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ARTIGOS

Pedagogies of sexuality: discourses, practices and (mis)encounters in integrated health care for adolescents [1] [2] [3] [4]

Pedagogias da sexualidade: discursos, práticas e (des)encontros na atenção integral à saúde de adolescentes

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Abstract

This ethnographic study analyzes sex education actions undertaken by health professionals in a primary healthcare center and in a public school in a peripheral neighborhood in São Paulo. Educational interventions focused on the individual responsibility of girls and the risks related to teenage pregnancy. The notion of pregnancy as a disruptive factor in life projects was in line with the traditionalist common sense present in girls' daily lives, reflecting gender asymmetries. However, the sexual health needs reported by adolescents involve comprehensive subjects such as gender diversity and sexuality, mental health issues and changes experienced in early adolescence. Sexuality education is part of the process of construction of the individual and can contribute reflections and experiences that engender a practice of care for self and others.

Keywords: adolescence, gender, sexuality, sex education

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Resumo

Este estudo etnográfico analisa as ações de educação sexual empreendidas por profissionais de saúde em uma unidade básica de saúde e em uma escola pública de um bairro periférico de São Paulo. As intervenções educativas centravam na responsabilização individual de meninas e na gramática do risco que contextualiza a gravidez na adolescência. A noção da gravidez como fator desestruturante de projetos de vida alinhava-se ao senso comum tradicionalista presente no cotidiano das garotas, refletindo assimetrias de gênero. Todavia, as necessidades de saúde sexual pontuadas por adolescentes trazem temas transversais como a diversidade de gênero e sexualidade, questões de saúde mental e as mudanças vivenciadas no início da adolescência. A educação para a sexualidade integra o processo de construção do sujeito, podendo contribuir com reflexões e experiências que engendrem uma práxis de cuidado de si e do outro.

***Palavras-chave**: adolescência, gênero, sexualidade, educação sexual*

Introduction

Brazilian policy for the comprehensive health care of adolescents and young people prioritizes integrated care and an intersectoral and interdisciplinary approach to disease prevention and health promotion[5] (Brasil, 2010a). This has led to the creation of the Health at School Program (*Programa Saúde na Escola* – PSE), which aims to coordinate efforts by family health teams and the public school system community to further the integral development of children and adolescents. Understanding the school as an environment that drives health promotion practices is strategic, given the low use of healthcare services by adolescents (Brasil, 2010b; Conceição & Costa, 2017). In this sense, the health service is also a means to provide socialization, responsible for specific health education actions.

Such actions include those aimed at providing teenagers with "sex education," acknowledging that primary care must contribute to the learning of social norms of sexuality and gendered behavior models by girls and boys. Health education action tends to focus on specific sexual behaviors by addressing STDs (sexually transmitted diseases), contraception and

[5] This policy is based on three pillars: healthy growth and development; comprehensive sexual and reproductive healthcare; reduction of morbidity and mortality from violence and accidents. The projects address a number of specialties, such as sexuality, mental health, reproductive health, oral health, vaccination control, healthy eating to fight obesity, hearing health, eye health, verminosis and trachoma.

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reproductive planning (Brasil, 2010b; Brasil, 2013). As agents of socialization, healthcare professionals also work towards the recognition and legitimation of sexual and gender identities among adolescents in undertaking governance technologies (Louro, 2018).

Sexuality is movement and eroticism is a subjective practice that relates to other aspects of an individual's life. New forms of relationship and lifestyle affect ways of living and producing sexual and gender identities (Louro, 2018). In line with such issues, it is up to sex education to approach culture as a "problematic issue" – contestable and contradictory – that establishes processes of regulation and exclusion as a condition for the production and recognition of its members. Problematizing the dynamics of cultural relationships involves questioning the hegemonic discourses on sex and the proper cultural form for sexuality. Such a process is key to discussing the "vicissitudes of knowledge, power and pleasure" woven into the historical moment and the actual relationships among people (Britzman, 2018).

