservativo en adolescentes: evaluación y análisis de su relación con el uso del preservativo'. *Revista Latinoamericana de Psicología*, 46(2), 127-136.
- UNAIDS (2014). 'Informe Nacional sobre Los Progresos Realizados en Argentina'. New York: United Nations, 31.03.2014. Retrieved 24.08.2015, from [http://www.unaids.org/sites/default/files/country/documents//file\\_92809.es..pdf](http://www.unaids.org/sites/default/files/country/documents//file_92809.es..pdf)
- UNAIDS (2013). 'UNAIDS report on the global AIDS epidemic 2013'. New York, NY: United Nations. Retrieved 19.08.2015, from [http://www.unaids.org/sites/default/files/media\\_asset/UNAIDS\\_Global\\_Report\\_2013\\_en\\_1.pdf](http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf)
- United Nations (2015). 'The Millennium Development Goals Report 2015'. New York, NY: United Nations.
- United Nations (2013). 'Millennium Development Goals Indicators'. New York: United Nations, Department of Economic and Social Affairs. Retrieved 19.08, 2015, from <http://mdgs.un.org/unsd/mdg/data.aspx>
- Wang, Lucia, Mariana Vazquez, María R. Ravalli & Adriana Durán (2011). 'Conocimientos, Actitudes y Prácticas en VIH y Salud Sexual y Reproductiva (SSR) y Uso de Tecnologías de la Información y la Comunicación (TIC) entre Adolescentes de Argentina'. Buenos Aires, Argentina: Fundación Huesped. Retrieved 26.08.15, from [http://www.unicef.org/argentina/spanish/salud\\_comunica\\_Informe-UNICEF-FH.pdf](http://www.unicef.org/argentina/spanish/salud_comunica_Informe-UNICEF-FH.pdf)
- WHO (2015). 'Family planning / contraception'. Fact sheet no. 351. Geneva, Switzerland: The World Health Organization. Retrieved 20.08.2015, from <http://www.who.int/mediacentre/factsheets/fs351/en/index.html>
- WHO (2013). 'Maternal mortality in 1990-2013'. Argentina. Geneva, Switzerland: The World Health Organization. Retrieved 20.08.2015, from [http://www.who.int/gho/maternal\\_health/countries/arg.pdf?ua=1](http://www.who.int/gho/maternal_health/countries/arg.pdf?ua=1)





## ENCUESTA

SALUD SEXUAL Y PROCREACIÓN  
RESPONSABLE EN JÓVENES UNIVERSITARIOS

Estamos  
**RENOVANDO**  
la SEUBE !!  
**ACERCATE...**

## PROYECTO DE INVESTIGACIÓN

Acción en Salud Sexual y Procreación Responsable en jóvenes universitarios de la Facultad de Medicina • UBA

La información obtenida a través de la siguiente encuesta servirá para promover políticas y estrategias de prevención y promoción de la salud de los estudiantes de la Facultad de Medicina.

Toda la información que se le solicita en este cuestionario es estrictamente confidencial y anónima, por lo cual no será asociada de ninguna manera a una persona particular. Los datos suministrados serán objeto de protección y quedarán amparados por el secreto estadístico, según establece el artículo 10 de la Ley 17.622.

La Secretaría de Extensión Universitaria y Bienestar Estudiantil de la Facultad de Medicina de la Universidad de Buenos Aires le agradece su valiosa colaboración en esta investigación.

Encuesta N°:

Secretaría de Extensión Universitaria y Bienestar Estudiantil  
Centro de Capacitación en Programas de Salud -**Ce.Ca.P.S**  
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## PARTE A. Datos Personales

Las siguientes preguntas nos permitirán conocer mejor las características de quienes contestan la encuesta.

**1. ¿Cuál es tu año de nacimiento?**

**2. ¿Cuál es tu sexo?**

- Mujer  
 Varón

**3. ¿En que país naciste?**

- Argentina  
 Bolivia  
 Brasil  
 Chile  
 Colombia  
 Paraguay  
 Perú  
 Uruguay  
 Otro (especificar) \_\_\_\_\_

**4. ¿Cuál es tu estado civil actual?**

- Soltero/a  
 Unión civil  
 Casado/a  
 Separado/a  
 Divorciado/a  
 Viudo/a

**5. ¿Tenés hijos/as?**

- Si  
 No

**6. Actualmente vivís:**

- Con tu familia parental (padres, hermanos, tíos, abuelos)  
 Solo/a  
 Con amigos/as  
 Con tu pareja  
 Con tu pareja e hijos  
 otros: \_\_\_\_\_

