

“Scotomes” or “blind spots” in the medical field that limit its role in adolescent sexual and reproductive health (ASRH): ideas about how to eliminate them

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ABSTRACT

This article reviews the medical field's role in adolescent sexual and reproductive health (ASRH) from the historical perspectives of two influential medical specialties: adolescent and young adult medicine and pediatric and adolescent gynecology. The article identifies aspects that act as blind spots, limiting the medical field's capacity to respond to the challenges of ASRH. The article reviews the theoretical contributions of the critical social sciences, highlighting some of Latin America's collective health movements and feminist theories, as well as the hegemonic medical institutional discourses and practices that perpetuate health inequities in relation to patients' sexualities, subjectivities and identities. Finally, this paper presents a new concept: that of “sexual citizenship,” a useful concept that integrates these theoretical and methodological contributions into a relational analysis that includes sexualities, subjectivities and identities. The incorporation of these theoretical developments into medical training programs would generate a radical change in the role of the medical field that has been challenged by the new conceptual and ethical framework of the UN system, as confirmed at the conferences in Cairo (1994) and Beijing (1995). These conferences urged states to offer policies that guarantee sexual and reproductive rights (SRR).

KEY WORDS

Adolescent; Adolescent Medicine; Sexual and Reproductive Rights; Sexual and Reproductive Health

INTRODUCTION

Adolescent medicine (AM) and pediatric-adolescent gynecology (PAG), which focus on the problems of health in young people, originated with the configuration of the concepts of “youth” and “adolescence” in the Western societies of Europe and North America in the nineteenth century. These fields arose from the need to regulate and intervene in the behaviors and diseases present in a life stage that is considered incomplete, that of the “transition from

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childhood to adulthood,” amid a social and political debate about sexuality that remains unresolved (1,2). Since the introduction of these fields, the adolescent stage appears to be an increasing focus of medicine, especially considering the tradition of intervening in and controlling sexuality and sexual behavior, as medical knowledge has characteristically done (2,3). These two medical fields arose to help clarify, without success, the polarized debate between actors: those who defended the need to delegate the sexual education and preparation of young people to the church and those who believed that the task was the responsibility of medical institutions (1-3). Since then, adolescence has been stigmatized as a stormy stage that conflicts with and threatens the established social order (1-4).

The genesis of the medical fields involved in adolescent health was the nineteenth century explosion of boarding school programs for adolescent boys, which led to the first scientific articles on prescriptions and medical characteristics aimed at the body and behavior (1,2,5,6).

Although there are writings by physicians in this field, the American psychologist Stanley Hall is recognized as the field's pioneer (1,2,4-6). Psychology, rather than medicine, was the discipline socially responsible for intervention in adolescent health. The author's work, *Adolescence: its psychology and its relation to physiology, anthropology, sociology, sex, crime, religion and education*, published in 1904, recommended medical and psychological interventions, stating that they were the only measures that guaranteed the acquisition of functions and capabilities for an adult life worthy of the standards of the time. Hall drew an analogy between the characteristics of youth and adolescence with the Middle Ages and the Renaissance, which he called "Recapitulation Theory" (1,4,5). According to Hall, if an adolescent is to face situations that evoke courage, judgment, responsibility, commitment and respect for others, he or she must have expert guidance to treat the emotional crisis caused by passing through an avid exploration and experimentation stage (1,2,4,5). This concept grounded the emerging medical specialties (2,4-6) and the notions of adolescence and youth that were shaped in fields such as psychology and sociology

(1,3). Medical specialties differ in their evolution according to the contexts, resources and interests of the ideological, political, religious and economic societies where they arise. No society escapes the debate about sexuality, sexual and reproductive health (SRH) and sexual and reproductive rights (SRR); this debate originated and then intensified in the second half of the twentieth century, when the international conferences on Population and Development in Cairo, 1994 (7) and on Women in Beijing, 1995 (8) echoed the political gains and recognition of women's rights, feminism and youth movements and of lesbian, gay, bisexual, transgender, transsexual and intersex (LGBTTI) groups with different identities (7-9). These groups fought to change the conventional scientific theories and ideologies behind the politics of sexuality; those conventional ideas were considered moralistic and exclusionary of sexual diversity (7-9). As a result of these conferences, the United Nations offered a new ethical, political and conceptual framework to comprehensively address SRH by including SRR as a fundamental human right, inclusive of gender, ethnicity, age, religion, social class, marital status and sexual orientation (7,8). This new framework facilitated the initiation of Latin American studies focused on guiding policy decisions to reduce the problem of ASRH in this region, where there are high rates of pregnancy among adolescents (10,11). A search conducted in specialized databases and repositories of doctoral dissertations using the keywords listed in this article found more than 3,800 publications. These publications share some of the information gaps in the theoretical approach that gave rise to the two ASRH medical fields described above. In fact, this review is intended to show the information gaps that act as blind spots, limiting the medical field's vision of and action toward the complex social phenomena underlying ASRH and SRR. These blind spots can be overcome via an interdisciplinary dialogue that recognizes theoretical contributions from alternative epistemological positions in the social sciences, health sciences, the Latin American collective health movement and feminist theories. It is the author's desire to contribute to the adaptation and transformation of approaches and discursive practices reproduced in the medical education process.