In this article, we analyze the pedagogy(ies) of sexuality available to health and education professionals through the PSE (Health at School Program). Empirical evidence came from an ethnographic study carried out in the outskirts of the city of São Paulo with professionals from a Primary Health Center (*Unidade Básica de Saúde* - UBS), educators of a public middle school and adolescents aged 11 to 16. We problematize the educational interventions and their differences in relation to a more comprehensive view of the set of relationships involved in the process of learning about sexuality and self-development which is intensified in this period of life. Lastly, we argue in favor of an approach to sexuality education, mainly focused on interaction with adolescents, as we understand that it would not only prompt questioning/reflection of certain values, hierarchies, production of differences and inequalities in society, but would also enable a more positive approach to adolescent sexuality by all agents involved (parents/guardians, health and education professionals and the youngsters themselves) (Cabral & Heilborn, 2010; Schalet, 2011; Britzman, 2018). Furthermore, placing the right to safe and healthy practice of sexuality at the heart of the debate implies treating adolescent sexuality as legitimate and an integral part of the process of education for life, which can greatly contribute to the construction of experiences that engender a practice of care for self and others (Freire, 2011; Guimarães & Lima, 2012).

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Methodology

This article results from a theme-based sampling of a broader ethnographic study on transition processes from childhood to adolescence. The fieldwork focused on monitoring sex education actions by healthcare professionals in two settings: between November 2018 and June 2019, the survey was carried out in a UBS located in a neighborhood in the east side of the city of São Paulo, and, between August and December 2019, it was conducted in a public middle school (6th to 9th grade) that was part of its service area.

At the time of the investigation, the school had 579 enrolled students ranging from 11 to 16 years old, divided into morning and afternoon shifts. The observation areas comprised classrooms, courtyard, multisports gym, hallways and the teachers' lounge. Besides the ethnographic conversations, interviews were carried out with 56 students, three teachers, one inspector and the educational coordinator. The intersectional approach privileged differences in gender, color/race, sexuality, religion and social class among students. This made it possible to reflect on the various social processes and hierarchies that encompass and constitute gender and sexual identities. These interactions enabled a broad discussion about sexuality, focusing on issues related to the changes experienced when entering adolescence; first-time experiences (kissing, dating, intercourse); perceptions about femininity and masculinity; gender socialization and sex education in the family, among peers and at school; and information about methods of prevention and contraception.

At the UBS, the observation focused on care offered to teenage girls and took place in the following areas: front desk, waiting area, meetings of "family planning" (emic term) and pregnant women groups, medical and nursing consultations and home visits by a family health team. One doctor, two nurses, one social worker and three community health agents were interviewed. The conversations and semi-structured interviews aimed to understand the approach to adolescent care, the singularities of their health needs and the kind of feedback provided by the service. However, visits by adolescents were restricted to pregnancy tests and prenatal care. The monitoring of home visits did not prove to be relevant beyond the lectures on sex education at school, which highlighted the professional behavior of instruction of norms and values related to gender and sexuality.

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The project was submitted to and approved by the Research Ethics Committee of the School of Public Health of the University of São Paulo (CAEE number 10382018.7.0000.5421). Fictitious names are used in the text, when necessary, to preserve the participants' anonymity.

"Do you want to waste your life?": moralities in primary health care for teenage girls

In addition to the school environment, educational actions involve procedures based on process technologies, which are able to promote sexual and reproductive health in the UBS. They include pregnancy tests, Pap smears, nursing care for women, reproductive and prenatal planning, educational groups, home visits and lectures in schools or communities (Brasil, 2013). This educational conversation may involve a more emancipatory approach based on the understanding of individuals and of the relationships and circumstances that define their affective-sexual life. Alongside the offer of inputs, dialogue on prevention aims to raise awareness and mobilize people. It is a step in the development of individuals' autonomy, as they jointly decode the daily difficulties and possibilities of promoting their sexual health (Bellenzani, Santos, & Paiva, 2012).

Adolescents normally visited the UBS for pregnancy and HIV tests only, when they were offered some educational guidance. This was usually in the form of "advice," trying to stir in the girls a sense of responsibility to no longer put themselves at "risk." We cite here two emblematic cases observed in the "reception" sector of the primary care facility. In the first, Daniela, 12, was already "dating"; her mother "more or less knew," because she "suspected." Such early sexual practice constituted an inescapable "irrationality": after the girl had left, the nursing assistant commented: "Having intercourse so early, it's a matter of time. She'll soon show up here pregnant." Despite being so young, the girl should have been referred to the nurse and then to the "family planning" course offered by the center as a requirement to obtain (and learn about) contraceptive methods.

