Esc Anna Nery 2024;28:e20240079

RESEARCH

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Qualitative evaluation of the comprehensive approach to sexual health with marginalized adolescents[a]

Avaliação qualitativa da abordagem integral da saúde sexual com adolescentes marginalizados

Evaluación cualitativa del abordaje integral de la salud sexual con adolescentes en situación de marginación

Luz Verónica González Colunga[1]
Yesica Yolanda Rangel Flores[1]

1. Universidad Autónoma de San Luis Potosí, Facultad de Enfermería y Nutrición. San Luis Potosí, SLP, México.

Abstract

Objective: to evaluate the approach to sexual health based on the six transversal axes proposed by the 2020–2024 Specific Action Program on Sexual and Reproductive Health, specifically focusing on adolescents in marginalized situations. **Method:** this is a qualitative ethnographic study. Semi-structured individual interviews were conducted with 14 nursing professionals involved in adolescent sexual health, both in clinics and schools. The analysis followed the grounded theory framework proposed by Strauss and Corbin and was triangulated with observational records. **Results:** the approach to sexual health is not comprehensive, operating within a hegemonic medical model that does not consider comprehensive sexual education as a right. It gives little attention to the impact of masculinities on sexual health, perpetuates heteronormative ideologies, and fails to recognize the sexual, cultural, and physical diversity inherent in human sexuality. **Final considerations and implications for practice:** new policies need to be promoted alongside changes in health professional training programs. These changes should aim to dismantle the hegemonic medical model and develop the human and social skills needed to integrate new approaches to health.

Keywords: Adolescent Health; Health Policy; Qualitative Evaluation; Sex Education; Sexual Health.

Resumo

Objetivo: avaliar a abordagem da saúde sexual com base nos seis eixos transversais propostos pelo Programa de Ação Específica sobre Saúde Sexual e Reprodutiva 2020–2024, com foco específico em adolescentes em situação de marginalização. **Método:** este é um estudo qualitativo-etnográfico. Foram realizadas entrevistas semiestruturadas e individuais com catorze profissionais de enfermagem envolvidos em temas relacionados à saúde sexual de adolescentes, tanto em consultórios quanto em escolas. A análise seguiu a abordagem da Teoria Fundamentada de Strauss e Corbin, triangulando os dados com registros de observação. **Resultados:** a abordagem da saúde sexual não é integral, sendo estruturada dentro de um modelo médico hegemônico que não reconhece a educação sexual integral como um direito. Esse modelo pouco problematiza o impacto das masculinidades na saúde sexual, reproduz o imaginário da heteronorma e não reconhece a diversidade sexual, cultural e física presente na vivência da sexualidade humana. **Considerações finais e implicações para a prática:** é fundamental promover, juntamente com novas políticas, mudanças nos programas de formação dos profissionais de saúde. Essas mudanças devem visar à desconstrução do modelo médico hegemônico e ao desenvolvimento de habilidades humanas e sociais necessárias para incorporar abordagens emergentes na área da saúde.

Palavras-chave: Avaliação Qualitativa; Educação Sexual; Política de Saúde; Saúde do Adolescente; Saúde Sexual.

Resumen

Objetivo: Evaluar el abordaje de la salud sexual a partir de los seis ejes transversales propuestos en el Programa de Acción Específico Salud Sexual y Reproductiva 2020-2024, con un enfoque en adolescentes en situación de marginación. **Método:** Se trata de un estudio cualitativo-etnográfico. Se realizaron entrevistas semiestructuradas e individuales con 14 profesionales de enfermería involucrados en temas de salud sexual en adolescentes, tanto en consultorios como en escuelas. El análisis se llevó a cabo según la propuesta de Strauss y Corbin para la Teoría Fundamentada y se trianguló con los registros de observación. **Resultados:** El abordaje de la salud sexual se realiza de forma no integral, dentro de un modelo médico hegemónico que no reconoce la educación sexual integral como un derecho. Este enfoque problematiza poco el impacto de las masculinidades en la salud sexual, reproduce el imaginario de la heteronorma y no reconoce la diversidad sexual, cultural y física presente en la vivencia de la sexualidad humana. **Consideraciones finales e implicaciones para la práctica:** Es fundamental promover, junto con nuevas políticas, cambios en los programas de formación de profesionales de la salud. Estos cambios deben enfocarse en desaprender el modelo médico hegemónico y desarrollar habilidades humano-sociales necesarias para incorporar enfoques emergentes en salud.