Adolescent Medicine (AM)

The first scientific article to summarize the needs and specific medical problems of the adolescents visiting the clinic at Stanford University was published in 1918 (12). This paper established the principles governing the care of adolescents. However, it took almost 40 years from the paper's call for the development of a specific AM field before the first adolescent unit opened. This unit, located at the Boston Children's Hospital, innovated with a model of care that put adolescents' interests and rights ahead of those of their parents. This measure ensured that adolescents could hold confidential interviews with their physicians without the presence of other adults who might constrain their right to discuss and make independent decisions about their mental health and sexuality (13). At the same time, laws were enacted in the majority of states in North America to grant adolescents, under the principle of emancipation, access to services and treatments that included ASRH hospitalization and treatment and mental health services, including access to contraception and abortion (14). This model of care became the prototype for services in a large number of children's hospitals in the United States and Canada (5,13-15).

The AM specialty developed over three stages. The first stage was the creation of a school health field to meet the needs of the male students at secondary boarding schools and higher education institutions. The school health field was established in 1884 with the Medical Officers Schools Association (4,5). The second stage was characterized by the consolidation of professionals and academics specializing in the field through the deployment of public and private hospital units, the development of a training program at Boston Hospital in 1941, the creation of the new AM specialty by the American Academy of Pediatrics (AAP) and lastly, in the late 1960s, the creation of the Society for Adolescent Medicine (SAM). The creation of the SAM led the World Health Organization (WHO) to adopt scientific knowledge derived from the American experience, which was subsequently replicated in member countries in the late 1980s (5). The third stage formalized specialization programs in the medical disciplines of pediatrics, family medicine

and internal medicine in the late 1980s and early 1990s (4,5). Within this development, several events are worth highlighting:

1. The Guidelines for Adolescent Preventive Services (GAPS) were published, prescribing the conditions, characteristics, types of services and health issues that those working in this field of medicine should follow (14).

2. The first certification exams in this specialty in the United States were in 1994, and the following year saw the accreditation of 39 training programs in the United States and Canada (5). Several Latin American countries offer training modules in AM, but these are not consolidated within formal programs in medical schools (5); in contrast, AM is institutionally based and well-developed in the United States, Canada and Europe. One explanation for this difference in the development of this specialty in Latin America is that structural changes introduced by health and education reforms in this region coincided with the development of the specialty in North America.

3. Research leading to new knowledge in ASRH is fully justified by the discrepancy between the sexuality and youth policies that emerged the 1990s in the Americas in conjunction with the states' agreements to comply with the mandates of the Cairo and Beijing conferences (7,8), the poorly developed academic programs in the AM and PAG fields and the emergence of new contexts arising from health and education system reforms in the same decade. The author's experience during her AM training at George Washington University (GWU) in the Adolescent Unit at Children's National Medical Center between 1992 and 1995 confirms adolescents' reliance on technical and scientific advances that these specialties have achieved for improved health, including morbidity and mortality (14,15).

