Sexuality Research & Social Policy
Journal of NSRC http://nsrc.sfsu.edu

Expanding the Flexibility of Normative Patterns In Youth Sexuality and Prevention Programs

Vera Paiva, José Ricardo Ayres, and Ivan França Jr.

Abstract: This article reviews normative ways of presenting sexual health in intervention programs for the sex education and health care of young people in Latin America. These programs usually consider adolescence and youth as naturalizing categories and can be described as strongly preventionist. Based on our activities in Brazil, ongoing research and training of health professionals and activists, and inspiration from recent debates about youth sexuality and reproductive health in Latin America, we present and analyze face to face scenes from the field. Co-constructions of sexual citizenship and sexual subjects arise from local meanings and agendas that need to be shared and negotiated. We conclude: that sexual health and adolescence should be strongly contextualized categories; that adolescent identities should be understood as "ipse identities" (Ricoeur, 1991), or as reflexive identities constructed continuously in relationship with otherness; and that there is a promising relationship between sexuality and human rights.

Key words: youth; adolescence; sex education; sexual health; identity; human rights

It is striking to observe the diversity of proposals for sex education and the sexual health promotion for young people, as well as the growing number of systematically evaluated models for such programs available in the international health literature, especially from 1997 onwards.[1] As pointed out by Dowsett and Aggleton (1999), the novelty of the research from the previous decade in this area has now led to the publication of a steadily growing number of studies that focus on the sexual cultures and social contexts in which different types of sexual conduct occur. There is an increasing diversity of target populations for projects and research, and a growing recognition that programs regarding young people's sexuality must understand and consider their singularities. In this expanding literature, studies of school-based initiatives remain important, but the number of reports about other forms of community-based intervention have grown even more rapidly. These interventions occur in a range of different ethnic and religious groups, within various identity groups, in organizations in poorer neighborhoods, and in street situations frequented by homeless youth and young sex workers.

Only a small part of the current international academic literature describes activities in developing countries, and most of these result from collaborations with North American or European researchers and bear the imprint of their models. Latin American research on sexuality in youth emerged first in the fields of demography and epidemiology, and has been encouraged since the 1980s within the clinical and reproductive health fields, the feminism and

1 *This is visible when searching PsycINFO, using the keywords: "young or youth or adolescent" AND "sexual health or sexuality or sexual behavior or sex education" AND "intervention or education or prevention."*

Correspondence concerning this article should be addressed to Vera Paiva, Social Psychology Department, Institute of Psychology, University of São Paulo, Av. Prof. Mello Moraes, 1721, São Paulo, SP, Brazil., 05508-030. E-mail: veroca@usp.br; José Ricardo Ayres, Preventive Medicine Department, Medical School, University of São Paulo. E-mail:jrcayres@usp.br; Ivan França Jr., Maternal and Child Health Department, Faculty of Public Health, University of São Paulo. E-mail: ifjunior@usp.br

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

reproductive rights movements, and the movement to confront the HIV/AIDS epidemic (Oliveira, 1999; Pimenta, Rios, Brito, Terto, & Parker, 2000). The trend toward expanding the fields of intervention and research is also visible in the Latin American literature, which has sought to confirm the argument put forth by regional social medicine that points to the influence of social inequality as a central category when analyzing and dealing with the different types of risks to the sexual health of young people (Hoyos & Sierra, 2001; Pimenta et al., 2000; Stern & Medina, 1999; Waitzkin, Iriart, Estrada, & Lamadrid, 2001; Weller, 1999).

Our aim in this essay is to reflect upon the "face to face interventions," encounters that occur on a daily basis on the frontlines of sexual health care and sexuality education for young people. It is a difficult task, as there are few examples of objectives-based and theory-driven modes for evaluation of research outcomes that would enable one to think about how change and prevention are brought about or to analyze and explain the results one has obtained. Regardless of the evaluation approach, it is rare to come across a detailed written description of what in fact happens in each program and project, beyond the outlines set out at the beginning of each intervention, or a generic analysis of results, with statistical significance sometimes being the most important concern.

In the existing database for health care in Latin America, LILACS[2], the majority of available publications indexed on the themes of youth sexual health and sex education consists of proceedings of meetings and thematic conferences, or of program guidelines and booklets from official documents of governmental and non-governmental organizations (NGOs), from international organizations such as the Pan-American Health Organization or from international foundations engaged in social development. Other significant materials consist of articles in academic journals that largely present social and epidemiological investigations or doctrinal arguments. Descriptive qualitative research as well as epidemiological studies of knowledge, practices, and beliefs in several countries (for example, studies of prevalence of knowledge, attitudes, and sexual practices and their associated factors) have mapped the ages at which sexual life begins, demonstrated the prevalence of condom and contraceptive use, and described sexual meanings, beliefs, trajectories, and scripts for various groups of youth (Caceres, 1998; Calero & Santana, 2001; Chiavarro, Flacké, & Dellepiane, 2001; Eggleston, Jackson, Rountree, & Pan, 2000; Hoyos & Sierra, 2001; Monteiro, 2002; MS/CEBRAP, 2000; Oliveira, 1999; Paiva, 2000; Péres, Quintana, Hidalgo, & Dourojeanni, 2003; Pimenta et al., 2000; Pinho et al., 2003). This kind of research–which would have been almost impossible to conduct among young people two decades ago–has clearly shown that early sexual activity is a reality among young people, that it is quite prevalent in most social groups well before the age of adulthood or marriage, and that the manner in which sexual initiation and conduct occur is still relatively uninformed and unprotected (Eggleston, Jackson, Rountree, & Pan, 2000; Millán, Valenzuela, & Vargas, 1995; Padilla de Gil, 2000; Paiva, Venturi, França, & Lopes, 2003; Stern & Medina, 1999; Weller, 1999).

Our reflections on this subject are based on our activities in Brazil, including conducting research and ongoing training initiatives for health professionals and activists over the past decade (Paiva, Ayres, Buchalla, & Hearst, 2002); learning from regional conference reports, such as those from the Regional STD/AIDS Conferences and Sexuality and Reproductive Health Meetings;[3] participating in such conferences; and communicating with colleagues in other Latin

[2] *LILACS is a Latin American and Caribbean Data Base System for Health Sciences (www.bireme.br), which includes peer-reviewed journals, books and chapters, congress annals, techno-scientific reports, theses, and national databases from Latin American Countries. To review it, we used the keywords "young, youth, or adolescent" AND "sexual sex education" AND "intervention or education or prevention" AND "1986-2002."*

[3] *For example, "Foro en HIV/ SIDA / ITS en America Latina y el Caribe"[Latin American and Caribbean Forum for STD/HIV/AIDS] in 2000 and 2003, "Congresso Brasileiro de Prevenção em DST e AIDS [Brazilian Congress for STD and AIDS prevention] in 2000 and 2001)", EDUCAIDS [Aids and education conference], yearly from 1999 to 2003, "Sexualidade e política no movimento social de luta à AIDS latino-americana [Sexuality and politics against AIDS] in 2001, to name some regional conferences.*

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

American countries and networks.[4] For some of our ideas we are indebted to initiatives published by ABIA (Brazilian Interdisciplinary AIDS Association) (Pimenta et al., 2000) and by the Consórcio Latino Americano de Programas em Saúde Reprodutiva e Sexualidade (Latin American Consortium for Reproductive Health and Sexuality) (Oliveira, 1999).