Palabras clave: Adolescente; Educación Sexual; Evaluación Cualitativa; Política de Salud; Salud Sexual.

Corresponding author:
Yesica Yolanda Rangel Flores.
E-mail: yesica.rangel@uaslp.mx

Submitted on 08/30/2024.
Accepted on 12/27/2024.

DOI:https://doi.org/10.1590/2177-9465-EAN-2024-0079en

INTRODUCTION

Adolescence is the stage in which most individuals enter economic activity, embark on their professional projects, build their life plans, and begin to exercise agency in making decisions about their sexuality and reproduction. While this period is marked by growing autonomy, it also presents new self-care challenges. Among these are the beginning of romantic and sexual relationships, situations where adolescents face risks such as early and unplanned pregnancies, sexually transmitted infections (STIs), and/or experiencing dating violence.[1]

In line with the above, in Mexico, the average birth rate among mothers aged 15 to 19 between 2017 and 2021 was 35.3 per 1,000 adolescents.[2] This placed the country first in adolescent pregnancy rates among the member countries of the Organisation for Economic Co-operation and Development (OECD).[3] The latest *Encuesta de Salud y Nutrición* (Health and Nutrition Survey), conducted in 2022, reported that approximately 26% of adolescents in Mexico did not use a condom during their last sexual encounter.[4] Lastly, the most recent *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares* (National Survey on the Dynamics of Household Relationships), conducted in 2021, documented that the highest prevalence of intimate partner violence occurs among single women (53.9%) compared to married or cohabiting women (41.1%). Higher prevalence rates were also noted in psychological violence (34.9% vs. 30%), physical violence (12.4% vs. 10.1%), and sexual violence (39.1% vs. 17.9%).[5]

Within the framework of the public health challenges outlined above, the Mexican State has taken steps to promote the creation and implementation of public policies that ensure this population's comprehensive, healthy, safe development. Among the most significant are the Estrategia Nacional para la Prevención del Embarazo en Adolescentes (National Strategy for the Prevention of Adolescent Pregnancy [ENAPEA])[6] and the model of Adolescent-Friendly Services. This model operates through spaces specifically designed to provide sexual and reproductive health care for adolescents, addressing the biopsychosocial needs characteristic of this stage of life.[7] Despite these efforts, cultural resistance to recognizing the sexual and reproductive rights of this specific population persists in Mexico. This contributes to and reinforces existing health disparities, which ultimately affect not only individuals but also communities and, more broadly, the country's development.[8]

One of the strategies that has faced the greatest resistance is ensuring Comprehensive Sexual Education (CSE) for children and adolescents. This approach aims to help this population understand the sexual health practices needed to achieve genuine physical, mental, and social well-being—not merely the absence of disease, dysfunction, or discomfort.[9] To do so, Mexico has committed to developing and implementing policies that not only define what should be done regarding adolescent sexual health but also specify how it should be done. This involves moving beyond a purely biological view of sexuality and recognizing it as a socio-historical phenomenon. It requires approaches grounded in interculturality, human rights, gender perspective, youth inclusivity, and disability awareness.

In this context of growing demands, the Programa de Acción Específico Salud Sexual y Reproductiva 2020–2024 (2020–2024 Specific Action Program on Sexual and Reproductive Health) was introduced. This program includes six essential transversal axes aimed at reducing inequalities in access to healthcare, promoting the exercise of sexual and reproductive rights, and fostering social development. These six axes are: Human Rights, Gender Equality, Interculturality, Youth, Masculinities, and Population Approach.[10]

This research aims to answer the following questions: How are these six transversal axes implemented in actions targeting marginalized adolescent populations? And what are the limitations or challenges faced by nursing personnel in addressing these populations based on the proposed six axes?

The objective was to evaluate the approach to sexual health based on the six transversal axes proposed by the 2020–2024 Specific Action Program on Sexual and Reproductive Health, specifically focusing on marginalized adolescent populations.

