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Adolescent males in the City of Buenos Aires: gender-based barriers to health care and prevention

Varones adolescentes en la Ciudad de Buenos Aires: barreras de género en la prevención y atención de la salud

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ABSTRACT This study is based on our previous work, in which we found evidence of the difficulties in including the experiences and needs of adolescent males in the design of clinical models aimed at that age group. We identified a need to explore the subjective dimension of gender in the practices of the healthcare sector directed at adolescent males, in order to determine if they constituted barriers to advancement in this field. Semi-structured interviews were conducted with 21 professionals from different disciplines who made up healthcare teams, as well as 14 adolescent males using healthcare services in the City of Buenos Aires. Additionally, group techniques were employed with adolescent male secondary school students, and in-depth interviews were conducted with key informants. We were able to determine that institutional dynamics do not adequately respond to the risks faced by adolescent males – for whom hegemonic constructions of gender play an important role – given that they are based on exclusionary biopolitical paradigms.

KEY WORDS Gender and Health; Masculinity; Adolescents; Adolescent Health Services; Argentina.

RESUMEN La presente investigación surge a partir de identificar la dificultad para incluir las experiencias y necesidades de los varones adolescentes en el diseño de los modelos clínicos dirigidos a esa franja etaria y etapa vital. Por tal motivo, se decidió indagar la dimensión subjetiva de género en las prácticas que el sector salud dirige a la prevención y atención de la salud de los varones adolescentes, con el objetivo de visibilizar si estas se convierten en barreras para el avance en este campo. Para ello, se realizaron entrevistas semiestructuradas a 21 profesionales de distintas disciplinas integrantes de equipos de salud y a 14 varones adolescentes usuarios del sistema de salud de la Ciudad Autónoma de Buenos Aires; además se implementaron dispositivos grupales de indagación a adolescentes varones estudiantes de escuela secundaria, y se realizaron entrevistas en profundidad a informantes claves. Se ha identificado que las propias dinámicas institucionales no responden de modo adecuado a los riesgos que enfrentan los varones adolescentes –dentro de los cuales las construcciones hegemónicas de género cumplen un importante papel– ya que están ancladas en paradigmas biopolíticos de exclusión.

PALABRAS CLAVES Género y Salud; Masculinidad; Adolescente; Servicios de Salud del Adolescente; Argentina.

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INTRODUCTION

Based on the results obtained from a previous work entitled "Gender equality in health care quality for adolescents" ["*Equidad de género en la calidad de atención en adolescencia*"],[1,2] we found out that there are difficulties in including adolescent males' experiences and needs in the design of clinical models aimed at that age group and that stage of life. Regarding the subjective dimension of gender, it was not found sufficiently visible and applied to the practices of the health care sector, whose work is to control and treat adolescent males. The abovementioned investigation could prove that there is gender inequality in the quality of the medical attention that teenagers receive in the health sector. For example, the group of people that make more use of the health system is made up of women and the professional team has little impact on efforts to change the situation regarding men. This supports the traditional values of gender that society establishes, which are also promoted by the health care sector; however, this logic of taking care of our body is mostly applied to adolescent females, considering males in second place.[2]

Our research problem is focused on the invisibility of elements in the subjective dimension of gender applied to health care practices related to adolescent males. In this sense, the connection between health services and male patients could be translated into accessibility barriers to men.

The objectives of this investigation are, on one hand, to update the state of the literature on adolescent males' health from a point of view concerning gender, public health, and subjectivity; and, on the other hand, to develop supplies to take preventive actions in this field from a perspective related to the right to health and gender, in order to apply them to strategies of health personnel training. In this way, we hope we will be able to provide useful knowledge for prevention and development of effective and appropriate interventions. We also hope this information will be useful in order to institute tools for gender transversality in health public policies, directed at prevention, promotion, and treatment of adolescent males' health, so that these tools have an impact on their following stages of life.

Different actions or specific objectives emerge from the objectives described above, such as identifying and analyzing the professional imaginaries about adolescent males, their needs, and their types of healthcare demands.

Experts do not usually acknowledge when their actions are based on their professional imaginaries, which are universes of meaning or naturalizations that rule different systems of beliefs, theoretical convictions, and/or techniques that shape values, sensitivities, ethical and esthetical criteria, behavioral and/or attitudinal patterns of their daily way of acting and/or thinking as professionals in a specific historical and cultural event. It is important to recognize these professional imaginaries since experts usually believe that they only act according to their scientific knowledge. It is also necessary to identify and analyze whether professionals consider the particular risks that adolescent males take regarding the identification of epidemiological issues, types of consultation, models of prevention and treatment, from a comprehensive approach to the matter that includes a gender and subjectivity perspective.

Furthermore, it is significant to recognize the imaginaries, particular risks, and practices of adolescent males in their daily lives according to the impact these may have in their integral healthcare and their interaction with the health system. It is also important to know and study, from the perspective of adolescent male patients and potential male patients, the actions that the healthcare system may take in response to their health difficulties.

As opposed to previous works published by the team,[3] this article contains the preliminary results obtained from the analysis of data collected through three research techniques: semi-structured interviews, in-depth interviews with the key informant, and group techniques for inquiry purposes.

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

The research titled "Gender barriers in prevention and treatment aimed at male adolescents' health care: meanings and practices by patients and health care professionals" ["*Barreras de género en la prevención y atención de la salud de los varones adolescentes: significados y prácticas de usuarios y de profesionales de la salud*"] belongs to UBACyT 17/19 [a list of programs owned by the Department of Science and Technique at the University of Buenos Aires]. This investigation theme is a continuation of previous works conducted by the same team, who studied gender equality in health care quality for children and adolescents.