In the second occurrence selected, in providing care to a 15-year-old girl, the nurse recommended the use of the three-month injection and condoms and pointed out: "You cannot be careless, you have to be more responsible for yourself, it's your life! Do you want to waste, throw your life away?" The girl remained silent, listening with apparent shyness to those

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"recommendations." In the post-pregnancy test referrals and in the reproductive planning group (consisting of three sections), educational intervention was aimed at prescribing "self-control of desires" through sexual abstinence or the postponement of the first intercourse. However, the explanation about contraceptive methods provided no information about the main advantages, contraindications and limitations, basically consisting of advice in an accusatory tone such as "the injection is more practical if you keep forgetting to take the pill" or "you can't relax, thinking nothing will happen to you. You are special, right? You have immunity (smiling)." In one of the sessions of the reproductive planning group, the participation of three adolescents prompted a few specific explanations. The nurse showed slides depicting the benefits of dating with images of couples romantically kissing, hugging, holding hands. The background song was "Love and Sex" by Rita Lee. This song summarizes the nature of love, relating it to something serious and responsible, difficult to find and hold on to, and which therefore requires self-governing behavior, compliant with social rules, while sex is symbolized by contingencies and lack of control.

Being "romantic" is shown as a preliminary way of exercising sexual restraint. This adjective/attribute bears the responsibility of waiting for/recognizing the ideal moment and partner for the first sexual intercourse. Criticism of sexual intercourse for hedonistic reasons is usually more intense among girls, to the point of reproducing prejudiced, sexist ideas that demean them (Vidal & Ribeiro, 2008; Medeiros et al., 2016). Although virginity was not valued in the context in question, its moral repercussions persist in the idealization of young love (Heilborn et al., 2006). Most of the girls expressed fear that made them try to repress their desire for sexual intercourse: "I have a lot of desire, I really want it, I keep thinking about all the time, but it's not right, it's sinful" (Mila, 15 years old); "I have a boyfriend, but I'm afraid he'll leave me later" (Pilar, 15 years old); "I tried, but I couldn't do it because I had that bad feeling. . . Imagine doing it now and later not being able to get another boyfriend because I'm no longer a virgin" (Isabela, 16 years old).

Even the teenagers who mentioned pleasure were faced with the idea of sex as "wrong," "sinful," showing ambivalence between what they feel and what they think is correct in relation to sexual intercourse. Experiencing desire as threatening is a dilemma for the "good girl," a stereotype that undermines the position of teenage girls as sexual individuals, leading to a notion of gender mediated by self-perception formed from the viewpoint of boys (Tolman, 2005).

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"Unwanted" pregnancy was a recurring theme. The meetings of the reproductive planning group were viewed by the professionals as "an opportunity to learn to guide and control behavior, not only in terms of sex. . . building such capacity is essential." Emphasizing the discourse of teenage pregnancy as a disrupting factor in life aimed to establish an attitude of rationality and self-control that is necessary for girls. Internalizing risks is seen as edifying for behavioral changes:

> [. . .] pregnancy compromises your life. Having a child in adolescence represents a lot of bad things. When the child is born, everyone is happy, there are a lot of visitors, but friends gradually drift away because the mother has to take care of the child, she can't hang out with them. . . Besides, most of the time, teenagers who become parents drop out of school. And without an education, you're NO-THING. . . If it's hard enough to get a job, a good college by studying, imagine then. . . (nurse)

The difficulty of talking about sex and the tendency to judge the sexual behavior of adolescents in health care are serious barriers for young people to access these services and obstacles to actual health promotion (Conceição & Costa, 2017; Silva & Borba, 2018). Voicing moralistic comments/advice about female behavior prevents youngsters from feeling effectively supported in health services, for example. The lack of sympathetic dialogue about the conditions of the relationship experienced by girls, the method adopted (or not) and how it is effectively used withholds information about more effective alternatives for their lifestyle that lead to more appropriate contraceptive planning (Bellenzani, Santos, & Paiva, 2012; Brasil, 2013). Studies have shown that encouraging sexual abstinence and instilling fear of the risks of sexual intercourse are inefficient strategies against teenage pregnancy, while educational support for female sexuality results in more active, safe and pleasurable sexual experiences (Schalet, 2011; Magalhães & Ribeiro, 2014).