Sexual Health and Unique Contexts: Considering the Concept

Most professionals in Brazil working in programs that address the sexuality of young people, as well as in other Latin American countries such as Peru, Mexico, Chile, and Argentina, are not able to benefit from access to the findings of relevant studies or to the ongoing theoretical debate in the field. Also, such professionals rarely are able to evaluate their programs or have the opportunity to discuss their experiences in settings that permit consultation and critical examination of their efforts. Generally these professionals serve as underpaid agents for delivering health care and for the socialization of young people into sexual health, and often serve as activists as well on behalf of their own beliefs and values, whether conservative or tolerant. Although they attain authority because of their professional training and technical and scientific knowledge, they almost always rely on their own personal notions and experiences to promote healthier living and healthier sexuality among young people. Some, as a result of their professional and graduate training, have access to and therefore import techniques and approaches that are generally inspired by rational decision-making and social-cognitive models, which primarily promote the implementation of rapid intervention initiatives. This is often true as well among those professionals based at internationally funded NGOs that work with particular minority groups and disenfranchised communities.

Definitions of what constitutes sexual health vary, and a great deal of silence still prevails at many prevention and care sites—a silence that is shared by both participants and service providers—over what is actually considered "healthy" or indicative of "sexual health." The term sexual health has circulated in the health field and in the women's movement since the early 1970s, and was subsequently used in sexual rights initiatives and right-to-health movements within broader democratization processes in Latin America. One landmark in the spread of this concept was a February 1974 World Health Organization (WHO) meeting, where twenty-three experts in the field, primarily European and North American physicians and including one university researcher from Colombia, met to evaluate experiences in sexuality-related health care and teaching (WHO, 1975). These experts developed an agenda for sexual health-related training and care, referencing the sexology dominant in the field of sexuality at that time. The text of their report declares that there is an important relationship between sexual health and the rights to information and to pleasure. This relationship was described as: "the integration of the somatic, emotional, intellectual and social elements of the sexual being, by means that are positively enriching and potentiate personality, communication and love" (WHO, 1975, p. 6).

In introducing the term sexual health, the document suggests a semantic equivalence with "sexuality," and alternates use of the terms sexuality and sexual health. Although admitting that both the right to pleasure and sexual norms should be understood and respected in relation to local standards and values, the authors avoided talking about youth sexualities or homoerotic preferences. This document came to be a reference for a varied set of social stakeholders: physicians (including psychiatrists, sex therapists, gynecologists, obstetricians, and other specialists), psychologists, and activists in the social movements who agreed with the need for a positive view of health and sexuality. Since then, the idea of sexual health has continued nearly intact, although international and local networks of professionals in the field have attributed different meanings to the notions of "integration," "positively enriching," and other concepts associated with it.

Before AIDS, training for careers associated with the institutionalized task of dealing with young people's sexuality, such as those in education, health care, and religion, was limited primarily to instruction about the anatomy and physiology of the reproductive system

4 *See acknowledgments.*

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

and about the description and clarification of a prescribed moral code for sexual behavior. More recently, these professionals have benefited as well from free and accessible literature and workshops about such topics as sexually transmitted infections (STIs), AIDS, pregnancy, and contraception. This literature is usually provided by international agencies, foundations, and organizations that promote collective health, education, and development policies, which strongly encourage rational choice or social-cognitive models, rather than other approaches developed by groups that might promote guidelines based on local standards and needs (Paiva et al., 2002).

For example, the socio-cultural factors leading to increased vulnerability to HIV infection are almost invisible in such educational materials, which continue to be focused almost exclusively on biomedical information about transmission of STIs, reproduction, condoms, and contraception. Data presented in the research literature about the importance of the contexts that affect young people's social vulnerability to HIV infection and AIDS, including poverty and structural violence, gender norms, and unequal access to health care, are rarely included in the information presented to young people or to the adults responsible for them during interactive programs. Such data are used to justify target populations, to create programs and approaches that speak in terms of "empowerment" or "awareness building" ("conscientization"), and to provide suggestions for projects to strengthen communities. But in most settings where services are delivered these factors are assumed and simply built into pre-defined techniques for rapid intervention focusing on changing individual knowledge, attitudes, behaviors, or training individual skills.

Training young multipliers, or parents, teachers, and doctors, as sexual educators within psycho-social emancipation frameworks aiming for vulnerability reduction has not been an easy task (Ayres, Freitas, dos Santos, Saletti-Filho, & França, 2003; Paiva, 2000a, 2003). Community projects, using empowerment or awareness building approaches, may be executed as yet another effort to shape young people's behaviors and culture. Paul Farmer (2003), reflecting on the invisibility of structural violence in health programs, offers an emblematic example of the many similar scenes we have observed in our work:

> [The class]...was being held in a parish school at the end of a muddy road that led up one of the small mountains looming over Huehuetenango.... The pupils were natives, the instructors two young women from the capital city. The instructors were slender and wore jeans; they looked a lot like those of us who'd come from Boston...More specifically, the women from Guatemala City were conducting a "gender sensitive workshop." They had asked each of those present—about twenty locals, mostly young women, although Julia's father was there too—to draw a scene from childhood. The adult pupils sat crammed into children's desks, supplied with crayons.... The theme of the questions was gender relations.
>
> It was difficult to know how all this was being received—the participants were impassive and spoke only when the women from Guatemala City addressed them. Some, it was clear, did not speak Spanish well; at least one young woman needed a translator. Furthermore, the prominence of dramatic biographical events—deaths, most notably, but also violence that had little to do with gender relations within the indigenous communities—kept pushing the discussion off the course charted by the facilitators. One young woman explained that the death of her mother in childbirth meant that at the age of ten she had by necessity assumed a great deal of responsibility for the care of her younger siblings.
>
> Facilitator (expectantly): "So your father treated you differently because you were a girl?"
>
> Respondent (matter-of-factly): "No, not really. He loved us all the same."
>
> A stilted silence followed.... It was not the silence that rankled. It seemed to us that the exercise was demeaning—the participants, having survived genocide and displacement, were now being treated as children. They were being asked to respond to an agenda imported from capital cities, from do-gooder organizations like ours, from US universities with the right answers to their every question. No harm done, perhaps, and the topic

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

> was important—but how helpful was this exercise, with its aim of changing the mentality of the locals, who were, after all, the victims of previous decades of violence? (pp. 3-4)

Farmer's example is extreme, but portrays a powerful scene in order to illustrate different languages and priorities that are encountered in face to face situations. Scenes like this one may happen in sexuality education programs in which NGOs are pressured by funding agencies to secure long-term sustainability for local and community-based initiatives. Among other things, the ideas of empowerment and awareness can be reduced to issues of individual self-esteem, effort, and resolve. For example, students may be encouraged to: "Be egalitarian!" "Be an empowered girl!" "Communicate with your partner!" Empowerment has thereby been translated into something that occurs in the restricted realm of individual subjectivity rather than as something that is created in relation to solidarity, collective construction, and social rights.