State of the literature on the problem area under analysis

According to different innovative authors on masculinity,[4,5] men considered as the "subjects" who consolidated the universal human being that belongs to the Modern Era, remain neglected when it comes to their practices and true needs. Although there has been significant progress on scientific production regarding health care and masculinity,[6,7,8,9] the current understanding of difficulties related to male vulnerability and their health-illness-care processes does not include all their experiences and their particular problems, beyond potential consequences in the work field or, in the case of adolescents, the preparation they need in order to be part of that area in the future.[9,10,11]

As noted by De Keijzer,[10] there is a model of hegemonic masculinity that gives rise to a mainly dominant subjectivity reflected in the discrimination against women and their submission, and some men who cannot adapt to such model. This type of hegemonic socialization system shows evident advantages that men have; however, as time goes by, this stereotype entails risks regarding health care along three main courses: a) women and children at risk: concerning gender violence, child sexual abuse, imposed pregnancy and lack of male involvement in contraception methods; b) men at risk: through authentication of jibe, pressure, and violence; c) at risk to oneself: when boldness is shown as a proof of masculinity, danger levels increase regarding child injury. In this sense, some male behaviors, considered authentic and even "expected", place men in vulnerable situations such as accidents, problematic alcohol and drug use,[12] violence, or lack of self-care of their own bodies. Roles and stereotypes of gender drive them to deny their health conditions, without showing any sign of vulnerability,[14] and it is also difficult for them to ask for help or take self-care actions.[10,15]

Adolescence is a key period in their human development. In this vital stage, risky and protective behaviors begin to appear, which will have an extensive impact on men's health, because of their effects in their future adult life.[16,17,18] In epidemiological terms, studies conducted in the region show that mortality is higher among adolescent males than adolescent females. They do not take an active part in activities concerning primary self-care, their levels of unmet health needs are higher than with women, they rarely have a stable source to give them access to the health care system, it is unlikely for men to have made an appointment with a health professional over the past 12 months, but they are more likely to have used urgent consultation services in their medical history over the last 12 months.[19] Since they are adolescents, men make less use of the health system; and the campaigns aimed at them do not seem to have much impact at the time of adopting preventing health care actions or when they actively make a consultation because of the most prevalent health conditions that affect this society.[20]

In this way, mortality due to external causes (such as homicide, suicide and accidents) represents an issue of great epidemiological importance in the health care sector, both globally and nationally. It constitutes the main cause of death for adolescent males and young men aged 15 and 25 years, accounting for 5.6 men per 1 woman.[21,22] Suicide constitutes the second main cause of death in Argentina, among young people aged 15 to 24

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

years, accounting for 4 men per 1 woman.[23] International studies have proven that, in homosexual adolescents, this risk increases, because of stigma, discrimination, the different ways of violence they suffer from (verbal, physical, and sexual violence), the absence of social support, and the barriers that they encounter when they need to have access and make use of the health services, among other troubles.[24] This problem gives rise to the phenomenon known as *"excess young adult male mortality,"*[25] which mostly portrays the difference in life expectancy among men and women[26] when they are born. Therefore, it is a must to prioritize the suicide prevention programs regarding public health and public policy worldwide, also to raise awareness about suicide as a matter of public health.[17]

On the subject of sexual and reproductive health, in the construction and maintenance of identity, the traditional sexual performance is a key element for adolescent males and the reproductive processes are not as relevant as sexuality.[13,14] In general, men rarely resort to health care services, unless they need to make use of them in cases of extreme urgency, but they do not do it in a preventive way.[27] Most men gather information about sexually transmitted diseases through social media, relatives and, as a last resort, they decide to search for medical advice.[28] This shows the importance of offering them help to develop a procreative consciousness; in this way, they can see themselves as sexual human beings, who are capable of creating human life and protecting their own health and wellness, so they can also protect their partners and future children.[29] Similarly, it becomes essential to design and implement comprehensive plans of general health as well as sexual and reproductive health, especially for this population group.[30,31]

Adolescence also constitutes a period of exploration and self-discovery, where awareness and understanding of gender identity and sexual orientation starts to develop. At present, fixed or permanent identity categories, such as "heterosexual," "gay," or "lesbian," are meaningless for adolescents, who prefer "fluency" instead of "classifying" themselves.[32,33] In addition, self-description of identity does not exactly match their practices and/or imagination.[34,35] Despite this, at this time, and considering the Argentine context, there is a tendency to make an increasingly earlier diagnosis regarding "gender dysphoria," especially in adolescence. This theory has not been scientifically proven yet, its ideological grounds have been refuted and criticized by the transsexual population, since they do not classify themselves in a determined identity; but they do understand their identity as an exploration and a transition between both genders and others. These are elements that should be considered by health professionals in order to offer them adequate medical attention.[36,37]

It has been established that the costs of physical and emotional dominant gender codes are not clear for male adolescents. There are not enough spaces or opportunities to ask questions and express their frustration, or even report situations of physical and symbolic violence in which they are involved; on the other hand, they do not usually notice how gender representations affect other dimensions of their lives.[13] Moreover, there are different obstacles in the health sector, such as professionals who are not well-trained to treat male patients and the absence of specific models, programs, and resources directed at self-care and health prevention in adolescent males,[3,13,14,38] from a gender perspective.