MÉTODO

This research is part of a broader project titled "*Evaluación cualitativa del abordaje de los ejes transversales del Programa de Salud Sexual y Reproductiva 2020-2024 implementado con población adolescente en la Unidad de Cuidados Integrales e Investigación en Salud (UCIIS)*" ("Qualitative Evaluation of the Approach to the Transversal Axes of the 2020–2024 Sexual and Reproductive Health Program Implemented with Adolescent Populations at the Comprehensive Care and Health Research Unit [UCIIS]", our translation). The project was developed as a thesis to obtain a Master's degree in Public Health by the first author, registered with the Academic Committee of the Master's Program in Public Health under registration number GXII-04-2023.

This was a qualitative evaluation study with an ethnographic approach. This design allows for an understanding of the perceptions, meanings, lived experiences, and interactions of both the beneficiaries and implementers of the programs, enabling an assessment of the actual impact of health programs.[11]

The study was conducted from January 2023 to January 2024. The research setting was the Comprehensive Care and Health Research Unit of the Autonomous University of San Luis Potosí (UCIIS-UASLP), a primary care center serving marginalized adolescent populations. This center also aims to provide learning experiences for the training of professionals in this field.

The UCIIS facilities include various modules, three of which are dedicated to sexual and reproductive health for adolescents. These are the women's health module, the prenatal care module, and the school health module. These spaces provide direct care to individuals seeking services. In addition to the operation of these modules, social service students, along with students from different semesters, conduct activities at childcare centers and primary and secondary schools. They organize health fairs where one of the most frequently requested topics is sexuality.

This unit operates in collaboration with the Ministry of Health, meaning that all its actions must align with current health policies

and regulations as well as the Specific Action Programs that guide the actions of health care personnel.

The study participants included all social service interns from the UASLP Bachelor's Degree in Nursing program who were involved in work within the modules or schools with adolescent populations. Social service interns are students still enrolled at the university but who have completed all academic credits. This means they are qualified to engage professionally and responsibly with the population. However, enrollment is required for the university to provide them with opportunities to strengthen their professional competencies while fulfilling the obligation to give back to society for the opportunity to pursue higher education at a public institution.

Because of the study design, both interviews and observations were used as data collection techniques, allowing for the triangulation of discourse and practice. A semi-structured interview guide was developed, consisting of two sections. The first section collected sociodemographic and work-related information, while the second included open-ended questions designed to identify how the transversal axes were addressed (see questions in Chart 1). An observation guide was also specifically created for the study and applied to work conducted both in clinics and schools.

The interviews were conducted in private spaces within the UCIIS and lasted approximately 40 to 60 minutes each. In all cases, a single session was sufficient. The information was recorded on digital audio devices with the participants' prior authorization. Transcription was performed by using the Otanscribe software, and manual categorization was performed by following Strauss and Corbin's grounded theory framework. This process included open, axial, and selective categorization, which was then organized into the six axes previously identified as the program's guiding principles for better understanding.

The research protocol was submitted to and approved by the Human Research Ethics Committee of the Facultad de Enfermería y Nutrición at the Universidad Autónoma de San Luis Potosí, located in San Luis Potosí, Mexico. This approval ensures that ethical and legal standards were upheld throughout the study. The research methods and procedures adhered to the ethical principles of the Declaration of Helsinki, the General Health Law for Research in Mexico, and the International Ethical Guidelines for Biomedical Research Involving Human Subjects. Additionally, we confirm that no invasive procedures were conducted, classifying the study as a minimal-risk intervention.

Finally, we declare that written consent was obtained from all participants at all times. Participants were guaranteed anonymity and confidentiality regarding the information they provided. Their names, as well as any identifying characteristics, have been omitted from this article. The names of both the participants and the institution have been kept anonymous in accordance with ethical and legal standards.

Chart 1. Questions included in the semi-structured interview guide.

When a minor adolescent attends a sexual and reproductive health consultation, what criteria do you consider when providing care, and what topics do you address during the consultation? Do you approach it differently if the adolescent is female, male, or a member of the LGBTTTIQ+ community? If so, please explain the differences.
When an adolescent mother attends a consultation for guidance and/or the application of a contraceptive method, which method do you recommend and why?
When a young person comes in for a sexual and reproductive health consultation, how is the care provided from the moment they enter the facility?
When conducting outreach activities (e.g., health fairs, conferences, or workshops in schools), what criteria do you use to organize the information, and what topics do you address?
What conditions must an adolescent meet to access sexual and reproductive health care in the module?
What requirements do you establish for conducting sexual and reproductive health activities in public spaces?
If an adult refuses to leave an adolescent alone during a consultation or while receiving information, what is the appropriate course of action for nursing professionals?
How often do adolescents attend consultations with their partners for sexual and reproductive health services? How is the consultation conducted in such cases?
Are there specific strategies developed in the module for adolescent males, females, or other adolescent groups? If so, what are they?
Are there specific strategies developed in schools for adolescent males, females, or other adolescent groups? If so, what are they?
What types of topics are covered in educational talks at schools, and how are these topics selected?
What risk factors do you discuss with attendees at the module, health fairs, or conferences/workshops? Do you emphasize certain factors for females, males, the LGBTTTIQ+ community, or other specific groups? Why do you do so?