As we have pointed out previously (Paiva, 2003), rapid intervention models often reduce participants to consumers of pre-established mentalities, values, attitudes, and behaviors and even of a pre-defined consciousness, especially when working with disenfranchised people like many Latin Americans. Those models may or may not be presented using culturally sensitive language, but they will not make sense to people if, when they leave workshops or care settings, real life presents different structural obstacles that are hard to confront and have had no space or voice within such rapid intervention models. In contrast, long term interventions can help individuals to develop more complex and specific responses to personal and collective difficulties when acting sexually, to make informed choices about sexual behaviors, and to consider processes and emotions as they occur in the real world.

Intervention scenes similar to that described by Farmer have been seen in public health care settings where boys feel uncomfortable because they perceive clinics or hospitals as "female places" (Barker, 2002; Lyra, 1998) and where health educators (who may also look like Boston citizens) may require contextually impossible adherence to safer sex guidelines, for example, when young people do not have access to contraceptives or condoms, or feel they have other risk priorities to negotiate in their lives (Paiva, 2000a; Peres, da Silveira, Paiva, Hudes, & Hearst, 2002). The following vignette presents a doctor in such a setting who simply asks a young woman to adhere to his own values:

> Some young…students involved in a project tested out available services in reproductive health, and in sexually transmitted infection and AIDS prevention and treatment…. One 20 year-old girl had reached an excellent level of communication with her mother concerning sex and contraception as a result of this program. The mother and daughter talked and decided that whenever the daughter was ready for sex, she would seek out the health service for medical orientation on contraception before her "first time." When she and her boyfriend made the decision to have sex, she went to a public health center to consult with the doctor and was told: "Why don't you just remain virgin? Men do not like women who have already slept with someone." (Paiva, 2000b, p. 231)

Co-constructions of sexual citizenship and sexual subjects (Paiva, 2000b; Rance, 2001) arise from local meanings and agendas that often include open or concealed political priorities that need to be shared and negotiated, as in the next example extracted from our field notes.

> A trained educational psychologist invited a group of parents of sixth graders (11-13 years old) for a meeting to describe a sexual health and HIV prevention program to be developed with their children. She began by sharing many pieces of paper with questions that their children had formulated to be answered by the program. The most common question, put in different ways was: What is normal, or most frequently, what is the normal age to begin sexual life? These fathers and mothers from a middle class Catholic community in São Paulo looked at the pieces of paper either nervously joking about ages ("17!") or exclaiming: "Never!" "Not my girl!" "My boy should…" or "21 would be good!"
>
> A father voiced loudly: "And what would you, the

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

> teacher, answer for them?" Her response was: "I would tell them they should be prepared to do it, that it doesn't matter at what age, but to do it with consciousness and using a condom."
>
> "But what is the normal age?" a mother insisted. With poise, she answered: "Well, most kids in Brazil have their first experience of sexual intercourse around 16 years old, most boys perhaps earlier, many around 13 years of age..."
>
> A silent uneasiness could be felt around the room. The silence was broken by a sensitive father who made the point: "There is a difference between means and statistics gathered in research and role models to present to children in sex education programs. These we should be discussing...." (Field notes from the Training on Sexualities and Genders & AIDS Research Methods Course, see Paiva et al., 2002)

Fortunately she took this advice. She wasn't trained or experienced in discussing with parents the values, goals, and definitions of sexual health used in the program. She had previously worked with children in state schools, where less educated families may be less assertive in confronting technical discourses. She had taken for granted that she "knew the right answer, otherwise she wouldn't be there," as she revealed to the authors.

Sexual health professionals are often unaware that the technical health materials used in many sexual health promotion initiatives and studies generally serve to prescribe when they describe, as do all discourses that aspire to the status of providing the universal guiding truths underlying practices. Such prescriptions may serve to establish norms for behaviors, and are rarely placed in the public domain for examination and criticism. Thus, in various settings representatives of the techno-scientific community serve to determine what is good and what is not, and their evaluation generally aims to be universal.

In contrast with these universalistic definitions, whether derived from scientific or activist groups, we believe that the concept of sexual health would be more productively constructed in interactions between the technician—the teacher, health worker, or social researcher—and the individuals or the members of the community in question. Effective communication would enable conclusions to emerge that are informed both by scientific findings and by local socio-historical needs, and would encourage their cross-fertilization. It would permit the values, senses, and meanings that are important in each location and for each person and community to be expressed and debated. Rather than serving to model or to repress a specific behavior or a pre-defined characteristic of the aware young citizen and subject, such interaction would encourage technical discourse to collaborate with and nurture the sexual subject, who ultimately has to respond for the course of his or her life, in different and ever changing sexual scenes, and where sexuality will always be transformed (Paiva, 2000b).

Collaboration and communication with adults who join in sexual health promotion initiatives, as well as critical reflexivity and reflexive partnerships between communities, health educators, and social scientists have been valued as key assets for effective prevention and sexuality education. (Kippax & Kinder, 2002; Malcom & Dowsett, 1988). Why should adolescents and young people not also be seen as capable of critical reflexivity and able to participate in such dialogues concerning their health and well-being?

Preventionist Approaches and the Category "Adolescent"

Projects and published articles about the sexual health of youth tend to base their relevance upon the claim that there are specific vicissitudes and singularities, which are generally qualified as "problematic" in the life of a young person. The need for intervention projects are justified by virtue of the negative impact these "problems," if they are not properly solved, may have on the social life of the communities or on the future of the individuals in transition and adapting to adult life.