The Pediatric and Adolescent Gynecology (PAG) Specialty

The emergence of pediatric and adolescent gynecology (PAG) as a specialty followed a different path from AM (6). As noted by Barbosa, R. Peter, a Czechoslovakian gynecologist and obstetrician, led the first pediatric gynecology service (in 1940) and the first medical training program (in 1953)

(6); although books were published in the United States, Britain and France during that decade, John Fuman was the pioneer, writing the first treatise on medical training in and the practice of pediatric and adolescent gynecology in the late 1960s in the United States (6). Around the same time, in the same country, Althec and Capraro led specialized courses (6). In contrast to what happened in AM, PAG benefited from the International Federation of Pediatric-Adolescent Gynecology (FIPAG), which was created in Switzerland in 1971. FIPAG confederates, regulates and certifies professional practitioners in the field of PAG. In Latin America and the Caribbean in 1993, the Latin American Association of Obstetricians and Gynecologists, Child and Youth (ALOGIA), a chapter of the FIPAG, was established. This partnership provided management support to the pharmaceutical industry and governmental and non-governmental organizations and facilitated technological research, in sharp contrast with the poor development of the field in academia. While five universities offer the specialty in North America and are certified by the Federation, only six universities (in the Czech Republic, Hungary, Venezuela, Chile and the Philippines) hold proper FIPAG accreditation (6).

The Blind Spots in the Medical Field of Adolescent Sexual and Reproductive Health

The consolidation of biomedical, hygienic and preventive approaches in health is consistent with the development history of these two medical specialties. Thus, the first texts present sexual behaviors and practices that were considered “normal” and worth encouraging, rather than “aberrant” practices such as masturbation, oral sex and homosexuality, which the era’s moral canons and understanding of sexual deviances dictated should be banned in boys’ schools (2,4). Later, in 1909, the first description of the stages of breast development in adolescents was published, while no scientific advances beyond those indicated above were made regarding the school-aged health of adolescent males (5,6). From the 1930s through the 1970s, a period marked by the further consolidation of power of the elite medical institution in the United States (16), Dorfman, Greulich and colleagues outlined the hormonal functioning of puberty, thereby establishing a clinical and classification measurement

system to evaluate the sexual maturation process of males and females, differentiated by biological sex (17,18). This system ordered sexual characteristics based on the degree of gonadal development to meet reproductive functions. Tanner and Marshall perfected the system in 1971; today, it forms the substantive theoretical core of the medical field of adolescent sexuality (19-23). The system was an important theoretical contribution; however, it was insufficient because it did not include other aspects of adolescent sexuality that are not related to anatomy and reproductive function.

Specialized reference books describe in detail the standard growth and performance patterns and “normal” sexual behavior of women and men who pass through pubescence and adolescence (14,18 -23). This manner of interpreting ASRH leads to medical action that is limited to signs, symptoms, drug therapies and practices for hygiene and curing and preventing disease and deviances without paying sufficient attention to other equally determinant human and social dimensions of ASRH (14,19 - 23). However, some chapters in these books reflect the ideological struggles regarding the sexuality debate that gave rise to the two fields and that continues to this day, contrasting the functionalist, hygienist and preventive approaches with the traditionalist and moralist approaches (14,19 - 23). In some books, references to secular, liberal and humanist approaches appear; these references recognize that ASRH encompasses diverse sexualities and identities. Furthermore, these books discuss access to technologically improved contraceptive methods and abortion during pubescence and adolescence in cases of unwanted pregnancy (14, 22,23). It is likely that these latter discussions and references are the result of the call for improved ASRH by youth movements, women, feminists, ethnic groups and the LGBTTI population, all of whom acquired prominence in the global political arena after the second half of the twentieth century (3,9). This effort, as reiterated in this review, paid off with the redefinition of ASRH and the inclusion of SRR in human rights at the international conferences in Cairo and Beijing, and it fully supports these new approaches as they align more closely with democratic principles (3,7-9).

In light of this new framework and with the intention of helping governments meet the obligations established in Cairo and Beijing, epidemiological studies to diagnose ASRH's problems with supporting the formulation of policies has intensified, but the epistemological stance that guided traditional medical action has remained unchanged (10,11,14,15).

Undoubtedly, scientific advances from such epidemiological studies allow the standardization of a monitoring system for comparing studies from different contexts, reinforcing the practice of establishing the patterns, rate trends, and behaviors that reflect the risks and the occurrence rate of ASRH issues; determining the diagnostic values to these patterns, trends and behaviors; and using them to understand the magnitude, probability of occurrence and some of the causes of ASRH issues (10,11,14,15,19-23). All of these studies report an inverse relationship between indicators, for example, the rate of teenage pregnancy and adolescents' access to material and social resources in their environment. Some studies corroborate the resistance of health sector staff in Latin America to discuss issues with adolescents without taboos, moralism and prejudices (10, 11,14), while another study shows that when professionals shed such barriers, teenage pregnancy is reduced (15). The lack of positive actions on the part of states to reverse this tendency supports social and political movements' allegations about the need for research ranging from epistemologies and theories that explain inequalities and differences by gender, to subjectivities, norms, cultures, politics and health inequities that have been analyzed from the perspective of different disciplines, such as public health, social medicine and gender theories.