RESULTS

The participants in this research included 14 members of the nursing internship team, consisting of 10 women and 4 men. Their average age was 23 years, with a minimum age of 18 and a maximum of 27.

Analysis of narratives

The central category that emerged was "non-integral approach," as it was identified that the approach is rooted in a conservative, biologicist perspective framed within what is known as the Hegemonic Medical Model (HMM). Below, we detail the categories that contributed to the construction of this central category.

Axis 1. Human rights: rights with obstacles

Participants reported that, in the work carried out in schools, teachers still require parental or adult authorization to allow the intervention to take place:

> *Parents are notified to ask for permission if we can give these talks to their children, because it is a delicate subject in these matters.* (E2, school module intern)

This approval is always granted through a consent form directed at parents or guardians, disregarding the adolescent's own will:

> *Parents have to give the consent forms, the children who are not given a chance, we have to take them out, but that is the school's responsibility.* (E5, school module intern)

In other cases, adolescents are allowed to receive information, but the topics covered are restricted:

> *They tell us to talk to them about sexuality, but not about rights, the assistant director told us "I mean, it's fine to tell them, but also tell them not to do it here."* (E5, school module intern)

Axis 2. Masculinities: what do I say to men?

The importance of addressing masculinities is often overlooked. Indeed, it is sometimes preferred that men not engage with services, as there is uncertainty about how to fully integrate them into sexual and reproductive health actions.

> *In the form all the questions are directed to the woman, then the man is answering for her and the woman is just silent, so I prefer to take them out* (E1, prenatal care module intern)

In school-based work, there is also a lack of clarity about which topics can be explored from a masculinities perspective, while topics directed at women are increasingly prioritized:

> *A topic to be addressed with men? no, not something specific, maybe violence, you see how children are, how they sometimes hit each other and so on, with them we already incorporate menstrual health* (E4, school module intern)

Some efforts to include men were identified, such as during care provided in the prenatal module:

> *In prophylaxis for childbirth should preferably go with the couple, so that they can be supported* (E3, prenatal care module intern)

Axis 3. Gender equity: the reproduction of heteronormativity

The lack of a perspective on sexual diversity is evident, beginning with the assessment forms, which do not account for sexual orientation or gender identity:

> *As such, I don't ask it, it's not in the format and it never occurred to me to ask it.* (E1, prenatal care module intern)

> *It never occurred to me to question their sexual orientation, you assume they're heterosexual, I think because it's a prenatal module, we come to assume it.* (E3, prenatal care module intern)

The educational talks held in schools also maintain a heteronormative focus:

> *We only talk about vaginal and oral sex, we tell them that when they have oral sex it is also necessary to use a condom to avoid sexually transmitted infections, and they are shocked by this.* [sic] (E5, prenatal care module intern)

Axis 4. Interculturality: diversity within the same territory

Interculturality is not limited to its application among groups with indigenous origins. It also applies to groups that, while existing within the same temporal and geographical context, face differences (social, cultural, and political) that lead them to interpret life processes differently. This occurs when a shared geographical space includes schools with differing policies.