Although preventionist approaches (Arilha & Calazans, 1998) to a problematic future are hegemonic in what we analyzed in relevant Latin American material, it is interesting to note also the importance of material that focuses on structural aspects, on socio-demographic elements, and on the institutional and psychosocial realms relevant to the topic, specifically,

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

poverty, unemployment, dysfunctional families (from alcoholism to illegal activities), family agglomeration, malnutrition, migration from rural areas, and resulting value conflicts between generations (Stern & Medina, 1999). As mentioned above, a number of Latin American authors are in agreement that the socio-demographic profiles of people who have become infected with HIV in recent years, or of youngsters who have children during adolescence, indicate that social inequality and structural violence may be the most important factors affecting young people's vulnerability (Ayres & França-Junior, 1996; Ayres, França-Junior, Calazans, & Saletti, 1999; Hoyos & Sierra, 2001; Oliveira, 1999; Pimenta et al., 2000). As S. Weller (1999) asks, should we not "...start to ask to what extent the risks traditionally associated with young people's sexual activity as such (lack of information, early start to sexual activity, carelessness) are not in fact concealing social inequality?" (p. 34).

Adolescence is a conceptual construction that attempts to reduce variable and complex characteristics to a set of natural and universal phenomena. We have chosen to use the term "youth" over "adolescence" as a broader age bracket going from 10 to 24 years old, as defined by the World Health Organization (1986), while understanding that age itself does not mean a great deal out of the social, cultural, and inter-personal contexts in which it exists. The WHO practical recommendation is to demarcate three categories as youth: 10-14, 15-19, and 20-24 years old (Oliveira, 1999, p.102). Many interventions directed to the sexuality of youngsters target this broad age bracket using the WHO boundaries, but they often view young people as reduced to what they conceptualize as adolescents with some essential set of typical and distinctive marks that frequently include the assumption of "problematic." Almost all such programs talk about how to resist sexual urges, how to say no to sexual activities, and how to enact sexual behaviors safely; in contrast, they almost never debate ways to choose or to construct enjoyable ways of saying yes to sexuality. The problems described in relation to sexuality are unwanted or early pregnancy, diseases, and more recently, abuse (of women). The widespread wish, or the right moment to choose, to be a father or a mother, or concern about other more positive meanings of sex, such as intimacy, exchange, sharing, surrender, and autonomy, are not presented, except as variables or meanings to explain the lack of prevention of the "problems." The literature on the topic is almost exclusively written from an adult-centric perspective, or conceived of from the point of view of adults who are responsible for the socialization, care, and control of young people and their future and who tend to view adolescence exclusively as a period of crisis, passage, and transition to adulthood (Calazans, 1999). Presumably problems with irresponsible and risky behaviors are automatically resolved when these young people reach adulthood (Stern & Medina, 1999).

From such a preventionist perspective, it is as though adult life and adult sexuality do not involve phases, passages, or transitional periods, and that adolescence alone includes experiences of crisis, passage, and transition. In fact our understanding of the AIDS epidemic has served to demystify the vulnerability of adults in relation to sexuality as well, and to demonstrate the difficulties adults encounter in acting according to their decisions and intentions regarding their affective and sexual lives. While each stage of life and each new situation poses specific challenges regardless of age, and adults face similar types of stigma regarding sexuality that is forbidden by cultural norms and suffer equally from the impact of inequality and structural and symbolic violence, sexual health programs directed to youth convey the message that these issues affect only young people.

Such a negative and stereotyped notion of adolescence, as filled with rebellious content, does not do justice to the large group of young people who do not fit these images, for example, those who leave school at a very early age to work, or to take responsibility for domestic labors, or to be parents, with little choice and with no expression of rebellion. They may be burdened down with early responsibilities or, alternatively, choose a path to autonomy through work and parenthood at a young age, often as their parents had done before (Knauth et al., 2003).

A recent multi-site Brazilian home based study (Aquino et al., 2003) showed that approximately 19% of young men and 38% of young women interviewed were involved with a pregnancy before the age of 20, most at around age 18. Among the adolescents who

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

became parents, many did not want to get pregnant (42% of men and 38% of women), although a significant number of them did want to become parents (15% of girls and 6% of boys) or at least were thinking of getting married soon (34% of boys and 46% of girls). Approximately 44% of these young people were already out of school before pregnancy, and many more girls (42%) than boys (24%) abandoned school after having a child. Two thirds of the boys (66%) and 14% of the girls had a job before pregnancy. Half of the youngsters did marry, and about 16% of them began working and 34-40% stayed in school after the baby was born.

How do young people see youth and entry into adult life? What are the definitions of adulthood, and therefore of socialization for adulthood, that projects on young people's sexuality are working with? In many societies marriage is (or has been) the definitive ritual marking adulthood. However, studies among North Americans indicate that instead of facts and events, certain qualities of character define the arrival at adulthood for many young people today. These qualities include agreeing to be responsible for oneself, being independent in one's decisions, and being financially independent. In addition, many describe becoming a father or mother, but not marriage, as relevant to becoming an adult (Arnett, 1998).

Our experience with young people in the São Paulo (Brazil) metropolitan area indicates that for these youth, in contrast, being financially independent is not simply a problem of personal and character development. Almost all studies in Latin America point to unemployment and the lack of financial opportunity for young people as among the most significant factors in making them vulnerable to disease (Calazans, 1999). Differences in social status, level of schooling, and placement in the labor market thus raise different expectations for these young people than for their counterparts in North America. Boys and girls who anticipate more years of schooling tend to postpone plans for having a family and children (Calazans, 1999; Knauth et al., 2003; Paiva, 2000) and may hold a definition of adulthood similar to that described above among young people in North America. However, the poorer children and their families anticipate that these events will occur at an earlier age and see them serving as more definitive rites of passage to adulthood. Such a view gives meaning to the sacrifices they make as a result of early employment and their efforts for social advancement, the success of which they see as depending on family solidarity. Young sex workers or incarcerated teenagers, with whom we have worked in STI prevention projects, who come from the same poor communities as the schoolchildren studied in other projects, feel they are rebels in transition to adulthood—which they have decided is the life of the "full consumer"—to which they took a shortcut via illegal activities (Peres et al., 2002; Simon, Silva, & Paiva, 2002). They argue that their socialization for professional life occurs in the social organization of illicit enterprises, mainly drug trafficking and consumption, and they accept responsibility for (and are more worried about) the risks they run on the street from the police and from other offenders, while STIs and AIDS trail at the end of their list of threats to their life and health. As Peres et al. (2002) describe:

> Many believed they would not live beyond 25 years of age and few of these adolescents believed they will be able to change their lives. The criminal life was the only option they could see to get things they dreamed of in their lives: "a brand new car, a beautiful girl, and money." (p. 41)

What sort of opportunities for thinking about their socialization for sexual life would be in keeping with the ideas of these young people regarding their development and lives? We are still a far cry from working with them without considering them to be somehow defective, lacking in some factor that needs to be fulfilled or cured (such as knowledge, responsibility, or capacity to choose), although recently a growing appreciation for the value of young people's perceptions and voices has begun to arise. Increasingly they are being incorporated as peer educators in projects in the field of sexuality directed to schools and, more rarely, to clinics. But traditional skills training-based models are still primarily developed for those who are both entitled to the rights of citizenship and also have the personal and social resources to access the adolescence they see described in magazines and the media, students who are going to schools, can choose when they begin their professional careers, have access to health care and to condoms, can be consumers of the products typically marketed to youth,

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

and are able to enact their sexual preferences and choices. These models are quickly called into question, however, when working with disenfranchised young people. Even if they are legally entitled as citizens to state services and support, the real daily lives of such disenfranchised youth are so distant from the scientific and technical discourse on adolescence that in fact little connection can be established between these youth and the services supposed to be focused on their needs.