The home visit – a potential resource of support and attentive listening to adolescents and a unique opportunity to provide adequate information and referral – was directed to the so-called priority groups (Oliveira, Carvalho, & Silva, 2008) and generally occurred during school hours. The approach to adolescents was restricted to visits to mothers and newborn babies, and feedback was limited to requests for examinations or curative procedures performed by adult mothers for their children. The health center's "teenage group" was regularly discontinued, depending on the psychologist's position being filled and on the latter's initiative to revive it and

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work to "cultivate" participants. One year of observation in the neighborhood clearly revealed the interdependence between the frequency of meetings and the lack of participants.

Regarding structural conditions, staff shortage, work overload and excessive bureaucracy (increased by the high number of programs in place) stand out, resulting in priority of curative and care services given to "urgent assistance to pregnant women, small children and older adults" (Oliveira, Carvalho, & Silva, 2008; Farias et al., 2016; Chiari et al., 2018).

The implementation of specific care for adolescents based on health education has come up against other obstacles. Introducing intersectoral practices involving education and health is still a challenge, as is the poor coordination between frontline workers and management (at the various governmental levels), resulting in a mismatch between formal adherence and the activities carried out in programs aimed at teenagers/youth. Such hierarchical organization with poor intercommunication also affects knowledge about the programs and their goals, influencing the implementation of educational practices (Farias et al., 2016; Sousa, Esperidião, & Medina, 2017; Chiari et al., 2018).

(Mis)encounter in the school and the reification of heteronormativity

Despite the various actions provided by PSE, visits by family health teams to schools were limited to vaccination campaigns and, when requested, to lectures on "sexuality in adolescence." Four of these encounters were observed.

In the first, a nurse and three community agents were welcomed by the school coordinator. "Early pregnancy" was claimed to be one of the problems faced by the school. He defined the students as a "risk group," "especially those in 9th grade [aged 14 to 16]" and, as an example, described the case of a "13-year-old girl who had a child with another student, aged 15." In the conversation, the nurse then mentioned a girl she had seen regarding a pregnancy test, which was negative. She was 12 years old and wanted to get pregnant. Both the school and health center staff thought it inconceivable that "people so young" might intentionally want to have children. The coordinator believed that "having several of these lectures is necessary to try to solve these problems."

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The normative discourse of "wasted life" caused by teenage pregnancy prevailed in the lectures. This is associated with the social expectations of youth as a period dedicated to vocational training and social learning, which culminate in personal "maturity" and the inadequacy of reproduction at a young age (Heilborn et al., 2006; Medeiros et al., 2016; Santos, Guimarães, & Gama, 2016).

The presence at school of students who were mothers indicated changes caused by motherhood (although to different degrees and attenuated with the help of their own mothers) (Heilborn et al., 2006; Santos, Guimarães, & Gama, 2016). The experience of resuming their studies was erratic, marked by "a lot of difficulty," absenteeism and poor academic performance. They claimed they didn't want a second child, because "it's hard work, I could never imagine..." (Amanda, 15 years old).

This sociocultural context highlighted the empirical understanding – consensual among young people – that having a child in adolescence is "a lot of responsibility," "it will hinder you," "you won't be able to study." It also revealed a certain conformity to the reproduction of gender asymmetry in the responsibility of caring for children and the restrictions faced by adolescent mothers. As Sofia (15 years old, no children) argued: "Your mother can babysit so you can go out, but the bottom line is: you don't have a job, you're underage, it's very difficult [. . .] you'll have to look after your baby 24 hours a day until it's one year old. You won't be able to finish school, you'll have no future, you'll have no stable life. You'll just hang in there."