There is an international consensus that confirms this need of including gender perspective, along an individual's life cycle, in the promotion of health and medical attention,[39,40] since adolescence is an essential stage in this cycle. Adding a gender perspective means to consider two main elements: a) gender specificity: knowing the particular needs that young men have concerning health and development in their socialization process, that is, for example, assisting them to get involved in discussions about the use of drugs or risky behaviors, helping them to critically understand why they feel pushed to act in different ways, among other activities; b) gender equality: inviting men to take part in

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

the discussion and the reflection about gender hierarchy, so as to guide them to accept their responsibility in the care that children need, in connection with reproductive health and household chores.[13] Additionally, it is necessary to include the contributions of the subjectivity field,[41] in its gender dimensions,[9,42] and add the notion of *"ways to subjectivize gender,"* that came from research studies on gender and psychoanalysis.[9,43] This idea is crucial to understand the early composition of values, requests, veracities, methods of unfolding motivation, distinguishing self-esteem standards for men and women connected with differentiation ways by gender in the psyche construction,[44] that have differential consequences on the health-condition-care process of those who belong this gender group.[45]

Health promotion public policies lose impact in the male adolescent population by not considering the modalities in which hegemonic masculinity, as an ideal, drives men to participate in risks in which they end up being involved.[9] The possibility of adolescents leaving behind a risky behavior is closely related to the possibility of being offered satisfaction options that have proven valuable to them.[16] One of the current challenges is to transfer the results obtained from these studies to the health care systems in order to include them in the models of prevention and medical attention for adolescent males, a challenge that this research attempts to address. This will be a contribution to improve preventive policies in the short and long term, also to get more efficiency in the long term, since, among other issues, precaution is better than regret (and less expensive, in economic terms).[1]

Hypothesis

As mentioned in the introduction, the objective of this research is focused on the invisible elements of the subjective dimension of gender in health practices aimed at the prevention and treatment of adolescent males. In this sense, the connection between health care services and male patients could be translated into different accessibility barriers to men. Therefore, the following samples are the grounds for the productions and investigations carried out by this team and literature examined,

- There may be a slant on identifying the different ways men can get sick, their medical consultations and the treatment they receive, which would be barriers when it comes to prevention and providing medical attention to this specific group.
- Lack of gender perspective in the models of medical consultation and the way health is addressed in male adolescent patients may hide the complexities presented by their specific and differential bio-psycho-social needs.
- Gender prejudice would be reflected in the ways of disseminating preventive health actions, which may restrict the efficiency of specific risk prevention in adolescent males.
- There would be deficiencies when it comes to the identification and promotion of the early "masculinity as a risk factor," which may become reinforced in the adolescence stage and which may endanger men and reveal their vulnerabilities, particularly related to hegemonic masculinity in their future stages of life.

METHOD

Research approach and method design

Specialized literature shows that there is no method innovation regarding research designs and the emphasis on epidemiological studies[24]; therefore, there are scarce qualitative and participation researches to better understand problematic phenomena in adolescent males. Furthermore, most of the studies on the adolescent population demonstrate an adult-centered bias, where the discussion is held with adults "about" adolescents instead of holding a discussion "with adolescents about themselves."[46,47] In fact, some

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

information obtained from the Program UBACyT 2013/16 titled "Gender equality in the quality of medical consultation in adolescent patients" [*"Equidad de género en la calidad de atención en adolescencia"*] reveals that there is no involvement and participation in adolescent males concerning their own self-care and other's health care. Considering this information, it is a must to carry out a qualitative and participatory study[48,49] that promotes a stance of a man capable of managing himself, in order to contribute to the development of public policy and programs that recognize adolescent and young population regarding their citizenship and their ability to position themselves as strategic individuals.[16,39,40]

This research has applied an open, adaptable, and emerging method of examination and understanding to provide a more exhaustive investigation in this area that has not been studied thoroughly. In this way, it will adjust to the new knowledge that will come out from this phenomenon being studied. The sample we will present is non-probabilistic and intentional.

Participants and investigation techniques

The fieldwork includes, at this stage, 21 interviews with professionals of different disciplines and 14 interviews with adolescent males that make use of the adolescent services at a public hospital, a health care and community action center, and a community hospital located in the City of Buenos Aires. Additionally, two research mechanisms were applied to male adolescents from a state-owned secondary school.

The participants of the research that shape the analysis units are health professionals, male patients of the health care system aged 15 to 19 years, and secondary school male students of the same age. This age group has been chosen according to the hypothesis concerning the lack of medical consultations by adolescent males within the health system, and the need of providing them with more information than they have as members of the general population, their social imaginaries about their own health, and the response they receive from the health system.

We have been working in this field in the City of Buenos Aires since 2018 in the adolescent services provided by five health care sectors: two public hospitals, two health care and community action centers (related to primary care) and a community hospital. Similarly, we have developed group mechanisms of investigation in a state-owned secondary school and, shortly, we will start the interview process in a private school.

The information was gathered from semi-structured interviews with professionals who are part of health teams specializing in adolescence and male patients of the health care system; group research mechanisms aimed at male adolescent students from secondary school; in-depth interviews with key informants.

During the interviews with professionals who are part of health teams specializing in adolescence, the objective was to identify critical matters in health care preventive messages and health promotion, as well as aspects in the mechanisms applied to medical consultations for adolescent health that may be material and symbolic accessibility barriers to the health care system directed at adolescent males. The individuals we interviewed, who are key informants, were chosen purposely so they could guide the main ideas of this investigation, concerning their areas of expertise, practice, or responsibility. It should be noted that the main ideas addressed in this investigation are: 1) Differential epidemiology; 2) Problematic drinking and drugs; 3) Violence; 4) Nutrition; 5) Sexual and reproductive health care; and 6) Gender identity.