Adolescence, Identity, and Diversity

The recent movement towards a diversification of intervention approaches directed to young people's sexual health is very hopeful. This trend represents progress from the universalized, large-scale approaches that emerged from the development and widespread application of techno-scientific methods of managing adolescence. Divesting medical care settings and schools of their status as the privileged, or even exclusive, loci for this type of intervention signals some degree of recognition that the processes of adolescence are not monolithic and allows for the identification of different strategies for intervention as a function of diverse populations and settings. Perhaps most important, such strategies may encourage the emergence of needs that are unlikely to find channels of expression in schools and, even more so, in medical environments.

Whether because of the rigid rules for social behaviors in medical and school environments or because of the representations that regulate expectations even before they enter these institutions, young people frequently tend to restrict the expression of their values, needs, and feelings, indeed of anything that is not immediately associated with their role as the objects of the institutional intervention, in such settings. This phenomenon is clearly much more intense in medical care services than in schools. Medical care services are seldom sought out by young people, who only do so in moments of crisis, while school occupies a significant part of most young people's daily lives. In addition, in the medical care setting, the young person is generally either alone in the relationship with the institution, or at times accompanied by those responsible for him or her; whereas at school, relationships occur in groups, and collectively. However, even in school, it is hard to escape the stamp of the school identity, which strongly molds and subordinates all other identities and which generally includes an unhelpful categorization as a good or bad student.

Acknowledgment of identities other than those of patient and student, such as those associated with ethnic, cultural, and community groups, opens up possibilities for escape from the straightjacket of biphasic classification into normal and pathological and good and bad, and toward the greater intimacy provided by shared group attitudes, knowledge, and practices that can serve to identify and control harmful and beneficial factors. In the realm of community living, for example, the chances are better that judgments about a young person will escape the biphasic model, given that a community's normative ideal is generally the product of an open process of construction. Working within a specific culture or group, whether a sexual culture like "being gay," an artistic or sporting tradition like "being a soccer player," or belonging to a "carnival samba school" or "hip-hop" group, may help enrich normative discourses by depriving the techno-science authorities of the exclusive prerogative to define what is desirable. In such situations, the ethical, political, and particularly, aesthetic dimensions gain a status comparable, or even superior, to the techno-scientific certainties in choosing directions and avenues to well-being.

Avoiding bipolar alternatives, constructing plural, open, and consensual criteria, and enriching normative judgments aesthetically, ethically, and politically are extremely helpful strategies for developing a more democratic and creative space for considering different sexual activities, beliefs, and attitudes among youth. However, such outcomes will be difficult to achieve unless there is also a critical examination of the very conceptualization of adolescence to allow for greater normative flexibility. Originating from science, the term adolescence continues to be applied to phenomena that are interpreted as being essentially the same whether they occur in a hospital or in a samba-school, in Mexico or in Senegal, among Brazilian indigenous peoples or among African-Americans, or among boys or girls.

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

In fact conceptual categories with pretensions to such universal validity are not constructed by chance. The historical utility of such categories is closely related to their communicational—and thus practical—efficacy that often renders them so pregnant in theoretical terms. The issue that we are raising is to consider the extent to which the category of adolescence is still valid for describing the normative events present among different populations and in different settings in the present day, particularly in relation to sexuality. The diversity of the settings for intervention with regard to young people's sexual health and sexual citizenship does not always allow for a diversity of expression of the values, assumptions, and objectives that guide actions associated with these realms. At this point, the greater freedom afforded by choosing subjects and locations not immediately subject to medical or pedagogical mindsets does not seem to have been taken beyond a greater plurality of methods and strategies for intervention, all essentially oriented to the same notions of young people as transitional subjects and of a prescribed "good sexuality" that will be achieved by all subjects in the same way. As a result, the diversification that has taken place is often more superficial than substantive. While different languages, images, and strategies may be employed in order to make the effort to actually say something to different groups of young people, the same expectations for their normative behaviors are preserved.

In the health sciences field, which has coined the expression "normal adolescence syndrome" (Aberastury & Knobel, 1971), a phrase designed to indicate a provisionally tolerable deviation from the norm, or a "normal pathology," adolescent problems are usually attributed to some type of physical, intellectual, or psycho-affective immaturity. From this point of view, adolescence is understood as a time of great suffering. In addition to suffering from experiences of limitation, consisting of a "painful" awareness of what they do not yet have, adolescents are considered to be absorbed by a variety of "mourning" events that they need to work through in their transition to adult life, for example, mourning over their bodies, over their identities, and about losing the parents of their childhood. (Aberastury & Knobel, 1971). From this standpoint, the direction of intervention is always towards breaking away from childhood, which is seen as a preparatory existence, and to molding desirable adult attributes. Thus, childhood and adolescence can ultimately be cured by passage into adulthood.

In the field of the social sciences, the deficit associated with adolescence is seen as marginality, that is, the peripheral situation of young people in the various arenas of social interaction, including economic, political, cultural, and legal. This situation of marginality, on the other hand, is often called on to explain the nonconformist, restless, and subversive nature of youth. The general intention underlying various forms of intervention based on such marginality is to control and to progressively include young people in the various arenas of social interaction, for example, their incorporation into the labor and consumer markets, their setting up new nuclear families by way of conjugal relationships, and ensuring their preparedness to vote and to assume other civil responsibilities (Calazans, 1999; Stern & Medina, 1999).

Because of the broad and often incorrect assumptions implied by the concept of adolescence, we believe that health care providers, teachers, and activists must ask themselves how useful this term is today and whether or not it should still be applied to young people in health care and educational settings. The following example (taken from Enhancing Care Initiative, 2003[5]) illustrates the risks in making interventions with young people based on attributed "age identities." It was taken from an interview with M., an 18 year old girl, describing how she learned that she was HIV positive when she was 16 and pregnant.