With this outlook, the medical field's historical "blind spots" that limit its response to ASRH needs gain importance when explaining the various causes of failures to prevent health problems in adolescents and young adults.

The historical-hermeneutic and critical social epistemological trends (24,25) offer opportunities to address these blind spots and achieve greater understanding of adolescent health problems and their solutions. Such an understanding would help overcome discriminatory and unfair practices where sexist and false moralist ideologies predominate.

The Contributions of Social Science Historical-Hermeneutic and Social-Critical Theoretical Trends in Health to Overcoming the Blind Spots in ASRH

Health care models imposed by market rules (26-30) do not correspond to the principles and mission of medicine, and such models prevent the advancement of ASRH goals. There is debate about the theoretical and political implications of this discordance. On one hand, since the 1970s, the social medicine and public health movement in Latin America has spoken of a "model of social determination" (26) that involves subjecting the field of health in "peripheral" countries to the economic and political interests of "powerful" or "Northern" countries, thereby establishing discursive practices and social institutions that reproduce structural inequities and seriously impair the health rights and status of the less-powerful countries' populations (26-28). Moreover, in 2007, the WHO established the Commission on Social Determinants of Health (SDH). These determinants were defined as "circumstances in which people are born, grow, live, work and age," and they include access to "health systems" to facilitate the necessary power to control, mitigate and combat diseases and risks that impair one's ability to enjoy life (29,30). In essence, these are "the set of economic, social, regulatory forces and policies" that affect individual, daily, institutional and structural environments; on a personal level, these circumstances define individuals' everyday "lifestyles" and are materialized as various "ways of living" (26) or "collective life styles" (29,30). The results of the determinants in medicine and ASRH are a blind spot that limits practitioners to make recommendations that are powerless to change unhealthy life styles, without taking into account that such determinants are the product of the opportunities that define the social environment in which the daily lives of adolescents occur (26-28). The substantive difference of the "model of social determination" proposed by scholars in the collective health movement and the WHO's SDH focus is the emphasis that this model places on the economic and political power of the world powers represented in the structural reforms taking place in Latin America (26-28). Both perspectives mention the categorical role of "health inequities" (HI) in the

analysis of social determination because HIs reveal the avoidable differences that result from unfair or inequitable state action toward excluded population sectors to overcome access barriers to the material conditions for the promotion of health—barriers that policies should aim to eliminate (26-30). In the case of ASRH and SRR, these theoretical approaches regarding limitations on ways of life reveal inequities in access to technical and technological resources, health services and the recognition of rights (3, 9,1, 32). Changes in approaches to ASRH policies that seek to prevent teen pregnancy show the advantage of their reach with the mainstreaming of the SDH and HI. While the AAP uses terms such as “premature pregnancy,” “early pregnancy,” “school pregnancy” or “adolescent pregnancy” based on the focus of rational and individual logic to explain its occurrence as a result of poor decisions made due to physical, cognitive, emotional and social immaturity typical in this stage of human development, the AM calls it “social breakdown syndrome,” the “gateway to poverty” or the “poverty trap” to intervene in the consequences of the event in the futures of those who suffer it (33-35). In contrast, the incorporation of the focus on social determination and the analytical category of HI indicates the “failure of the rule of law” and shows the impact on access to social services and effective prevention considering both unsatisfied and satisfied basic needs (31).

A second contribution that is useful in expanding the analysis of ASRH’s determinants is the effect that the type of historical medical institution has: i.e., the institution is largely developed to meet the political and economic interests of the dominant elites and has little to do with medical duties and patients’ rights (36-40). Since the 1980s, studies of the medical institution’s historical approaches have proliferated, revealing effects on professional practices that tend to underestimate patients’ knowledge and interests and reproducing over time the same practices of socially excluding and violating the rights of some social groups classified as “erratic” based on their lives and sexualities (36-39). Without distinguishing theoretical and methodological frameworks, several studies highlight the determinant power of medical knowledge in the persistence of moralist and arbitrary approaches and in the broad deployment