> *Over there, sixth-grade students are very well-informed, while those around here are much less knowledgeable about these topics. Over there, they're super engaged, but here they're more withdrawn.* (E2, school module intern)

In fact, they recognize that this should influence the type of information shared and how it is delivered, although they are unsure of how to implement this:

> *Maybe in the population around here, we first need to give them an introduction to things and explain everything*

> *very simply, and with the people who are there, we can start to address other things.* (E2, school module intern)

Axis 5. Youth: adults in charge

The adult-centered and paternalistic mindset is not limited to parents; it is also evident among teachers, who decide whether certain topics can be addressed and whether anatomical models can be used. More concerning is that nursing interns themselves adopt this stance, selecting topics and approaches based on their own (often conservative) perspectives. Their focus is almost exclusively biologicist, lacking consideration of pleasure and sexuality as a right:

> *They are taught about the importance of not having sex at an early age, they are taught about the use of contraceptive methods, but we are focusing a little more on the changes in adolescence* (E2, school module intern)

Another example of adult-centeredness involves the strategies nursing students use to "control" adolescents, relying on coercion and threats:

> *We always have the support of the teachers, they control them more, we also do things to control them, like raising our voices to make them be attentive, we tell them that if they don't keep quiet we are going to leave* (E4, school module intern)

Axis 6. Population approach: the absence of inclusion

Disability is often perceived as a disease rather than a condition:

> *For the most part they are healthy, unless as typical diseases, hypertensive or with thyroid disease, but, as well as some disability, not.* (E1, prenatal care module intern)

The UCIIS lacks accessible facilities to serve individuals with disabilities:

> *We do not have here any accommodation or anything that is suitable for a person with a disability, so we do need it, we are not up to date on these issues of pregnancies with people with disabilities.* (E3, prenatal care module intern)

There is a belief that if the necessary infrastructure and knowledge are absent, there is no obligation to serve this specific population. This view disregards inclusion as both a right for individuals and an obligation for institutions:

> *We may come across a case of a woman with a disability, but no, the infrastructure does not have the conditions to receive patients with any type of disability.* (E3, prenatal care module intern)

DISCUSSION

The central emerging category was labeled "non-integral approach." We identified that the actions carried out both within the modules and in schools do not align with the logic and dynamics deemed appropriate by academia and health policy to ensure a comprehensive approach. This type of approach has been described as one that:

> Considers biological aspects, but also emotional, relational, ethical, sociological, cultural, economic, and political factors … incorporates a gender perspective, recognizing that this is not limited to the male-female binary, as international and regional regulations also recognize the rights of LGBT+ individuals … incorporates perspectives of new masculinities with approaches that challenge and engage cisgender men as well.[12:276]

Regarding the conditions associated with this non-integral approach, we identified that the primary reason lies in the fact that the actions of healthcare personnel remain strictly framed within the HMM. This paradigm has been widely criticized for its limited relevance in addressing the health-illness-care processes, as it absolutizes biology, tends to pathologize diversity, and seeks to homogenize experiences related to these processes.[13] Similarly, other authors have highlighted that this model often fosters vertical and hierarchical relationships, which can even become violent and authoritarian, between healthcare personnel and service users.[14]

This study highlights that, although healthcare personnel are beginning to identify obstacles posed by other actors and groups that prevent them from working as dictated by health policy, they have not critically examined the need to adopt new paradigms of care that are more humane, contextualized, and politicized. This aligns with much of the existing literature in Latin America, which identifies parents,[15,16] and educational actors,[17,18] as barriers to implementing Comprehensive Sexual Education (CSE). However, there has been little critical examination of the weaknesses among healthcare personnel in addressing sexuality from a situated, politicized, and human rights-based perspective. Recent research show that nursing students and professionals in training often hold conservative preconceptions that limit the effectiveness of their involvement in sexuality-related care.[19]

In this research, we identified that among the six axes proposed by the policy for implementing adolescent sexual health care, participants are only beginning to critically address two: human rights and gender equity, and even then, in a biased manner. Regarding the first, while healthcare personnel have begun to recognize the obstacle posed by parents and educational authorities deciding on behalf of children and adolescents what information they receive, who receives it, and who does not, they do not view this as a violation of human and sexual rights. Consequently, they do not assume their professional obligation to act as defenders of these rights, which contradicts the very nature of the nursing profession. The American Nurses Association (ANA) Code of

Ethics explicitly states the professional responsibility of nurses to protect patients' rights.[20] This is particularly relevant when "it comes to sexual rights, which are often in constant tension between health care workers and officials. This creates a contested field where moral and legal perspectives clash in ongoing disputes about guaranteeing these rights" (our translation).[21]