> M. arrived at a public primary health care clinic for pre-natal care in her fourth month of pregnancy. She obtained a prescription for a blood screening, which she completed. Nobody mentioned an HIV test to her, although it is recommended but not compulsory in Brazil. But something happened with her blood examinations during the following months. She kept going to

5 *This is an ongoing project, aiming to enhance care for young people living with HIV in São Paulo, Brazil. http://www.eci.harvard.edu/eci_teams/brazil/index.html*

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

every scheduled pre-natal care visit, but only at the eighth month visit with the doctor, a female gynecologist trained in mother to child HIV transmission, was she asked to bring her mother along for her next visit at the center. M. gave her description of the scene at the next appointment, where mother and daughter listened to the doctor:

> "She said: 'You know, your daughter has the virus!' Like that! And I said 'Me????' And the doctor said: 'Yes! And that's why you kept delaying taking the exams, you knew you were positive!' And I said: 'Ai, ai, aiii, doctor, but I didn't know! Every time I came here there was a problem for taking the exams... No, it cannot be me!' And the doctor added: 'In my opinion you knew it.' And then I was desperate, I began to cry, and she said: 'Now, it doesn't help crying'...so I got straight and went home....
>
> "Everything we got in our body we first talk to our father and mother... My mother said we had to wait and see other exams...my father was sad, and told me I had to take care, I had a baby to take care of, and sure, the baby would have a grandfather... He was sad, yet, because his brother also died of AIDS. I was ten, I never knew he had AIDS, and there was no medication at that time, but my father took care of him.... My boyfriend, the father of my boy, was negative.... I found out that my ex-boy friend had died one year before, but his family wouldn't say if it was because of AIDS.
>
> "I wanted to die, and I stopped the medication once. I never came back to the pre-natal care clinic.... They sent a car with two women, gave me the little paper and spoke about this AIDS Reference Center address. My mother took me there. I had the baby there.... It shouldn't be like that, accusing people, as she did with me. It has to be with a careful attitude. Listening to such bad news is hard! And I was in my eighth month...." (Enhancing Care Initiative, 2003)

M. was adjusting to become a responsible woman and her story was one of a vibrant teenager becoming a mother to be. Most Brazilian boys and girls who become pregnant during adolescence interpret this event as an initiation and part of a trajectory towards autonomy and adulthood. M. was dealing with this process, but was instead treated as a dysfunctional girl who did not prevent a problem, or worse, was accused of being an irresponsible grown up woman and mother, by a doctor who appeared to be more worried about her unborn baby and possible vertical transmission of infection to the child than with the young woman. This may not have been an atypical rapid intervention aimed at preventing vertical transmission of HIV infection from mother to child and assuring adherence to treatment, as most clinicians would explain such approaches. A closer look may reveal that the doctor herself was very worried about being accused of not offering appropriate treatment for preventing mother to child transmission, or was attempting to get rid of an undesirable HIV positive patient. In this instance was M. viewed as a rebel adolescent or as an irresponsible adult? In the end, she fulfilled both destinies when she abandoned treatment.

The label "adolescence" is generally applied by adults to young people and often may not even reflect the young person's perceptions or experiences. The study of adolescents requires a careful contextualization of the population being studied, including consideration and definition of their specific ages and of the social processes and interactions that are being examined and an understanding of the setting within which these processes occur at a particular time and place. Such contextualization may bring with it the risk of an extreme relativism, one where ethical standards, for example, in relation to sexuality or parenthood, could not be specified as a basis for understanding growth and development. To prevent such a paralysis, we must also appreciate the need for certain universal dimensions of some conceptual categories (for example, "adolescent," "mother to be," and "HIV positive patient") because of the connections they serve to establish between diverse individuals and contexts, thereby making a common basis for dialogue and sharing of experiences and values.

To resolve any potential tension between an essentialist universalism and a paralytic contextualism in the application of the categories adolescence and sexual health, we value in our work Ricoeur's (1991)

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

contrast between "idem identity" and "ipse identity." He defines an idem identity as one marked by sameness, immutability, and unvarying permanence, and an ipse identity as a reflexive identity constructed continuously as selfhood in relationship with otherness. In the case of an idem identity, this understanding allows us to develop a priori tools for normative interventions; whereas in the case of an ipse identity, we attempt to create an effective dialogue with youth to identify together with them their real needs, wishes, and possibilities for improving happiness in relation to sexuality.

Attention to the ipse identities that exist in relation to adolescence and sexuality allows us, as a result of their inclusion of the contextual aspects of identity, to expand our exploration of young people's normative horizons. At the same time, we are called upon to find a common ground from which the diverse subjects involved in our research—including the young people and the researchers, the younger persons and the older persons, and the many different types of youth—can freely learn about, discuss, and validate the variety of normative discourses about sexuality and youth that we encounter.

Sexuality, Sexual Rights, and Citizenship

In conclusion, we would like to suggest that any discussion of adolescence and sexuality as strongly contextual categories needs to involve consideration of two interactive qualities: universality, to create a basis for cross-cultural and cross-contextual dialogues, and objectivity, to provide a concrete delimitation of the special needs of a given youth community. The academic literature supports such an approach that encourages thinking and acting both globally and locally, in a manner that simultaneously recognizes the value of cross-contextual dialogues and of creativity and innovation by local communities. For example, when describing effective sex education programs for young people, Kirby and Coyle's review (1997) of 35 school based programs to reduce sexual risk taking behavior further concluded that: "There do not exist any curricula that have been independently implemented and evaluated in two or more settings and found to be effective at changing behavior" (p. 442).

The UNAIDS (1997) review indicated that effective prevention programs share the following qualities: focus on activities that address social influences; encourage openness in communication about sex; teach and allow practice in communication and negotiating skills; equip young people with skills for decoding media messages and their underlying assumptions and ideologies about sexuality; provide focused curricula that offer statements about specific behavioral aims; and feature a clear delineation of the risks of unprotected sex and methods to avoid it (p. 27). To these characteristics, Kirby and Coyle (1997) add that effective school based programs use active learning methods of instruction, trained teachers, and participation of peers who believe in the program. Kirby and Coyle and the Joint United Nations Program on HIV/AIDS (UNAIDS, 1997) agreed that effective programs did not encourage sexual activity, helped delay the age of first intercourse, and could teach responsible and safer sex practices. In other words, from a preventionist point of view, these programs "do not cause harm, as some people fear" (Kirby & Coyle, 1997, p. 431). Although these studies were conducted in developed countries, no research appears to contradict the relevance of these findings in any setting.