of weak professional discourse and weak practice of the open and objective communication required for patients (36, 38,39). In short, the medical institution in North America and Europe, built in the 18th and 19th centuries, conquered elite positions in modern states because it could strategically combine the subculture and the exclusive technical language of the field with the power of clinical practice to dictate the acceptable (normal) and unacceptable (abnormal and aberrant) characteristics and behaviors of a society (37,38). In Latin America in 1990, the anthropologist Eduardo Menéndez proposed a framework for analyzing the medical institution as a determinant of health inequity in the population using a model called the hegemonic medical model (HMM) (40). This model explains the replication process of “colonization” during the 18th and 19th centuries in Latin American medicine. In Latin America, the medical field was the recipient of the expansion of medical institutions from northern countries, which was characterized by the exclusion of the cultural, social and political heritages of colonized peoples and the legitimization of the state’s acceptance of knowledge under the Eurocentric criteria of “scientificity” (accepted technical language. All of these factors succeeded in deepening the gaps in social inequality during the colonial era (40). Thus, social research into the fields of gynecology and obstetrics and family and general medicine under SRH in Mexico used this model and found that the strategy of “medicalization” is consistently used by medical personnel to control birth rates for demographic purposes, thereby creating a barrier to women’s access to scientific information and technological advances that would allow them to live their sexual lives comfortably, independently and without connection to reproductive functions, all of which are currently considered fundamental rights (41,42). In the same line of analysis criticizing the medical institution, the Mexican physician and sociologist Edgar Jarillo emphasizes the negative impact of the prevailing economic and political interests in the current Mexican context; Jarillo states that the logic, ethics and pedagogical devices that operate in medical training in Mexico negatively impact the quality of such training (43). He warns that medical disciplines have been affected by a blind spot that must be reduced through curricular changes that aim to provide services that are consistent with

the needs and demands of youth today, especially by providing friendly and respectful treatment to teens who embody the abandonment of the state and therefore intensely suffer from the issue of SRH.

The current approach in Latin America contrasts with communications and research from the perspective of AM and PAG in the United States and Canada, countries that have noted a decline in teen pregnancy rates as a result of access to specialized medical care (14,19-23,33-35).

Undoubtedly, the medical field should play a central role in formulating policies to promote ASRH and SRR, taking into account the influence of health and education reforms and the impact that neoliberal policies have on the lives of young Latin Americans, as reported in Mexico (44).

Contributions of Feminist Theory to Overcoming the Medical Field's "Blind Spots" in ASRH

The starting point of all feminist theories is the need to reveal the historical subordination of women and their exclusion from the processes of shaping societies and modern states, even in the sciences (45). Feminist theory also advances alternative interpretations that differ from those of conventional science and the debate on sexuality, gender, power, politics and health. These different interpretations relate to the separation of the biological condition (sex) from the social development that accompanies it (gender) and are accentuated by questions that arise from new feminist insights offered by women and by academic groups of people with sexual orientations and identities, social classes, cultures and ethnic groups other than those of the Anglo-Saxon and European upper-class women who originated egalitarian feminism in the early twentieth century (45).

The essay "Gender, a useful category for historical analysis," written in 1986 by Joan Scott, emphasized the need to test the concept of "gender" not as a single dependent variable, but as *the main category* of analysis. This essay enabled important developments in the field of feminist theories, particularly those focused on clarifying non-biological determinants of health and sexuality (46). This change led to the use of gender to define of conceptual frameworks,

methodological approaches and research questions by crossing its links with subjective identities, social structures, normative precepts and symbolic systems, to understand its translation into hierarchies of legitimizing power by traditional scientific and medical discourse that naturalizes inequalities and the historical subordination of women and other social groups who now claim their forgotten place in history (45,46). In this sense, the medical field should take into account the impact of gender on traditional health indicators and the perception and pursuit of the welfare of women, men and individuals with different identities. This impact should be viewed according to the frameworks of masculinity and femininity imposed by the social world from a constructivist and relational interdisciplinary perspective that has often been displaced by the positivist and functionalist approaches prevalent in the medical discipline since its origin (47,48).