**7. ¿Qué carrera estás cursando actualmente?**

- Medicina  
 Enfermería Universitaria  
 Lic. en Obstetricia  
 Lic. en Fonoaudiología  
 Lic. en Kinesiología y Fisiatría  
 Téc. Radiólogo universitario  
 Lic. en Nutrición

**8. ¿Qué año de la carrera estás cursando? (o de qué año estás cursando materias mayoritariamente?)**

- Primero  
 Segundo  
 Tercero  
 Cuarto  
 Quinto  
 Sexto  
 Internado anual rotatorio

9. ¿Cuál es el máximo nivel de estudios de enseñanza general y/o formación profesional que han terminado tu padre y tu madre?

	Padre	Madre
Analfabeto.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios primarios incompletos.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios primarios completos.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios secundarios incompletos.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios secundarios completos.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios terciarios incompletos.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios terciarios completos.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios universitarios incompletos.	<input type="checkbox"/>	<input type="checkbox"/>
Estudios universitarios completos.	<input type="checkbox"/>	<input type="checkbox"/>
No sabe el nivel de estudios de su padre o de su madre.	<input type="checkbox"/>	<input type="checkbox"/>

10. ¿Cuál de las siguientes categorías describe mejor tu situación laboral?

- Empleado/a a tiempo completo
- Empleado/a a tiempo parcial
- Trabajador/a independiente
- Buscando trabajo
- No trabajo
- Otro: \_\_\_\_\_

## PARTE B. (Información y conocimientos)

Las preguntas de esta sección se refieren a la información y creencias respecto de temas sexuales, métodos anticonceptivos y legislación vigente en la Argentina.

Recuerda que la información que se solicita es confidencial y anónima y no puede relacionarse con una persona concreta. Si hay alguna pregunta que te resulta incómoda, no estás obligado/a a responder. Igualmente, te pedimos que no abandones el resto del cuestionario.

11. ¿Cómo fue la comunicación con tus padres acerca de temas sexuales?

- Excelente
- Muy Buena
- Buena
- Mala
- No tuve comunicación alguna

12. Si hubieras podido elegir ¿de qué fuentes de información (persona o medio) habrías preferido aprender acerca de temas sexuales? (MARCAR COMO MAXIMO 3 RESPUESTAS)

- Madre
- Padre
- Madre y padre
- Hermanos/as
- Cónyuge/pareja

- Otro familiar/es
- Docentes de la escuela secundaria
- Docentes de la universidad
- Amigos/as de la misma edad
- Amigos/as más grandes
- Médico/a, enfermero/a u otro personal sanitario
- Medios gráficos (libros, diarios, revistas)
- Medios audiovisuales (radio, televisión)
- Internet

**13. En la práctica ¿cuáles fueron las fuentes de información sobre temas sexuales más útiles para vos? (MARCAR COMO MAXIMO 3 RESPUESTAS)**

- Madre
- Padre
- Madre y padre
- Hermanos/as
- Cónyuge/pareja
- Otro familiar/es
- Docentes de la escuela secundaria
- Docentes de la universidad
- Amigos/as de la misma edad
- Amigos/as más grandes
- Médico/a, enfermero/a u otro personal sanitario
- Medios gráficos (libros, diarios, revistas)
- Medios audiovisuales (radio, televisión)
- Internet
- Ninguna de las anteriores

**Conocimientos sobre métodos anticonceptivos**

**14. De las siguientes fuentes de información sobre métodos anticonceptivos, ¿cuáles fueron las más útiles para vos? (MARCAR COMO MAXIMO 3 RESPUESTAS)**

- Madre
- Padre

- Madre y padre
- Hermanos/as
- Cónyuge/pareja
- Otro familiar/es
- Docentes de la escuela secundaria
- Docentes de la universidad
- Amigos/as de la misma edad
- Amigos/as más grandes
- Médico/a, enfermero/a u otro personal sanitario
- Medios gráficos (libros, diarios, revistas)
- Medios audiovisuales (radio, televisión)
- Internet
- Ninguna de las anteriores

**15. ¿Crees que la información de la que disponés actualmente sobre métodos anticonceptivos es:**

- Excelente
- Muy Buena
- Buena
- Mala
- No tengo información

**16. ¿Qué métodos para evitar el embarazo o anticonceptivos conocés? [MARCAR TODO LO QUE CORRESPONDA]**

- Métodos Naturales (control de la temperatura, el ritmo menstrual, el flujo)
- Método del retiro o coito interrumpido
- Dispositivo Intrauterino (DIU)
- Implante
- Parche
- Anillos vaginales
- Pastillas para la lactancia
- Mantener relaciones sexuales durante la menstruación
- Pastillas anticonceptivas