These findings certainly speak for the co-construction of sexual health notions and dialogues by young people, their communities, and professionals. In addition, we argue for the following rights for young people in relation to their sexuality: the right to comprehensive information, including information about those social, economic, and cultural factors that contribute to their risks and vulnerabilities, about the values and assumptions underlying each intervention program in which they participate, and accurate and up to date biomedical information; the right to access condoms and other forms of contraceptives; the right to adequate medical treatment; and the right to gender equity. Indeed, the frame of human rights has provided an opportunity for an intense exchange of ideas between the health, social activism, and legal fields (Mann, Gruskin, Grodin, & Annas, 1999), which in turn has led to a series of advances by a variety of social movements, such as the women's movement, which has achieved extensive gains in the field of sexual and

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

reproductive rights. In Brazil, the Federal Law "Children's and Adolescents' Statute" (Estatuto da Criança e do Adolescente, 1990) has not only made it possible to identify and, to a certain extent, curb violations of children's and young people's fundamental rights, but it has also encouraged the development of a series of debates and reflections on the needs and social characteristics of these groups. Such outcomes lead us to believe that research relating to sexuality and young people can benefit by reference to the simultaneously universalizing and particularizing potential of the human rights movement, as well as from the greater explicitness and questioning regarding normative descriptions that will necessarily accompany all discussions of human rights. In addition, the more recent development within Latin America of the idea of sexual citizenship may be helpful (Rance, 2001).

However, we must also be aware of the limits of human rights as a basis for expanding the discourse on sexuality and young people. We must ask the extent to which sexuality, whether of young people or of adults, can be considered through the lens of human rights without risking the same type of contradiction raised when sexuality is the object viewed by the techno-sciences, that is, of gaining visibility while simultaneously narrowing the normative expectations that guide the construction of sexual beliefs and behaviors. The language of law rests on universal legal principles just as much as the language of the sciences rest on universal scientific principles. Perhaps the difference is that the former admits the human and consensual origins of the principles of law much more clearly than the latter does in relation to science. That is to say, the language of law also deals in idem identities, but allows the hermeneutics that operate in the processes of judgment to consider relevant variant and contextual elements.

As we have emphasized, we believe that otherness and contexts of inter-subjectivity should be central elements in the way we understand youth and sexuality. According to this view, there is no overall standard of "good sexuality," just as there is no single meaning of "being young." While the sexual rights and citizenship perspectives can serve as important instruments for achieving young people's psychosocial emancipation in these areas, as they have for women and for gay and lesbian individuals, and can stand as helpful ethical frameworks for our interventions, the problematic theoretical challenge of constructing categories and strategies that respond appropriately to the universal and specific dimensions of the topic will require ongoing effort. ◆

Acknowledgments

Special acknowledgment to Terry Stein, Managing Editor of this journal, to whom we are indebted for his patient and careful editing. Some colleagues and groups in Latin America have been special partners in the debate we bring to this paper: Carlos Cáceres and Alicia Quintana (Peru); Tim Frasca and José Olavarria (Chile); Ivonne Szasz (México); and colleagues based at Centro de Estudios Estado e Sociedade (Argentina). In Brazil, we should thank colleagues based at Associação Brasileira Interdisciplinar de AIDS (ABIA, RJ); Núcleo de Estudos de População (NEPO, Campinas) Promundo (RJ); Universidade Federal do Rio Grande do Sul (UFRGS); and members of two networks, Núcleo de Estudos para a Prevenção da USP (NEPAIDS, SP) and Escola de Havana.

References

Aberastury, A., & Knobel, M. (1971). *Adolescência normal* [Normal adolescence]. Buenos Aires, Argentina: Paidós.

Arilha, M., & Calazans, G. (1998). Sexualidade na adolescência: O que há de novo? [Sexuality and adolescence: What's new?]. In E. Berquó (Ed.), *Jovens acontecendo na trilha das políticas públicas: Vol. 2*. Brasília, Brazil: CPND.

Aquino, E., Heilborn, M.L., Knauth, D., Bozon, M., Almeida, M.C., Menezes, G., & Araújo, J. (2003, July). *Gravidez na adolescência em capitais brasileiras* [Pregnancy in Brazilian capitals]. Paper presented at the meeting of the Brazilian Association of Postgraduate Studies in Collective Health Congress (ABRASCO), Brasília, Brazil.

Arnett, J.J. (1998). Learning to stand alone: Adulthood in cultural and historical context. *Human Development, 41,* 295-315.

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

Ayres, J.R., Buchalla, C. M., & França-Junior, I. (1996). Saúde do adolescente [Adolescent health]. In L. Scraiber, M.I. Nemes, & R.B. Mendes Gonçalves (Eds.), *Saúde do adulto: Programas e ações na unidade básica* (pp. 65-85). São Paulo, Brazil: Hucitec.

Ayres, J.R., Buchalla, C.M., França Jr., I., Calazans, G., & Saletti-Filho, C. (1999). Vulnerabilidade e prevenção em tempos de Aids [Vulnerabilities and prevention in Aids times]. In R.M. Barbosa & R. Parker. *Sexualidades pelo avesso* (pp. 49-73). São Paulo, Brazil: Editora 34.

Barker, G. (2002). Engaging adolescent boys and young men in promoting sexual and reproductive health: Lessons, research and programmatic challenges. In Population Council (Ed.), *Adolescent and Youth Sexual and Reproductive Health: Charting directions for a second generation of programming* (pp. 109-154). New York: Population Council.

Cáceres, C.P. (1998). *Un programa comunitario en salud sexual con y para los jóvenes*. Lima, Peru: UPCH/REDESSS.

Calazans, G. (1999). Cultura adolescente e saúde: Perspectivas para a investigação [Adolescent culture and health: Investigation perspectives]. In M.C. Oliveira (Ed.), *Cultura, adolescência, saúde: Argentina, Brasil, México* (pp. 44-98). Campinas, São Paulo, Brazil: Consórcio de Programas em Saúde Reprodutiva e Sexualidade na América Latina (CEDES/COLMEX/NEPO-UNICAMP).

Calero, J.L., & Santana, F. (2001). Percepciones de um grupo de adolescenetes sobre iniciación sexual, embarazo y aborto. *Revista Cubana Salud Publica*, *27*(1), 50-57.

Chiavarro, M.C., Chumen, S., & Flacké, D.S. (2001). Por una sexualidade humana responsable. *Revista Soc. Argent. Ginecología Infanto Juvenil*, *8*(1), 15-17.

Dowsett, G., & Aggleton, P. (1999). Young people and risk-taking in sexual relations. In M. Caraël (Ed.), *UNAIDS, sex and youth: Contextual factors affecting risk for HIV/AIDS* (pp. 10-55). Geneva, Switzerland: UNAIDS.

Enhancing Care Initiative/Brazil. (2003). *Preliminary Report*. Unpublished manuscript.

Eggleston, E., Jackson, J., Rountree, W., & Pan, Z. (2000). Evaluation of a sexuality education program for young adolescents in Jamaica. *Rev. Panam. Salud Pública*, *7*(2), 102-112.

Hoyos, R.C., & Sierra, A.V. (2001). El estrato sócio econômico com factor predictor del uso constante de condón en adolescentes. *Rev Saúde Pública, 35*(6), 531-538.