Based on the semi-structured interviews, we searched for present advances and challenges in the preventing health approach and the treatment of adolescent males from a masculinity and gender perspective; the local situation of the preventive point of view and the treatment that this group of people may receive; the importance of including a gender

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

perspective; the subjective dimension of prevention and treatment of male adolescents' health care.

The main purpose of individual semi-structured interviews with adolescent male patients was to identify the causes of their medical consultations and the frequent use of the health system by young men. We examined the models of medical attention of the professionals they had visited and whether they had received the right information on how they could have a healthy lifestyle. We also looked into imaginaries regarding the health risks to which they were exposed, if they considered themselves prone to illness or have an accident related to a recreational activity, and their knowledge level on preventive messages concerning health conditions.

Through their participation, we searched for their perceptions and imaginaries on material and/or symbolic health care access barriers when they suffer from health problems; and tried to obtain sociodemographic data and information on their educational enrolment.

In the design of our research method, group mechanisms were applied to male students from secondary school (as current patients or potential patients that will make use of the health care system) as a way of navigating through the difficulties that may appear if they attend these services. In addition, we tried to find out when they make use of the health services, the reasons why they decide to make an appointment, how many times a year they do it and the frequency they consider appropriate to check up on their health. Moreover, we looked into the answers they received from the professionals in every medical appointment, the understanding of the health risks they were exposed to, if they consider themselves prone to illness or have an accident related to recreational activities, sports, or others. Our aim was also to study their imaginaries on sexuality, sexual health, reproduction, problematic drinking and drug use; actions referring to knowledge of their own health conditions; the understanding they had of preventive health messages aimed at young men about the connection between lifestyles and behaviors and their health risks, as provided by professionals, the media and the government; and what they understood by material and/or symbolic access barriers within health care services. We will present in this article the preliminary results obtained from individual interviews and group mechanisms applied to educational institutions.

Ethical considerations

In order to protect ethical aspects in our research, we asked every person interviewed to sign their informed consent under the recommendations set forth by Helsinki's protocol for investigations on human health care. In addition, it is important to highlight that this investigation has had ethical support from the University of Buenos Aires from the date the project was approved.

Considering that adolescents take part in this research, ethics is essential in this investigation, from the design of the project to its whole performance.[50] As this is inclusive and participatory research, adolescents' rights are protected while being conducted.[46,51] In line with this, the investigation tools were designed for the purpose of identifying and solving aspects and ethical problems involved, such as the balance of power differences among the research team and the participating adolescents. Informed consents signed by adolescents and the adults who were in charge of them were required, as requested by the progressive autonomy paradigm. They were adapted to the particular characteristics of the participants, considering and respecting their eventual refusal to continue or take part in the investigation. At all times, we took actions intended at protecting their willingness, confidentiality, and anonymity.

Through agreements made with health services and the use of informed consent, it was possible to interview adolescent male patients, who were given specific information about this research and were asked to take part. While conducting the interview in the waiting room of the sector used for adolescence matters, all the pertinent arrangements

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

were made to offer them privacy; we agreed to interrupt the interview if the patient was called to his medical consultation and, whenever possible or if the patient was interested, the interview would be resumed.

In the research group mechanisms applied to state-owned schools, through the use of informed consent designed for this research, we agreed to frame this work with the authorities, teachers, and male students, so the same principles were guaranteed.

Knowledge transfer activities

As stated above, one of the objectives of this research is connected with the transfer of results to health care services. In order to accomplish that purpose, we will prepare workshops for the health professionals that took part in this investigation. In this sense, some of the supplies needed for this research and a previous one carried out by this team (Program UBACyT 13/16: "Gender equality in the quality of the medical consultation received by adolescents" [*"Equidad de Género en la Calidad de Atención en Adolescencia"*] are now being used for different activities in high schools and pre-university schools located in the City of Buenos Aires. These activities deal with difficulties found in the educational sphere: bullying, abusive sexual behaviors from adolescents to their own female classmates, and ways that teenagers use to denounce these circumstances in public.[52] Also, we worked in places where it was possible to have a professional exchange, in a center for mental health and in an academic institute, where people are starting to be aware of the subjective dimension of gender and the difficulties detected during adolescence are being studied as well.

Finally, the research team that is in charge of the actions taken by the educational area receives constant feedback from every contribution resulting from the fieldwork; therefore, we encourage the Psychology students that take the course "Introduction to the Study of Gender" at the University of Buenos Aires to acquire updated information on matters related to health, mental health, gender and, subjectivity.

PRELIMINARY RESULTS

Next, we will provide the first results on our central ideas: differential epidemiology, problematic drinking and drug use, sexual and reproductive health, and nutrition, which were obtained from the interviews with health professionals. In addition, an analysis is presented regarding primary information acquired from the individual interviews with people that make use of the health system and also from the research group mechanisms applied to adolescent males that go to state-owned schools in the City of Buenos Aires.

Attendance and absence of adolescent males at medical consultations

The professionals that took part in the interviews mostly observed that male adolescents do not usually make appointments in health care centers; they only arrange a medical consultation if they need a "health certificate" to prove they are physically capable of doing physical activity. Some professionals take advantage of this motive as a "unique opportunity" to check their health, knowing that male adolescents would not ask for a medical checkup on their own. Social determinants for "being a man" and the role of women in the health care system (health care centers are usually attended by mothers and women who take their partners or accompany them) are some of the usual answers given by the professionals. One of them states the following,

> *... the social determinant that affirms that men are stronger, that they need fewer medical examinations, that it is not typical of a "macho image" to take care of their health: the man that decides to visit the doctor has issues or is weak, that is*

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

> *also a strong social determinant, and this view is getting increasingly stronger.* (Community hospital pediatrician).