- Anticoncepción de emergencia o pastilla del día después
- Inyecciones hormonales
- Evitar el orgasmo femenino
- Óvulos espermicidas
- Preservativo masculino
- Preservativo femenino
- Que la mujer orine luego de la relación sexual
- Que el hombre orine luego de la relación sexual
- Que la mujer tome té de yuyos luego de la relación sexual
- Diafragma
- Ligadura tubaria
- Vasectomía
- No conozco ninguno
- Otros: \_\_\_\_\_

**En caso de que hayas contestado que conocés la anticoncepción de emergencia o pastilla del día después, responde las preguntas 17, 18 y 19. Si respondiste que no la conocés, pasa directamente a la pregunta 20.**

**17. De las siguientes frases respecto de la anticoncepción de emergencia, indicá si estás de acuerdo o en desacuerdo.**

- 1- De acuerdo.
- 2- En desacuerdo.

	(1)	(2)
Pueden tomarse entre 3 y 5 pastillas de anticoncepción de emergencia por año.	<input type="checkbox"/>	<input type="checkbox"/>
Debe tomarse después de una relación sexual sin protección para evitar el embarazo.	<input type="checkbox"/>	<input type="checkbox"/>
Es igual de efectiva que otros métodos que se usan antes de la relación sexual (ejemplo: pastillas, inyectables, DIU).	<input type="checkbox"/>	<input type="checkbox"/>

	(1)	(2)
<b>Al tomarla, brinda protección por todo ese ciclo menstrual (es decir no existe riesgo de embarazo hasta la siguiente menstruación).</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tiene muchas contraindicaciones.</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Es de venta libre en las farmacias.</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Es un método abortivo.</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Si bien es de venta bajo receta, puede adquirirse sin la misma.</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Puede conseguirse de manera gratuita en hospitales y centros de salud.</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Debe ofrecerse a toda mujer que fue víctima de una violación.</b>	<input type="checkbox"/>	<input type="checkbox"/>

**18. ¿Cuándo te parece que sería mejor tomar la anticoncepción de emergencia para que sea más efectiva, evitando un embarazo no buscado? Marcar UNA SOLA OPCION.**

- En algún momento dentro de los 5 días posteriores a la relación sexual de riesgo, ya que luego su efectividad va disminuyendo.
- En algún momento dentro de los 3 días posteriores a la relación sexual de riesgo, ya que luego su efectividad va disminuyendo.
- En algún momento dentro de las 12 Hs posteriores a la relación sexual de riesgo, ya que luego su efectividad va disminuyendo.
- En algún momento dentro de la semana posterior a la relación sexual de riesgo, ya que luego su efectividad va disminuyendo.
- Al día siguiente de la relación sexual de riesgo.
- No sé.



**19. Respecto al mecanismo de acción de la anticoncepción de emergencia, indicá si estás de acuerdo o en desacuerdo.**

1- De acuerdo.

2- En desacuerdo.

	(1)	(2)
Impide que se una el óvulo con el espermatozoide.	<input type="checkbox"/>	<input type="checkbox"/>
Impide que se implante el huevo en el útero.	<input type="checkbox"/>	<input type="checkbox"/>
Detiene la progresión del embarazo si este se produjo.	<input type="checkbox"/>	<input type="checkbox"/>
Es abortiva.	<input type="checkbox"/>	<input type="checkbox"/>
Impide que los espermatozoides suban por el cuello y el útero.	<input type="checkbox"/>	<input type="checkbox"/>
Retrasa la ovulación.	<input type="checkbox"/>	<input type="checkbox"/>
Inhibe la ovulación durante ese ciclo.	<input type="checkbox"/>	<input type="checkbox"/>
Altera el moco cervical o flujo.	<input type="checkbox"/>	<input type="checkbox"/>
No sé cual es el mecanismo de acción.	<input type="checkbox"/>	<input type="checkbox"/>

**20. Los hospitales y centros de salud del sistema público en la Argentina, ¿entregan métodos anticonceptivos de manera gratuita?**

- Sí  
 No  
 No sé

**21. Las obras sociales y prepagas, ¿están obligadas a cubrir el costo de los métodos anticonceptivos?**

- Sí, están obligadas a hacer un descuento especial para la gente joven  
 Sí, están obligadas a cubrir una parte del costo  
 Sí, están obligadas a cubrir el 100%  
 No, el descuento depende de la decisión de cada Obra Social o prepaga  
 No sé