Regarding the axis of gender equity, we identified that, although some strategies have been implemented to involve men in sexual and reproductive health topics, these efforts have focused primarily on reproductive health and are framed more as support rather than shared responsibility. This stems from the social perception of reproduction as an exclusively female function, which also sustains hegemonic male power. As a result, it is seen as somewhat aberrant for men to take responsibility in this area.[22] The lack of training for health care personnel from the perspective of masculinities creates resistance to their inclusion, perpetuating the exclusion of men. This exclusion reinforces a patriarchal and hegemonic approach, which, when it does engage with men's bodies, does so primarily through medicalization and pathologization.[23]

The remaining four axes are not perceived as issues. There is no awareness of how harmful it is to continue focusing care on practices framed within a professional imaginary that aligns with heteronormativity. Neither is there recognition of the need to critically address the fact that sexuality occurs within a diverse group of individuals—diverse not only in sexual terms but also culturally, across different life stages, and with varying conditions of physical and psychosocial health and functionality. In other words, actions are still guided by an imaginary where all sexual practices are presumed to occur between heterosexual individuals, without significant differences based on life stage, functional abilities, disabilities, or diverse perspectives.

Other studies have documented that the imaginary of heteronormativity continues to shape the actions of healthcare personnel. This represents not just a choice but, more importantly, a form of discrimination and a violation of the human rights of the LGBTQ+ community. This has two significant impacts: first, it perpetuates social stigma, and second, it generates health inequities.[24] Sexual health education and care framed within the heteronormative paradigm contribute to the reproduction of the gender binary that upholds the family structure within a patriarchal system. This system organizes relationships based on gender-related inequalities.[25]

Regarding the lack of recognition of differences in sexual experiences within diverse cultural imaginaries—shaped by globalization and characterized by internal and external migratory processes—we identified that there is an absence of transcultural and intercultural competencies. These are essential for understanding that the resources people use to exercise their sexuality are not limited to material aspects of their contexts but are also deeply rooted in symbolic elements, their worldview, and their sense of purpose in life. Sexual health must be understood as a right that exists within a specific political, historical, and economic context. Addressing this requires interventions based on differential approaches that incorporate interculturality and gender intersectionality.[26]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The objective of this study was to qualitatively evaluate the approach to sexual health based on the six transversal axes proposed by the 2020–2024 Specific Action Program on Sexual and Reproductive Health, focusing on actions targeting marginalized adolescent populations. An integral approach to sexual health is lacking, largely due to resistance to adopting a model other than the hegemonic medical one. This model persists in addressing sexuality through an absolutist biologicist lens, tending to pathologize anything outside homogeneous norms and failing to critically engage with diversity. Health policies must be accompanied by curricular changes in the training of health care workers. These changes should aim to develop human-social skills that enable effective interventions based on new approaches.

A limitation of this study is that the population studied was limited to a single health center. Therefore, the specific characteristics of this center must be carefully considered when extrapolating the findings to other contexts.

ACKNOWLEDGMENTS

We thank the nursing interns who honestly shared the challenges they face in transforming adolescent health. We also extend our gratitude to the UCIIS for welcoming us and supporting this research.

FINANCIAL SUPPORT

This study was supported by a CONAHCYT scholarship awarded to the first author.

DATA AVAILABILITY RESEARCH

Data cannot be made publicly available as it could compromise the anonymity of the participants and put their work at the Care and Research Unit at risk.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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AUTHOR'S CONTRIBUTIONS

Study design. Luz Verónica González Colunga. Yesica Yolanda Rangel Flores.

Data collection. Luz Verónica González Colunga.

Data analysis and interpretation of results. Luz Verónica González Colunga. Yesica Yolanda Rangel Flores.

Manuscript writing and critical revision. Luz Verónica González Colunga. Yesica Yolanda Rangel Flores.

Approval of the final version of article. Luz Verónica González Colunga. Yesica Yolanda Rangel Flores.

Accountability for all aspects of the content and integrity of the published article. Luz Verónica González Colunga. Yesica Yolanda Rangel Flores.

ASSOCIATED EDITOR

Sofia Sabina Lavado Huarcaya

SCIENTIFIC EDITOR

Marcelle Miranda da Silva

[a] This article derives from the thesis to obtain the degree of Master in Public Health called "Qualitative evaluation of the approach to the six cross-cutting themes of the Sexual and Reproductive Health Program 2020-2024 implemented with the adolescent population in the *Unidad de Cuidados Integrales e Investigación en Salud* (UCIIS) in the *Universidad Autónoma de San Luis Potosí*, 2024.