From this change in the focus of gender research in health, evidence of increased exposure to health risks has been constructed by people who faithfully follow the "generic social norms" as a result of the role of gender in violence and in the lack of self-awareness and practices of self-care; on the contrary, this is the substantial improvement in health indicators among the disobedient critics of those cultural mandates who choose new lifestyles with greater conscience and self-awareness (49,50). In America, the anthropologist Courtenay analyzed the impact of gender on youth violence and adolescent male health, defending the idea of promoting awareness and critical skills in these individuals so that they can shed the regime that subjects them to these risks (48). In Mexico, research by the sociologist Stern, on gender, ASRH and SDH offer theoretical and methodological elements to the policy and health field for solving this problem with greater effectiveness (50,51). In Colombia, anthropological studies have helped to clarify the relationship of gender, race and class with expressions of sexuality and citizenship in young people, which could expand the perspectives of the medical field to ASRH (52,53). In all these examples there is recognition of the prevalence of gender in shaping social and political institutions that impose hegemony regarding identities, lifestyles, sexual behaviors and medical services that negatively impact health.

The significant struggle of feminism and the LGBTTI movement transformed theoretical, political and cultural foundations in the domain of SRR and introduced the novel concept of “sexual citizenship” (SC), which includes contributions of these new approaches to the analysis of policies and problems of ASRH (45, 54-56). Although the concept SC is under construction, the proposed definition put forward by Mexican authors with extensive research experience in these domains could become a useful framework for analyzing aspects of ASRH and SRR which have been outside the focus of medicine (54). According to the authors, SC is the “set of cultural, symbolic and economic practices, rights and duties (civil, political and social) that secure the belonging of people to a political body” that values the collective search for “opportunities to exercise SRR” and enables the construction of a citizenry that holds the actual idea of democracy in everyday life as it allows everyone to “live and act on their diverse sexual desires and pleasures” (54). This definition brings other theoretical contributions of feminist theories: 1) the need to recognize that there is a “sexual diversity” to counteract the social devices influencing the control of the sexual, subjective, individual and political body and which attempts to homogenize heterosexuality as the only acceptable standard (55,56), and 2) the redefinition of sexuality as a complex social product encompassing the erotic-loving human dimension that transcends the medical approach, which reduces this dimension to indicators, signs, behaviors and biology set by biological characteristics aimed at reproductive function (55). Therefore, the analysis of SC and of sexuality requires consideration of three conceptual overlapping axes, varying throughout the life of each individual, and which do not represent a disease: 1) sexual orientation as an expression of erotic affection for an object of love; 2) sexual identity indicative of assumed sexual definition; and 3) sexual expression as the result of adopted preferences, behaviors and sexual practices (55). This consideration involves recognizing that the process of building sexual identity may exclude individuals from the possibility of constructing identities that are socially acceptable, while preventing them from living a sexual life founded on the right to pleasure and desire, as an essential condition to consolidate

the desired culture that recognizes and respects sexual diversity (56).

Dialogue between medical and social science professionals about these approaches promises greater understanding of the complex issues intertwined with sexualities, subjectivities and identities in ASRH, and such understanding could free the field from its historical blind spots.

CONCLUSIONS

The diversity and complexity of the ASRH-determining issues this article raises demonstrate that the medical institution historically charged with the mission to promote such issues is inadequate. This inadequacy results from the blind spots that the medical field has acquired during its evolution. These blind spots limit the field’s analysis, understanding and action because the field’s original approaches assume an epistemological and ethical stance that assigns great significance to the logic and rationale of adolescence as a distinct stage marked by erratic and risky sexual behavior caused by the immaturity of characteristic biological, cognitive, psychological and social functioning. This viewpoint coincides with the role of other social and political components that influence ASRH.

However, there are studies that show that adolescents benefit from access to medical specialists in PAG and AM in North American and European countries, where these two medical fields developed. These benefits are reflected in low rates of unwanted pregnancies and other ASRH morbidity factors. In these fields, traditional medical practices have changed to improve their ability to address these issues with adolescents. However, advances in these specialties have not been sufficiently consolidated within the policies and institutions that train health professionals in Latin America, despite the noticeable rise of morbidity and unplanned or unwanted pregnancies among adolescents.

An interdisciplinary dialogue that enriches the medical education process with developments in these two fields, AM and PAG, and other theoretical contributions drawn from critical-social epistemological trends in health and feminism, can help to overcome these blind spots in the medical field. The new conceptual and

methodological tools that provide these contributions would eliminate the blind spots, with a view toward promoting a new “sexual citizenship” that promises to eventually generate political awareness and lifestyles capable of promoting pleasurable sexuality free of the problems with ASRH that threaten the lives and rights of adolescents. Additionally, these new approaches would effectively construct the new ethical, political and theoretical framework that was agreed upon at the world conferences of Cairo and Beijing. Ultimately, sexuality is a political issue that transcends rational logic and organ function at the individual level.

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