**22. En general, ¿Qué condiciones debería cumplir una persona para que un/a médico/a le prescriba anticonceptivos? (MARCAR TODO LO QUE CORRESPONDA)**

- Ser mayor de edad (mayor de 18 años)  
 Si es menor de edad, estar acompañado por un padre/madre o tutor/a  
 Haber iniciado relaciones sexuales hace más de un año  
 Tener DNI  
 Ir con su pareja  
 Haberse realizado un Test de Papanicolau en el último año  
 Hacerse otros estudios como análisis de sangre, ecografías, etc  
 Ninguna de las anteriores  
 No sé

**23. Si alguien quisiera acceder a la anticoncepción quirúrgica (ligadura de trompas en la mujer o vasectomía en el hombre) en la Argentina, ¿Qué condiciones debería cumplir? (MARCAR TODAS LAS OPCIONES QUE CORRESPONDAN)**

- No conozco estos métodos anticonceptivos  
 Tener más de 18 años  
 Tener más de 21 años  
 Estar casada/o  
 Tener por lo menos un hijo  
 Tener 3 o más hijos  
 Indicación médica  
 Que ambos miembros de la pareja firmen un consentimiento informado  
 Que la persona que se realizará la práctica firme un consentimiento  
 Nunca, no es legal en la Argentina bajo ninguna circunstancia  
 Ninguna de las anteriores  
 No sé

### Conocimientos sobre VIH

**24. De la siguiente lista, ¿De qué formas te parece que se puede contraer el VIH-SIDA. [MARCAR TODO LO QUE CORRESPONDA]**

- Por un beso de boca
- Al recibir una transfusión de sangre
- Saludo de mano
- Por tener relaciones sexuales sin protección
- Compartir artículos personales
- Durante el embarazo
- Al donar sangre
- Compartir el mate
- Mantener sexo oral sin protección
- Compartir jeringas
- Compartir un cigarrillo
- Al usar un baño público
- Ninguna de las anteriores
- Otro: \_\_\_\_\_

**25. Una infección de transmisión sexual es una infección que uno adquiere por tener relaciones sexuales con una persona que ya la padece ¿Cuál/es de los siguientes métodos te parece que sirve para protegerte de las Infecciones de Transmisión Sexual (ITS) y HIV? [MARCAR TODO LO QUE CORRESPONDA]**

- Métodos Naturales (control de la temperatura, el ritmo menstrual, el flujo)
- Método del retiro o coito interrumpido
- Dispositivo Intrauterino (DIU)
- Mantener relaciones anales
- Implante, parches
- Anillos vaginales
- Pastillas hormonales
- Anticoncepción de emergencia o pastilla del día después
- Inyecciones hormonales
- Óvulos espermicidas

- Que el hombre no llegue al orgasmo evitando la eyaculación
- Preservativo masculino
- Preservativo femenino
- Diafragma
- Anticoncepción quirúrgica
- Mantener relaciones sexuales cuando la mujer no está menstruando
- Otro: \_\_\_\_\_

### Conocimientos sobre la interrupción voluntaria del embarazo

**26. En la Argentina, la interrupción voluntaria del embarazo:**

- Es legal en todos los casos (pasar a PARTE C)
- En algunas situaciones no está penalizado (pasar a pregunta 27)
- Siempre está penalizado (pasar a PARTE C)
- No sé (pasar a PARTE C)

**27. ¿Sabés en qué casos no estaría penalizado? [MARCAR TODAS LAS OPCIONES QUE CORRESPONDAN]**

- Cuando el embarazo es producto de una violación
- Cuando el feto tiene malformaciones incompatibles con la vida extrauterina
- Cuando el feto tiene malformaciones de cualquier tipo
- Cuando la vida de la mujer embarazada corre riesgo si no se interrumpe el embarazo
- Cuando la continuación del embarazo representa un riesgo para la salud mental de la mujer



- |  |   |
|--|---|
| <input type="checkbox"/> Cuando la mujer embarazada tiene alguna enfermedad que pueda empeorar con el embarazo         | <input type="checkbox"/> Si la mujer, por el motivo que sea, desea interrumpir el embarazo, sin importar la edad gestacional  |
| <input type="checkbox"/> Cuando una mujer con retraso mental queda embarazada debido a una violación                   | <input type="checkbox"/> Si la mujer, por el motivo que sea, desea interrumpir el embarazo antes de la semana 12 de gestación |
| <input type="checkbox"/> Cuando la mujer embarazada y su familia carecen de recursos económicos para criar a un hijo/a | <input type="checkbox"/> Ninguna de las anteriores  |
| <input type="checkbox"/> Si la mujer quedó embarazada porque falló el método anticonceptivo                            | <input type="checkbox"/> No sé  |