Based on the preliminary information obtained from the interviews with the adolescents taking part in this study, we inferred that just a few men make medical appointments, which can be understood as a difficulty and an obstacle for our fieldwork. Therefore, we decided to look for them in the educational spheres where they study, and thanks to their enrollment rates, we could inquire about their experiences concerning health care services.

When we interviewed these users and asked them about medical consultations, most of them agreed on the theory suggested by the professionals: that they make use of the health care services when they need a "good health certificate" to prove they are physically capable of doing physical activity. However, we must underline the fact that some patients do make medical appointments in order to request a check-up or a medical examination depending on their particular conditions:

> *... I visit the doctor to check my health, just in case I'm ill or at risk, that's why I come here. The treatments I decide to have, which are rare, have to do with my blood tests and that stuff.* (Seventeen-year-old adolescent male, a public hospital user).

> *... I go to the doctor's to check my backbone, my skin, sometimes I visit a dermatologist, and I also check my inner ear.* (Sixteen-year-old adolescent male, community hospital user).

At school, boys agree on the fact that their mothers encourage them to make medical consultations, and it has been proven that most of the consultations are made by people who have private medical insurance (provided for workers under an employment contract).

The responses given by the patients and the professionals interviewed lead us to think that males' decisions to ask for consultations are influenced by women. Without women's encouragement, the number of medical consultations made by men decreases, and the main reason for consultation by them is the request of a "good health certificate" for physical activity. Only a reduced number of medical consultations have to do with physical issues, related to accidents, or for aesthetic reasons, or sports check-ups. That is to say, it could be affirmed that, in most cases, men attend health care centers if they are encouraged by an external factor: they make medical appointments if a woman takes them or goes with them, if an institution requires them to do so, or if they are suffering from pain or a severe physical due to accidents. This proves the lack of interest and inactive attitude that adolescent males have concerning their health care.

Another reason why adolescent males make use of the health care system derives from their attendance to emergency rooms due to traumas and different types of emergencies, regarding dangerous situations. Professionals come across accidents, problematic consumption, drinking and drug use, violence, absence of health self-care as behaviors prevailing in men, leading to serious consequences in their health. These actions and authentic behaviors are accepted as being an integral part of social masculinity, they place them in a position of particular vulnerability.[53]

In this sense, when we asked adolescent patients about the risk involved in accidents and situations involving fighting, most of them replied that those characteristics are typical of being "a man" and being also related to social mandates:

> *Yes, I've heard it many times, I've been told that if someone hits me I have to hit them back* [...] *because if I don't, then I'm a tattletale and a coward.* (Sixteen-year-old adolescent male, community hospital user).

> *Men tend to be more aggressive, so they solve everything in an aggressive way. That's why... but so do women.*

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

(Sixteen-year-old adolescent male, user of community health care center).

These users of the health care system often acknowledge the fact they, as well as their male friends and acquaintances, are exposed to and expose themselves to situations involving violence; however, they admit that the same problem applies to women. Based on the collected facts, it is interesting to restudy these particular answers, since users seem to question the traditional stereotype of femininity.[9]

Furthermore, adolescent males explained that exposure to these situations *"depends on the person."* What usually matters is individuality; however, violence known as a behavior required as a result of hegemonic masculinity is not acknowledged. Other adolescents talked about their exposure to fights, for example, *"I fight in the sports club."* In this way, sports appear as a method of showing masculinity[54]; they shape identity around defending the "honor of the colors of their team," their belonging to a certain group or team, and their rivalry with those who do not.

In the answers given by these users, the use of force and body play an important part in this fighting service as a way of acting to authenticate and/or protect hegemonic masculinity. In this regard, De Keijzer[10] maintains that hegemonic masculinity has three points of risk. Risk to peers and to oneself are the most important points. Risk to peers has to do with the validation of violent actions, which are of great contribution as an essential, albeit insufficient, characteristic of the male stereotype. The second risk reveals the negative side of the first one: hegemonic masculinity involves a risk to other men but also to themselves as individuals. That is, "using your body" for violent actions would mean "offering your bodies" in order to prove their masculinity, so it would also alternate between being the risk and putting themselves at risk, where health self-care ends up being unimportant.

Similarly, when we asked the professionals if they considered in their practices the particular risks faced by adolescent males in the models of health care and precaution, they noticed that it was difficult to send effective preventive health messages. Another barrier highlighted by professionals is the difficulty in creating essential mechanisms to give access and medical attention to adolescent males, which can be observed in the scarce number of medical consultations requested by men. These difficulties may be acting as material and symbolic barriers to adolescent males having access to the health care system. In this sense, they understand the importance of having a counseling department and workshops in the waiting rooms, and use them as mechanisms of awareness for men and make them take an active part in their own health self-care, as a way of expanding their accessibility to the health care system. Besides, they think that, if the number of male doctors increased, adolescents would make more medical consultations. In this sense, one of the professionals we interviewed noted: *"I think it should be available. But, well, health care systems impose circumstances. And, the primary health care level is 100% full of women"* (Dentist, community health care center). This statement shows some structural conditions that may act as access barriers that adolescent males have to face within the health care system: feminization of public health services and, especially, of the primary health care level, which is traditionally related to the health self-care role attributed to women.[55]