The discourse of the professionals on teenage pregnancy merely fed back into the traditionalist common sense that persisted in the daily lives of these girls, failing to contribute to the development of reflection, ideas and experiments that could support a practice of self-care:

> As you get older, what do you want to do? [answers: sex, sex!] Girls want to date, boys often want sex. That's the difference. [. . .] Your first sexual experience needs to be in your own time. When you're ready for it. Just because you're dating, it doesn't mean you must have intercourse. [. . .] It's in your own time. . . because if you get pregnant, do you think the child's father will stay with you? It happens sometimes, but it's rare. He stays for a year, the following year he's with another girl. Why? Because she has no child. She can hang out, and you can't [. . .] Nowadays, girls are more outgoing than boys [much excitement among girls]. Do you see any boys carrying babies up and down? No. [. . .] And I assist a lot of pregnant girls without the father. So don't be fooled. They won't stay with you just because they had a child with you. Don't be fooled. Think about it, a child is forever, a relationship ends. And worse, what if besides getting pregnancy, you caught an STD [sexually transmitted disease]? So, what would it be like? Not only pregnant, but with HIV. Geez, that would be the end, right? Your world would break apart (2nd lecture to a mixed audience of boys and girls).

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The boys' responsibility for having safer sex was never brought up in the reflections of these meetings. At the end of the two sections of the mixed-audience lecture, by decision of the school administration and the health professional, the boys returned to the classroom so that the girls could ask questions. The reason given was that "they feel embarrassed." The girls asked about the pill, the contraceptive implant and female condoms; there were no questions about STDs.

Although the lectures basically focused on girls, there was a difference in the slides that were shown exclusively to them. Early sexual initiation was addressed from the viewpoint of abortion, with uncomfortable images of fetuses that looked like tiny babies. The nurse did not use the word abortion or discuss issues related to this possibility, but the explanation aimed at making the girls accountable for getting pregnant culminated in the risk of "eliminating a human being." The presentation ended with slides, which raised repeated questions: "What do you want from life?", "Is this what you want for your life?", "What is your aim in life?", "What do you want to be when you grow up?", "What are your plans?" In the background, images of happy youngsters on trips or adventures such as jumping off a cliff into the sea.

This moral guidance becomes especially relevant when we consider the emphasis given to the male condom as the ideal contraceptive method for young people (Bellenzani, Santos, & Paiva, 2012; Vieira et al., 2014; Conceição & Costa, 2017). The male condom is "easily accessible, just come and get it [at the UBS]," said the nurse. Indeed, there was a condom dispenser attached to the wall in the access ramp to the consulting rooms and waiting area (corridors), a more "camouflaged" place, where people are coming and going. Female condoms were available from the pharmacy upon request to the sector's staff. Given that, as mentioned above, some of the girls had mixed ideas and feelings regarding the "desire to have sex," the barriers to obtaining possible contraceptives are yet another obstacle (Brandão, 2009).

Despite having announced that she would demonstrate the correct way to fit both condoms, the nurse ended up "forgetting" about the female condom in the mixed-audience lectures. When showing a sample, she said: "It's different from the boys' condom," to which a female student asked:

> Which is safer? [The nurse said:] The girls' one is safer, because it doesn't rip or break. Unlike the boys' condom, where if he [the partner] doesn't remove the air, it breaks, rips and comes off. Most boys don't know how to use a condom. So, prefer this one. If you're going to use the other one [male condom], because it's easier, fit it on him yourself.

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In addition to stressing its greater effectiveness, the nurse commented on an aspect that could have a positive impact on adherence: the female condom is supposedly "more comfortable for the penis, it doesn't squeeze it because it's wider. It adapts to the vagina." The safer contraceptive would also be appropriate to avoid a "turn-off" since it can be introduced before the beginning of sexual intercourse. As she had fewer samples, she decided not to distribute female condoms, only male ones. This option prevented the girls and boys from having the opportunity to try out a type of condom that is less known and accessible. And while the female condom may inspire a sense of greater freedom and decision-making power for girls, this type of approach was fairly restrained.