## PARTE C. (Prácticas y percepciones)

*Esta sección contiene preguntas para conocer las prácticas sexuales y cuidados de las personas encuestadas.*

*Recuerda que la encuesta es anónima, y que si hay alguna pregunta que te resulta incómoda, no estas obligado/a a responder. Igualmente, te pedimos que no abandones el resto del cuestionario.*

### 28. ¿Has iniciado relaciones sexuales?

- Si  
 No (*pasar a PARTE D*)

### Respecto a tu primera Relación Sexual

### 29. ¿A qué edad tuviste tu primera relación sexual?

### 30. ¿Con quién mantuviste tu primera relación sexual?

- Amigo/a  
 Novio/a  
 Esposo/a

- Trabajador/a sexual (prostituta/o)  
 Pareja ocasional  
 Otro: \_\_\_\_\_

### 31. ¿Usaron preservativo en esta primera relación sexual?

- Si  
 No  
 No recuerdo

### 32. ¿Tomaron precauciones para evitar el embarazo en esta primera relación sexual?

- Si  
 No (*pasar a la pregunta 34*)  
 No recuerdo (*pasar a la pregunta 35*)



**33. ¿Cuál fue el método anticonceptivo que utilizaste en tu primera relación sexual? [MARCAR TODO LO QUE CORRESPONDA]**

- Métodos Naturales (control de la temperatura, el ritmo menstrual, el flujo)
- Método del retiro o coito interrumpido
- Dispositivo Intrauterino (DIU)
- Implante
- Parche
- Anillos vaginales
- Pastillas para la lactancia
- Mantener relaciones sexuales durante la menstruación
- Pastillas anticonceptivas
- Anticoncepción de emergencia o pastilla del día después
- Inyecciones hormonales
- Evitar el orgasmo femenino
- Óvulos espermicidas
- Preservativo masculino
- Preservativo femenino
- Que la mujer orine luego de la relación sexual
- Que el hombre orine luego de la relación sexual
- Diafragma
- Que la mujer tome té de yuyos luego de la relación sexual
- Ligadura tubaria
- Vasectomía
- Otros: \_\_\_\_\_

**Pasar a la pregunta 35.**

**34. ¿Cuál es el motivo por el que no utilizaron un método anticonceptivo? [MARCAR COMA MAXIMO TRES OPCIONES]**

- No hizo falta, no hubo penetración vaginal
- No hizo falta, fue con alguien de tu mismo sexo
- No había riesgo ya que al menos uno de la pareja era virgen

- No había riesgo porque la mujer estaba con su período menstrual
- Fue algo repentino y no estaban preparados
- Tu pareja no los aceptaba
- Tu pareja te dijo que no había riesgo de embarazo la primera vez que mantenías relaciones sexuales
- Te preocupaban los efectos secundarios
- No podías pagarlo
- No tenías suficiente información sobre el tema
- Motivos religiosos
- No pensaron que era un riesgo en ese momento
- No sé
- Otro \_\_\_\_\_

**Respecto a las relaciones sexuales a lo largo de tu vida**

*Recuerda que la encuesta es anónima, y que si hay alguna pregunta que te resulta incómoda, no estas obligado/a a responder. Igualmente, te pedimos que no abandones el resto del cuestionario.*

**35. A lo largo de tu vida, has tenido relaciones sexuales:**

- Sólo con mujeres
- Más a menudo con mujeres, pero al menos en una ocasión también con un hombre
- Igual con hombres que con mujeres
- Más a menudo con hombres, pero al menos en una ocasión también con una mujer
- Sólo con hombres
- No contesta

**36. ¿Cómo describirías tu identidad sexual?**

- Heterosexual
- Homosexual
- Bisexual
- Travesti
- Transexual
- Otra \_\_\_\_\_
- No contesta

**37. Número aproximado de parejas sexuales en los últimos 12 meses (si la respuesta es "0" también indicarlo)**

**38. ¿Con qué frecuencia utilizás preservativo, vos o la persona con la que mantenés relaciones sexuales?**

- Siempre
- Casi siempre
- Algunas veces
- Casi nunca
- Nunca

**39. ¿Usaste un preservativo en la última relación sexual, vos o la persona con la que mantuviste relaciones sexuales?**

- Sí
- No
- No recuerdo

**40. ¿Utilizás actualmente -vos o la persona con la que mantenés relaciones sexuales- algún método para evitar el embarazo?**