Based on the previous information, professionals agree on the fact that there is a gap between what the health care system shows should be a cause of a medical consultation in adolescent males (referring to epidemiological signs of gender and generation) and the effective reasons why they decide to make use of medical services. Therefore, professionals highlight the importance of listening to adolescent males' opinions when it comes to the design and definition of medical attention policies that the health care system establishes for them. This may involve information on how they want to be treated and what needs are identified, so they can be included in promotion, precaution, medical

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

attention and self-care actions. Simultaneously, they observe that it is necessary for adolescents to acknowledge their particular risks regarding health care, in an understandable and meaningful way, taking into account that, at this stage of life, the risky and protective behaviors that they may acquire will have an impact on their integral health because of the effects they will have in their future.[16,18,39]

Concerning the treatment that they receive from professionals, in general, adolescents share good experiences. At school, they reported that it is advantageous to have a relative who has registered employment so they can have access to their *obra social* [employment-based health insurance]. In one of the workshops we shared, an adolescent said: *"I'd never go to a hospital."* This has to do not only with the access to public health in terms of social classes, but it also shows current precarious working conditions, and this widespread belief that hospitals are only for people from the lower class. Students mentioned economic matters that obstruct their access to health care services. They mentioned different topics, from public transport expenses to actions taken by force in a context where the budget for public health care is being cut (*"they are on a strike"*). Another student stated: *"Undergoing a private check-up is too expensive for such an unnecessary thing,"* which makes us think that, because of the price, in the end, they decide not to make a medical consultation unless they are having a serious problem that needs treatment.

> In addition, they mentioned other difficulties: waiting for a doctor's appointment in the public health care system and getting up early in the morning in order to get one and/or receiving medical attention: *"you have to go early in the morning if you want to get an appointment," "you have to wait for a month if you need to have a check-up… in that period of time you can die* [...] *someday you're going to die*". This means that not only do they see death as something distant from them and they do not show much interest in health care or the risks that today exist, but also they acknowledge clear and structural barriers in the medical system that obstruct their access.

Most prevalent problems in male adolescents' health

The professionals who were interviewed in this study recognized that those problems representing the greatest impact on adolescent males' health are: problematic drinking and drug use, risky behaviors, obesity, and sexual and reproductive health.

General aspects connected with problematic substance use and risky practices

Regarding the problematic drinking and drug use, and according to field research carried out in one of the services, alcohol represents a "battle" lost by public health and won by the market. Drinking alcohol is a well-established, trendy habit among adolescents, which gives them pleasure and is used as a way of overcoming shyness; of being able to socialize with other people and to feel a sense of belonging to a group and of plucking up the courage to flirt. This argument is also found when adolescents are talking about prevention campaigns:

> *...This message is important, and we need more of them. Beer and breweries are highly promoted in Argentina. People drink a lot of beer and this habit can cause you a lot of problems in the future, and, although we are not aware of this problem today, it could be serious.* (Eighteen-year-old boy, user of a community hospital).

Professionals consider that the adults' naturalization of this situation is problematic, as

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

they are responsible for adolescents' alcohol abuse. Adults have to face the considerable growth of the alcoholic beverage market and so they have also accepted – as a strategy of spontaneous harm reduction – that the so-called *"la previa"* – a meeting with friends before going out to another place, in which alcoholic beverages are usually drunk – would be better at home where alcoholic drinks are of higher quality than those they could drink in other places. This practice is no help at all in promoting healthy behaviors among adolescents, which also has a high impact on gender and generational morbidity and mortality indicators.

One of the indicators taken into consideration by professionals about problematic consumption is the role played by substances in each individual, which defines consumption as problematic or recreational/social. The professionals mention that they work with risk and harm reduction strategies, working along with mental health services and specialized centers. In line with health teams' narratives, most users understand that consumption becomes problematic *"when it becomes a habit"* (Seventeen-year-old adolescent male, user of public hospital), *"when you need to drink all the time"* (Fifteen-year-old adolescent male, user of community hospital), *"when you always do it"* (Fifteen-year-old adolescent male, user of public hospital) or *"when it becomes something you need"* (Sixteen-year-old adolescent male, user of community hospital).

It is interesting to highlight that those questions related to problematic substance use were primarily recognized by adolescents as other people's problems, directly associated with problematic use in contexts of addiction. In response to questions aimed at shedding light on events which occur when going out or in situations related to their own experience or to people who they knew very well, they told stories about risky situations while driving, and they also described events in which violence was involved.

Professionals also mention "elite use" of alcohol, or quoting a professional,

> *As they are kids, alcohol, as a depressant, makes them feel eventually drowsy, it makes them feel sick, they do not want to drink anything or they vomit, but an energy drink motivates them, wakes them up, provides them with caffeine, invigorates them and, as a result, they continue drinking. They are "wide awake drunks."* (Specialist in adolescents, community hospital)

In this case, it should be noted that the combination of psychotropic drugs, alcohol and designer drugs are the main examples of abuse. These uses imply very high risks and when adolescents are taken to an Emergency Room, doctors do not know the exact combination of the used substances and their effects can be mortal. On the other hand, the "polysubstance use" leads to risky practices, among which we can highlight: sexual abuse, unprotected sex, sexual harassment and violent events associated with the model of hegemonic masculinity.

The use of cocaine paste (known in Argentina as *paco*), which is extremely toxic, is widely spread among adolescents of greater social vulnerability. Although lots of efforts are made in healthcare sectors to reduce barriers so that adolescents may have access to health centers, the impact is very low, as the possibility to reduce risks in these adolescents is unnoticeable. In most cases, users express that they are not aware of the existence of other healthcare centers to treat problematic drinking or drug use; however, they know schoolmates or acquaintances that had abuse issues or are dealing with them. Additionally, they think it is relevant to have information about those issues: one adolescent stated the following about these prevention messages:

> *...I think it's fine, you can find messages everywhere. It is mainly a good option for those people who feel embarrassed when they talk about those matters. At least, you know where you can get them* (Sixteen-year-old adolescent male, hospital user).