Kippax, S., & Kinder, P. (2002). Reflexive practice: The relationship between social research and health promotion in HIV prevention. *Sex Education, 2*(2), 91-104.

Kirby, D., & Coyle, K. (1997). School-based programs to reduce sexual risk-taking behavior. *Children and Youth Services Review*, *19*(5/6), 415-436.

Knauth, D., Victoria, C., Leal, A., Heilborn, M.L., Rodhen, F., & Bozon, M. (2003, July). *Trajetórias afetivo-sexuais dos jovens: um estudo sobre sexualidade e juventude em três capitais* [Affective and sexual trajectories: A study on sexuality and youth]. Paper presented at the meeting of the Brazilian Association of Postgraduate Studies in Collective Health Congress (ABRASCO), Brasília, Brazil.

Lyra, J. (1998). Paternidade adolescente: Da investigação a intervenção [Adolescent fatherhood: From research to intervention]. In M. Arilha, S. Ridenti, & B. Medrado (Eds.), *Homens e masculinidades: Outras palavras*. São Paulo, Brazil: ECOS/Editora 34.

Mann, J., Gruskin, S., Grodin, M.A., & Annas, G. J. (1999). *Health and human rights: A reader*. Routledge: New York.

Millán, K.T., Valenzuela, G.S., & Vargas, N. (1995). Reproductive health in school adolescents: Knowledge, attitude and behavior in both sexes in a community at Santiago de Chile. *Rev. Méd. Chile*, *123*(3), 368-375.

Monteiro, S. (2003). *Qual prevenção? Aids, sexualidade e gênero em uma favela carioca* [Which prevention? AIDS, sexuality and gender in a slum]. Rio de Janeiro, Brazil: Ed. FioCruz.

MS/CEBRAP. (2003). *Comportamento sexual da população Brasileira e percepções do HIV/AIDS*. Retrieved January 10, 2003, from Brasília Ministério da Saúde, Programa Nacional de DST e

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.

AIDS, Dados e pesquisas em DST e AIDS Web site: http://www.aids.gov.br

Oliveira, M.C. (Ed.). (1999). *Cultura, adolescência, saúde: Argentina, Brasil, México*. Campinas, São Paulo, Brazil: Consórcio de Programas em Saúde Reprodutiva e Sexualidade na América Latina (CEDES/COLMEX/NEPO-UNICAMP).

Padilla de Gil, M. (2000). Sexualidade de los adolescentes Salvadoreños [Sexuality of the adolescentes from El Salvador]. *Revista de la Sociedad Chilena de Obstetricia y Ginecología Infantil y de la Adolescencia*, *7*(3), 64-72.

Paiva, V., Ayres, J.R., Buchalla, C.M., & Hearst, N. (2002). Building partnership to respond to HIV/AIDS: NGOs and universities. *AIDS 2002, 16*(Suppl. 3), S76-S82.

Paiva, V. (2003). Beyond magic solutions: Prevention of HIV and AIDS as a process of psychosocial emancipation. *Divulgação em Saúde para Debaten*, *27,* 192-203.

Paiva, V. (2000b). Gendered scripts and the sexual scene: Promoting sexual subjects among Brazilian teenagers. In R. Parker, R. Barbosa, & P. Aggleton (Eds.), *Framing the sexual subject* (pp. 216-241). Berkeley, CA: University of California Press.

Paiva, V. (2000a). *Fazendo arte com a camisinha*. São Paulo, Brazil: Summus.

Paiva, V., Venturi, G., França-Jr, I., & Lopes, F. (2003). *2-Uso de preservativos pesquisa nacional MS/IBOPE, Brazil 2003*. Retrieved December 2, 2003, from Programa Nacional de DST e AIDS, Dados e pesquisas em DST e AIDS Web site: http://www.aids.gov.br/final/biblioteca/ibope_2003/artigo_preservativo.rtf

Peres, C.A., Peres, R.A., Silveira, F., Paiva, V., Hudes, E., & Hearst, N. (2002). Developing an AIDS prevention intervention for incarcerated male adolescents in Brazil. *AIDS Education and Prevention, 14*(Suppl. B), 36-44.

Pérez, F., Quintana, A., Hidalgo, C., & Dourojeanni, D. (2003). *Sexualidad y mujeres jóvenes-negociación, protección y placer*. Lima, Peru: Instituto de Educación y Salud (IES).

Pimenta, C., Rios, L.F., Brito, I., Terto Jr., V., & Parker, R. (2001). Passagem segura para a vida adulta: Oportunidades e barreiras para a saúde sexual dos jovens brasileiros. Rio de Janeiro, Brazil: ABIA.

Rance, S. (2001). ¿Por qué ciudadanía sexual? [Why sexual citizenship?]. *Conciencia Latinoamericana (Revista de Católicas por el Derecho a Decidir*), *13*(3), 13-17. Retrieved October 10, 2003, from http://www.ciudadaniasexual.org

Ricoeur, P. (1991). *O si mesmo como um outro*. Campinas, São Paulo, Brazil: Papirus.

Simon, C.P., Silva, R.C., & Paiva, V. (2002). Female juvenile prostitution and AIDS prevention programs in Brazil**.** *Rev. Saúde Pública*, *36*(4 Suppl.), 82-87.

Stern, C., & Medina, G. (1999). Adolescência y salud en México. In M.C. Oliveira (Ed.), *Cultura, adolescência, saúde: Argentina, Brasil, México* (pp. 98-160). Campinas, São Paulo, Brazil: Consórcio de Programas em Saúde Reprodutiva e Sexualidade na América Latina (CEDES/COLMEX/NEPO-UNICAMP).

Waizkin, H., Iriart, C., Estrada, A., & Lamadrid, S. (2001). Social medicine in Latin América: Productivity and dangers facing the major national groups. *Lancet*, *358,* 315-323.

Weller, S. (1999). Salud reproductiva de los/as adolescentes: Argentina 1990-1998. In M.C. Oliveira (Ed.), *Cultura, adolescência, saúde* (pp. 9-43). Campinas, São Paulo, Brazil: CEDES/COLMEX/NEPO-UNICAMP.

World Health Organization/Organização Mundial da Saúde (1975). *Instruccion y asistencia en cuestiones de sexualidad humana: Formacion de profesionales de la salud* (Informes Tecnicos No. 572). Geneva/Genebra, Switzerland: World Health Organization/Organização Mundial da Saúde.

World Health Organization/Organização Mundial da Saúde (1986). *Young people's health: A challenge for society* (Série Relatórios Técnicos No. 731). Geneva/Genebra, Switzerland: World Health Organization/Organização Mundial da Saúde.

UNAIDS (1997). *Impact of HIV and sexual health education on the sexual behaviour of young people: A review update*. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS).

© Copyright 2004 National Sexuality Resource Center, San Francisco State University, all rights reserved.