- Sí (*pasar a la pregunta 42*)
- No

**41. ¿Cuál es el motivo por el que no utilizás un método para evitar el embarazo? (MARCAR COMO MAXIMO 3 RESPUESTAS)**

- No necesito, mantengo relaciones con personas del mismo sexo
- No necesito, no mantengo relaciones por vía vaginal
- Estoy buscando un embarazo
- Me diagnosticaron Infertilidad
- Estoy en postparto y amamantando
- Mi pareja sexual no lo acepta
- Me preocupan los efectos secundarios
- No puedo pagarlo
- No tengo suficiente información sobre el tema
- Motivos religiosos
- Me olvido de usarlo
- Los horarios de atención para conseguirlo son muy limitados y no puedo ir
- No estoy manteniendo relaciones sexuales actualmente
- No sé
- Otro \_\_\_\_\_

**Pasar a la pregunta 47.**

**42. ¿Qué métodos anticonceptivos utilizás de manera regular? [MARCAR TODO LO QUE CORRESPONDA]**

- Métodos Naturales (control de la temperatura, el ritmo menstrual, el flujo)
- Método del retiro o coito interrumpido
- Dispositivo Intrauterino (DIU)
- Implante
- Parche
- Anillos vaginales
- Pastillas para la lactancia
- Mantener relaciones sexuales durante la menstruación
- Pastillas anticonceptivas

- Anticoncepción de emergencia o pastilla del día después
- Inyecciones hormonales
- Evitar el orgasmo femenino
- Óvulos espermicidas
- Preservativo masculino
- Preservativo femenino
- Que la mujer orine luego de la relación sexual
- Que la mujer tome té de yuyos luego de la relación sexual
- Que el hombre orine luego de la relación sexual
- Diafragma
- Ligadura tubaria
- Vasectomía
- Otro \_\_\_\_\_
- No uso regularmente. **(Pasar a la preg. 47)**

**43. ¿Quién decidió usar este método?**

- Vos
- Tu médico
- Tu pareja sexual
- Lo decidieron juntos con tu pareja sexual
- Tus padres
- Otro \_\_\_\_\_

**44. ¿Qué factores influyeron en la decisión de usar este método? [MARCAR HASTA 3 OPCIONES COMO MAXIMO]**

**Si sos mujer, elegir de la siguientes opciones según corresponda (MARCAR COMO MAXIMO 3 RESPUESTAS)**

- La recomendación del médico o profesional de la salud
- La recomendación de amigas/os
- Es el más económico/barato

- Te lo dan gratis en el Centro de Salud
- Es el que resulta más adecuado a tus necesidades
- Es el que podés comprometerte a usar adecuadamente
- No requiere que estés pendiente todos los días del método
- Porque es el que más seguridad te da
- Porque no querés tomar hormonas
- Es el que eligió tu pareja sexual y respetás su decisión
- Protege de VIH e ITS
- Desconocés otras opciones
- No querés que tu pareja sexual se entere que lo usás
- No es algo que vos puedas decidir
- Otro \_\_\_\_\_

**Si sos hombre, elegir de la siguientes opciones según corresponda (MARCAR COMO MAXIMO 3 RESPUESTAS)**

- La recomendación del médico o profesional de la salud
- La recomendación de amigas/os
- Es el más económico/barato
- Te lo dan gratis en el Centro de Salud
- Es el que resulta más adecuado a tus necesidades
- Es el que eligieron conjuntamente con tu pareja sexual
- Porque es el que más seguridad te da
- Porque no querés que tu pareja sexual tome hormonas
- Es el que eligió tu pareja sexual y respetás su decisión
- Protege de VIH e ITS
- Desconocés otras opciones
- No es algo que vos puedas decidir
- Otro \_\_\_\_\_

**45. ¿Dónde obtenés los métodos anticonceptivos? Elegir la opción más frecuente.**

- En la farmacia, a través de la obra social o prepaga con un 100% de descuento
- En la farmacia, a través de la obra social o prepaga con un descuento menor
- En la farmacia sin receta
- En un centro de salud
- En el hospital
- En consultorio privado
- En kioscos
- Otros

**46. ¿Qué requisitos te solicitó el profesional de la salud antes de indicarte el método?**

- Ser mayor de edad (mayor de 18 años)
- Si eras menor de edad, estar acompañado por madre-padre o tutor
- Haber iniciado relaciones sexuales hace más de un año
- Tener DNI
- Ir con tu pareja
- Haberte realizado el Test de Papanicolau en el último año
- Hacerte otros estudios como análisis de sangre, ecografías, etc
- Ninguna de las anteriores
- No me lo indicó un profesional de la salud
- Otro \_\_\_\_\_