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

Sexual and reproductive health issues

Most professionals of health care services agree that, statistically, adolescent males do not consult spontaneously about these issues. Few questions are only made when health practitioners introduce these topics. If there is a consultation, the reason will be related to genital symptoms, generally associated with sexually transmitted infections, and this situation will be observed in adolescents' male consultations in centers for prevention, assistance and diagnosis of HIV/AIDS in public hospitals, healthcare centers and community institutions, as reported by one of the interviewed professionals.

Additionally, consultations are related to some difficulties in sexual performance linked to penetration. Reproductive processes – which involve their responsibility – are considered irrelevant in comparison to sexual performance.[13,14] This situation would show male sexuality constructed around traditional values, associated with practices in which relevance would be focused on male arousal as an emblem of hegemonic masculinity. Consequently, this imperative activity leads them to underestimate not only their own desire but also the desire of their sexual partners. Both desires decrease due to the pressure of achievement.[9,42]

Professionals highlight the fact that sexual health and reproductive campaigns are mainly aimed at women, and this is not helpful to include males, who naturally do not feel to be taken into consideration. In order to overcome these difficulties and accessibility barriers, one of the strategies is to take advantage of any male consultation to talk about this issue. On the other hand, they know that each professional has little time with their patients to discuss the wide variety of topics which concern a complete clinical history. Furthermore, consultation time seems to be not enough to motivate or inform those people who are more reluctant to talk, showing the way through which market logic builds healthcare assistance, in favor of "production" which refers to the number of consultations. In other words, efficiency is privileged over efficacy. This is the opinion of another professional:

> Something that worries me is the fact that they are not working on sexual and reproductive health: vasectomy is not promoted. Women are always exposing their bodies [...] medical patterns are centered on men [...] It is something to work with adolescents in their future, this is an option. Vasectomy is not being taken into consideration and they have this idea that their testicles will be removed. (Dentist, health and community action center).

Thus, the interviewee refers to those who are "invisible" in sexual and reproductive health according to the traditional approach which would be reproduced by public policies in the healthcare field.

The health and community action center includes a Sexual and Reproductive Matrix Network (*Red Matricial de Salud Sexual y Reproductiva*) which is interdisciplinary. This team developed a program to spontaneously record all the consultations about sexual and reproductive health, which takes place in the morning and the evening shifts. The administrative staff was the first team to be trained since it is recognized as *"the front door"* in the health system. This sexual and reproductive health team functions every day and consultations are received as primary care "urgencies." There is a counseling department that provides information about pregnancy tests and contraceptive methods or, if they have adopted one, its continuation. Despite the fact that the organization includes this department, male consultations account for 2% while female consultations account for 98%.

When users are asked whether they have information about the contraceptive options offered by the healthcare system, most of them state that they know about birth control pills and condoms. One of the users says: *"they give away contraceptives"* (seventeen-year-old adolescent male, community hospital user). This response, which represents the answers of the minority, is very

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

interesting as it makes us think about not only what are the methods offered by health services, but also the way they are offered, how adolescent males receive this information and if they realize it is their right.

Young people report that using condoms is an individual decision related to their health care. However, when they were asked if care or contraceptive methods vary with regular or occasional sexual partners, heterosexual adolescent males, who were interviewed for this study, take a time to think, doubt, or express that it can be a shared decision, and they finally delegate their partners the use of contraceptive pills.

It should also be noted that, although it is a small group, several adolescents express that they ignore the contraceptive options offered by the health system. These preliminary results support the idea that contraception and care are related to women's bodies, that men are excluded from this responsibility, despite the fact that the healthcare services offer them workshops, taking advantage of couple´s consultations during pregnancy or when parents accompany their son and/or daughter to consultations. A mental health professional (a psychologist, public hospital) mentions that a strategy to include adolescents in these consultations would be the organization of workshops for those men who are going to become fathers. They are provided with the text of the Humanized Childbirth Act (*Ley de Parto Humanizado*) so they can get involved. Professionals identify two main obstacles in men´s participation: on the one hand, their lack of information; on the other hand, the fact that they are unable to accompany their partners due to their first job in the market.

These professionals appreciate this "open listening," they know it is a way to guarantee users' confidentiality, and, at the same time, they transmit the information without "giving orders" as they consider it attacks habit promotion. In this way, they try to get adolescents' active participation in what they are experiencing and their concerns during consultations.

The interviewees highlight that centers for adolescents must include other specialties other than gynecology, because – when this is the only medical area available – men will think: *"Why must I go to this center if I am a man"* (Specialists in Pediatrics and Adolescence, public hospital). In this sense, they highlight the significance of including urologists, hebiatrists, and other male doctors for those who feel ashamed of being examined by female doctors.

Most of the professionals report that, in consultations, they ask adolescents if they have had sexual intercourse and at what age, the number of partners they have had, and whether or not they use any contraception method. In the case of male adolescents, professionals want to know if they are in a sex-affective relationship and some specific characteristics of those relationships, since male adolescents may be the ones who are abused. This is the case of those relationships which have started without consent, despite the fact that women are the ones who are commonly abused. While male users affirm that most of the time the professionals ask them if their sexual activity has already started, they are not asked about their partner's gender, taking for granted that they are women.