Adherence to contraceptive methods involves the notion of sexual negotiation between partners (Barbosa, 1999). The weight of sexual reputation continues to restrict the construction of an active sexuality by girls, as it remains signified as "depravity" (Guimarães & Cabral, 2019). The absence of a social discourse on pleasure and on the agency of girls in sexual decisions and intercourse affects relationship contexts (Schalet, 2011). Sexual practices among youngsters also represent a dynamic facet of the power relations and asymmetric symbolism between traditional patterns of masculinity and femininity (Nogueira, Saavedra, & Costa, 2008). Challenging social power relations leads to disassociating women from moralities and practices that produce passivity and submission in sexual intercourse and encounters. Communication and negotiation between partners require a shift in the social expectations regarding men in favor of a perception of joint responsibility. If, on the one hand, negotiation is based on female empowerment (Barbosa, 1999), on the other this process of increasing autonomy must be supported by a trend of (self) care in which both sexual individuals feel able to arbitrate and lead their own body towards a healthy relationship with themselves and with others (Guimarães & Lima, 2012).

The nurse's long explanation of contraceptive methods completely excluded the male role in contraception and prevention:

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> Sometimes you are ashamed of your boyfriend, ashamed of who you are dating, thinking "Ah, what will he think of me?" Don't be ashamed or think he has nothing. Because you don't know who he has been with, what his childhood was like, if he had any illnesses, if he had any other kind of relationship, and he passes it on to you. We had a case of a 15-year-old girl who contracted the HIV virus during her first sexual intercourse. In less than a year she died. But why did she die, because of the disease? Also. But she died because she got depressed. She got so depressed because it was her first boyfriend ever. She couldn't handle it. So you don't want to go through that, you can prevent it. Besides condoms, use contraceptives. We offer injections at the health center. There's an injection you have every three months or the pill (content recorded from the 2nd mixed-audience lecture).

The superficiality of these educational initiatives conforms with the non-recognition of adolescent sexuality and the reification of certain gender stereotypes. The unconsciousness of health professionals limits the effectiveness of educational practices for sexuality and the construction of youth autonomy. Practicing safe sex results from educational investment that affords tangibility and meaning to information (Guimarães & Lima, 2012). The conversations about sexuality that inspired greater engagement of adolescents referred to questions about experiences or situations related to sexual intercourse: "Can a girl get pregnant on the very first time?"; "What happens when the woman is menstruating and the man ejaculates inside?"; "A few days before the girl menstruates, is it easier for her to get pregnant ?"; "Is it okay to ejaculate at the entrance of the vagina during sex?"; "Can a woman have sex without a condom if she is taking medication?"; "Can you get pregnant after you stop taking contraceptives?"

One notes in such "sex education" lectures the absence of any mention to experiences of sexuality outside heterosexuality patterns. The processes of subjectification and identity building are not addressed, nor are their intersections with gender, sexuality, life context, race/color, among others. However, in a context outside the "educational meetings," the students reported psychic suffering stemming from doubts about sexual feelings and desires and in the very process in which they perceive themselves as "different" from heterosexual boys and girls (Magalhães & Ribeiro, 2014). Some of them also suffered from verbal and/or physical aggression by parents who did not accept them. "Fear of being beaten" and/or of being "thrown out of the house" generated "anxiety," "anger," "depression," "the desire to kill oneself," "to cut oneself". Care for the mental health of this group involves addressing the discourse of heteronormativity, their first sexual experiences and homophobic bullying:

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> I suffer a lot from it [being gay]. There are days when I don't want to get out of bed, there are days when I don't want to do anything, just stay in the dark room. [. . .] Now I've already accepted myself, but there was a time when I didn't speak of it [if a friend would ask]. I would avoid mentioning my sexuality, avoid people. I still avoid some people because it's a reason to become a laughing stock [. . .]. I have to be attracted to girls because the opposite is wrong, totally abhorrent, I'm a monster to society. Society acceptance is very complicated (Miguel, 15 years old).