**47. ¿Con qué frecuencia vos o la persona con la que mantuviste relaciones sexuales utilizaron métodos anticonceptivos en los últimos 12 meses?**

- Siempre
- Casi Siempre
- Algunas veces

- Casi nunca
- Nunca

**48. ¿Alguna vez tuviste que usar vos o la persona con la que mantuviste relaciones sexuales Anticoncepción de Emergencia o pastilla del día después?**

- Sí
- No (*pasar directamente a PARTE D*)

**49. En caso de que sí ¿Cuántas veces la has usado en los últimos 12 meses?**

- Nunca
- 1 vez
- Entre 2 y 5 veces
- Más de 5 veces

**50. ¿Por qué tuviste que usar Anticoncepción de Emergencia, vos o la persona con la que mantuviste relaciones sexuales? [MARCAR TODO LO QUE CORRESPONDA]**

- Falló el método anticonceptivo que estabas usando (rotura de preservativo, olvido de la toma de una pastilla, etc)
- No usaste ningún método
- Fue una relación no consentida
- Dudabas sobre la seguridad del método que estabas utilizando
- Otro \_\_\_\_\_

**51. ¿Dónde obtuviste la Anticoncepción de Emergencia? [MARCAR TODO LO QUE CORRESPONDA]**

- Te la entregaron gratuitamente en un hospital
- Te la entregaron gratuitamente en un centro de salud

- La compraste en la farmacia, con receta
- La compraste en la farmacia, sin receta
- La tenías en tu casa
- Te la dio un amigo/a
- Otro \_\_\_\_\_

**PARTE D.** (Salud Sexual y Sistema de Salud)

*Las preguntas de esta sección se refieren a tu experiencia con los servicios de salud, particularmente de salud sexual y reproductiva.*

*Recuerda que la encuesta es anónima, y que si hay alguna pregunta que te resulta incómoda, no estas obligado/a a responder. Igualmente, te pedimos que no abandones el resto del cuestionario.*

**52. En los últimos 2 años, ¿realizaste alguna consulta por temas relacionados con tu salud sexual?**

- Si
- No (*pasar a la pregunta 55*)

**53. ¿Cuál fue el motivo de esa consulta? [MARCAR TODO LO QUE CORRESPONDA]**

- Métodos anticonceptivos
- Prevención de infecciones de transmisión sexual
- Reproducción
- Problemas en las relaciones sexuales
- Violencia y/o abuso sexual
- Control periódico
- Otro \_\_\_\_\_

**54. ¿A dónde concurriste para realizar esa consulta?**

- A un hospital público
- A un centro de salud o salita
- Consultorio médico de una escuela
- A un sanatorio o clínica privada
- A un consultorio privado (médico/a de la obra social o prepaga)
- No recuerdo
- Otro \_\_\_\_\_

**55. ¿Alguna vez te hiciste un Test de VIH?**

- Si
- No (*Pasar a la pregunta 60*)

**56. ¿Cuántas veces te hiciste un Test de VIH?**

- 1 vez  
 Entre 2 y 5 veces  
 Más de 5 veces

**57. ¿Cuánto hace que te hiciste la prueba del VIH por última vez?**

- Hace menos de 12 meses  
 Entre uno y dos años  
 Entre dos y cinco años  
 Hace cinco años o más

**58. ¿Por qué te hiciste esta última prueba de VIH?**

- Estaba embarazada (vos o tu pareja sexual)  
 Había tenido relaciones sexuales con una pareja que no conocía y no usé preservativo  
 Me lo indicó el médico  
 Se rompió el preservativo durante una relación sexual  
 Tuve un accidente laboral  
 Me lo pidió mi pareja sexual  
 En un control de rutina  
 Quiero dejar de usar preservativo con mi pareja  
 Doné sangre  
 Tuve una conducta de riesgo asociada al uso de jeringas  
 Por iniciativa propia  
 Otro motivo \_\_\_\_\_

**59. ¿Llegaste a saber los resultados de esta última prueba del VIH?**

- Sí  
 No

**60. ¿Te ha diagnosticado algún médico a lo largo de tu vida alguna de las siguientes infecciones? (MARCAR TODO LO QUE CORRESPONDA)**

- Infección por clamidia  
 Gonorrea  
 Sífilis  
 Tricomonas  
 Herpes genital  
 Ulceras genitales o condiloma  
 Hepatitis B  
 Uretritis no específica  
 VIH  
 Otras infecciones: \_\_\_\_\_  
\_\_\_\_\_  
 No me han diagnosticado ninguna de las anteriores

## PARTE E. (Opiniones y vivencias)

Recuerda que la encuesta es anónima, y que si hay alguna pregunta que te resulta incómoda, no estas obligado/a a responder. Igualmente, te pedimos que no abandones el resto del cuestionario.

**61. Existen opiniones distintas acerca de los preservativos. Por favor, indique en qué medida estás de acuerdo con cada una de las siguientes afirmaciones respecto al uso de preservativos**

	1	2	3	4	5
Son complicados de usar.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crean desconfianza entre la pareja.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A las mujeres les corta el deseo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A los hombres les corta el deseo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impiden sentir verdaderamente el cuerpo del otro.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permiten disfrutar más por la seguridad que dan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son seguros.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1- Totalmente de acuerdo  
 2- Bastante de acuerdo  
 3- Algo de acuerdo  
 4- Nada de acuerdo  
 5- No lo se

**62. ¿Conoces a una mujer que haya decidido interrumpir su embarazo?**

- Si  
 No  
 No estoy seguro/a

**63. ¿Crees que la interrupción voluntaria del embarazo debería ser legal?**

- Si, siempre (pasar a pregunta 65)  
 Si, pero sólo en algunos casos  
 No, nunca (pasar a pregunta 65)  
 No sé

**64. En qué casos considerarás que debería estar permitido? [MARCAR TODAS LAS OPCIONES QUE CORRESPONDAN]**

- Cuando el embarazo es producto de una violación  
 Cuando el feto tiene malformaciones incompatibles con la vida extrauterina  
 Cuando el feto tiene malformaciones de cualquier tipo  
 Cuando la vida de la mujer embarazada corre riesgo si no se interrumpe el embarazo  
 Cuando la continuación del embarazo representa un riesgo para la salud mental de la mujer  
 Cuando la mujer embarazada tiene alguna enfermedad que pueda empeorar con el embarazo  
 Cuando una mujer con retraso mental queda embarazada debido a una violación  
 Cuando la mujer embarazada y su familia carecen de recursos económicos para criar a un hijo/a  
 Si la mujer quedó embarazada porque falló el método anticonceptivo  
 Si la mujer, por el motivo que sea, desea interrumpir el embarazo, sin importar la edad gestacional  
 Si la mujer, por el motivo que sea, desea interrumpir el embarazo antes de la semana 12 de gestación  
 Ninguna de las anteriores  
 No sé

**65. ¿Conocés a alguien que haya sido víctima de un abuso sexual?**

*(A los fines de esta encuesta, entenderemos como abuso sexual todo acto sexual, la tentativa de consumir un acto sexual, los comentarios o insinuaciones sexuales no deseados, o las acciones para comercializar o utilizar de cualquier otro modo la sexualidad de una persona, mediante coacción por otra persona, independientemente de la relación de esta persona con la víctima, en cualquier ámbito, incluidos el hogar y el lugar de trabajo)*

- Si
- No

**66. ¿Vos has sufrido alguna vez abuso sexual?**

- Si
- No
- No estoy seguro/a

**67. ¿Qué opinas de las relaciones de pareja entre personas del mismo sexo?**

	1	2	3	4	5
Tienen derecho igual que el resto.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Las respeto.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No las considero aceptables.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Me incomoda que manifiesten su afecto en público.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1- Totalmente de acuerdo
- 2- Bastante de acuerdo
- 3- Algo de acuerdo
- 4- Nada de acuerdo
- 5- No lo se

**Fin del cuestionario**





**Las preguntas que hacemos a continuación, PERMITIRÁN PLANIFICAR ACTIVIDADES DE EXTENSIÓN UNIVERSITARIA QUE RESPONDAN A LOS INTERESES DE LOS/AS ESTUDIANTES**

1. ¿Alguna vez has asistido a un taller o una charla sobre sexualidad?

- Si  
 No

2. ¿Te interesaría asistir a un taller o una charla sobre sexualidad?

- Si  
 No

3. ¿Sobre qué temas? [MARCAR TODO LO QUE CORRESPONDA]

- Métodos anticonceptivos  
 Relación de pareja  
 Procreación  
 Erotismo  
 Interrupción del embarazo  
 Preferencia sexual  
 Otro \_\_\_\_\_

¿Hay algún tema que no preguntamos y del cual te gustaría hacer algún comentario?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Te agradecemos mucho que hayas completado esta encuesta!*