The multiple ways of becoming a woman or a man point to new perspectives of pleasures and desires, forms of relationship and lifestyle (Louro, 2018). But there is a strong set of social conventions and knowledge that teach ways of being and disseminate the normalization and standardization of individuals and behaviors. At the same time, they produce a certain reference gap for those who escape hegemonic norms, which produces disorientation, suffering, and experiences of aggression and discrimination in relationships with peers and adults (Magalhães & Ribeiro, 2014; Silva & Borba, 2018). Adolescents who self-identified as bisexual reported feeling confused by their "undefined" feelings for both sexes; at 14 and 15 years old, they did not envisage "being able to have a life" in more flexible sexualized relationships. Likewise, those who self-identified as non-binary reported a feeling of instability in their experiences that "goes mixing things up, liking men and women things and not knowing where it will end up." Hence, they challenged family beliefs, especially religious ones, which they considered "prejudiced," "hypocritical" and conflicting with the current reality. The strain in the relationship with parents is summarized in the excerpts below:

> Agustina (14 years old): [...] as we change our way of thinking, we change our behavior and that generates totally different things in our nuclear family.
>
> Frederico (14 years old): And parents often don't understand our nuances, so they often end up drifting away a bit, being blunter.
>
> Agustina: They don't have a very open mind to understand us. . . to pause and try to get into our heads a little, try to understand us in a way that can help us and help them also.

A few conclusions on sexuality education

As provided in the PSE, educational actions should integrate health services, parents/guardians and the school community. However, what kind of pedagogy of sexuality is encouraged by those institutions? Their agents (family, health and education professionals) and

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adolescents clearly have different needs and demands. So, what kind of problematization is possible that would give a new meaning to moralities, behavioral expectations for adolescents and practices of control and restriction of the various expressions of sexuality in such spaces?

An initiative of support/preparation for sexuality necessarily involves capacitating health and education professionals to dialogue with the practical knowledge of people and groups, offering elements that can make sense in their cultural universe and life projects (Lopes et al., 2011; Silva & Borba, 2018; Silva, 2019). Adolescence experiences were signified from a gendered differentiation that reproduces hegemonic narratives of the naturalness of gender binarism and ideological discourses about how certain practices and positions are supposedly inherent to men or women. For example, if for boys puberty is a milestone of becoming a man and the advent of youth enjoyment, for girls it brings a fragile and limiting body, essentialized by the effects of menstruation and PMS (premenstrual syndrome). Commonly, educational practices (at school, home, health services) consider sexual differences based on the biological organism (hormones, male and female physiologies, etc.) to reference/justify social differences produced in the body, such as variations in skills, cognitive patterns and sexuality(ies) (Fausto-Sterling, 2020). This interpretation gives rise to categorizations based on normative predicates and moral behaviors used to contrast groups of people and shape a certain gender ideology (Evaldsson, 2005). This discussion is particularly important, as it is in early adolescence that girls and boys start to diverge most strongly in terms of independence, mobility, schooling and household responsibilities (Ribeiro, 2006; Mmari et al., 2018).

In age transition, rites of passage, first-time experiences (kissing, dating, sexual intercourse) and status modifications lead to changes in subjectivities (Bozon, 1997; Heilborn et al., 2006; Moreau et al., 2019). It is about learning certain cultural codes that guide standards and behavior for becoming a woman or a man. In the wake of this transition, fast body development and the first affective-sexual experiments can bring about mental health issues related to "low self-esteem", self-mutilation and "depression" for those who do not fit the pattern of heterosexual attractiveness (especially reported by black girls).

Gender diversity is a social issue guided by practical learning of concepts of equality and human rights (Braga et al., 2018; Renold, 2018). Integrating the right to health with human rights requires introducing new values, moving towards the demarcation of respect for differences. The focus on gender as a social construction is transfigured into gender as identity, stereotypes and expectations, popular culture, forms of violence(s). . . It should be noted that sexuality education becomes part of the process of education for life by encouraging learning that enables

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young people to develop awareness of self and their surroundings. It therefore favors the development of adolescents as individuals who think, feel and have autonomy.

It is therefore urgent to design public policies and actions for and with youngsters based on the perspective of sexuality education, which includes accurate reflection on sexual rights and related responsibilities, as well as on the processes of differentiation and stigmatization founded on social, racial, sexual, generational and regional hierarchies, among others. In other words, actions and initiatives for sexuality education must provide safe spaces and support networks that lead to non-compliance and gender openness. This implies exploring the foundations not only of the divergence of conceptions, practices and values between generations, but also of the very notion of youth as a preparatory stage for a future guided by adults or institutions based on *pre-established norms and rules*. (Pais, 2003).

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