One of the professionals who has been interviewed mentioned the difference between sexual orientation and practices:

> In some circumstances, some questions are annoying: "Who do you have sex with?" [...] People often lie because they are worried about the professional's moral judgment. Heteronormativity must be written on paper [...] But finding out about sexual relationships [...] We must focus on the practices (Dentist, health and community action center).

Therefore, during consultations about sexual and reproductive health, pregnancy of Cis-Heteronormativity – highlighted by professionals and adolescents who have been interviewed – could be an access barrier, insofar as it can lead to failures in medical

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

attention misdiagnosing patients with some health problem, providing wrong information about prevention measures and/or promoting invisibility actions, mistreatment or other forms of discrimination.[56]

When asked from whom or where they get answers about sexuality, most of the interviewees mention they look for something or someone they can trust, including friends, siblings, parents, the Internet, teachers, or their partners. The collected information reinforces the hypothesis that in health organizations, certain structural conditions could function as access barriers in two ways that are complementary: on the one hand, the health system finds it difficult to provide access and care to men; on the other hand, men do not always consider the health system a source for information when they have some doubts about their sexuality or prevention and care. In this regard, some professionals mentioned that schools should play the most important role in this issue, by implementing the Comprehensive Sexual Education (CSE) Act. Similarly, adolescents mentioned they have attended some school workshops about this subject and they were focused on pregnancy and condom use. One adolescent mentioned: *"They are always talking about pregnancy and I don't like it."* It should be mentioned that students appreciate the Comprehensive Sexual Education program although they criticize its implementation, as it only concerns a series of annual workshops or lessons.

Food safety and specific problems

Regarding obesity as a high impact problem for male adolescents' health, professionals report that it is a result of their living conditions, determined by economic factors.

For most of the men suffering from overweight, they observe that only a small percentage shows compulsive overeating or anxiety to eat. They identify that the greatest percentage lives in family settings where most of their members are obese, and this is not identified as a problem. This condition is more frequently found in socially vulnerable families, where feeding is principally based on the consumption of carbohydrates (mainly flours).

An additional factor that promotes obesity is fear or insecurity. As families consider their neighborhood unsafe, they must "lock themselves in." On this matter, a professional highlights that

> From a very early age, they are locked in their houses due to fear. This situation promotes overweight from childhood to adolescence [...] They are always using their cell phones or tablets which they obtain from school. They are sitting while eating. (Pediatrician, public hospital).

Therefore, this population of sedentary young people is connected to electronic devices, doing little physical activity, constrained by adults' fear of insecurity. Additionally, they lack resources to go to sports centers, which are considered safe places.

With regard to bigorexia, it is frequently observed in middle-class adolescents and this trend also keeps growing. These adolescents focus their concern on anabolic steroids consumption when they have not reached their complete physical development. According to practitioners, bigorexia symptoms are related to an increase in enzymes as a result of muscular fatigue due to excessive physical activity in order to increase muscle mass or as a consequence of the intake of anabolic steroids. Their interest could lean on the construction of their bodies which should show strength taking into account some stereotyped male aesthetic patterns. Considering the perspective of subjectivity, this interest leads to the construction of the body from the mechanistic point of view, that it is something to be trained, but not as a part of their subjectivity or as something with which males can establish a type of connection.[9,42] Therefore, males would take care of their bodies if they "are not working" properly. This would partially explain why adolescents are not concerned about bigorexia as opposed to the concern shown by the interviewees – and, as

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

has been mentioned before, the great number of their consultations in emergency rooms.

According to those adolescent males interviewed, professionals referred to food safety as linked to specific health issues or sports activities: *"I used to play rugby, so I was told what to eat to have a healthy diet and all that stuff. For sport-related issues, I was told to follow a routine so I would stay healthy and in good shape"* (Sixteen-year-old adolescent male, public hospital user). Furthermore, another adolescent male refers to his physical recovery period *"I was told to eat fruit. Mainly bananas... because of my knee, my bones. And going to the gym center and exercising my legs, cycling, mainly cycling for my legs"* (Seventeen-year-old adolescent male, public hospital user). However, a healthy diet does not seem to be the main topic in consultations, in relation to prevention and promotion; it only appears in relation to sports or aesthetic issues. It is professionals that introduce this subject in consultations.

CONCLUSIONS

All the collected information shows that professionals link the presence of adolescent males in the health system to risky events and they also connect this population to situations of a specific vulnerability. The facts gathered in this study match the testimonies given by young men who mention possible barriers to access to the health care system: they identify barriers to the administrative system due to institutional bureaucracy when they need to have access to services; due to the traditional approach, they feel excluded from sexual and reproductive health issues (this approach is focused on pregnancy prevention); they consider prevention consultations to be irrelevant compared to those involving some painful event or specific diseases; and they also accept that, in some cases, their visits are due to the fact that they accompany their mother or partner.

Furthermore, they consider that controls and preventive actions are of little importance, and their consultations are related to sports activities, to heal some injury or because they want to improve their physical performance; due to some aesthetic reasons or they have some pain which interferes with their daily activities. With regard to sexual and reproductive health, they only know two contraceptive methods: condoms and pills. They emphasize that they try to prevent pregnancy or sexual illnesses, although they are not strictly concerned about both conditions. It is relevant to highlight that sexual diversities or different care methods are not mentioned as usual practices. Neither do they see healthcare institutions as a possible place to get information about sexuality; they rely on their parents, teachers, or peers instead, with people they trust.

According to their testimonies, they accept the existence of situations of violence, but most of them highlight that women also have violent behaviors. The collected information would reveal the naturalization of violence, as violence is also attributed to women, offering no chance to analyze the relationship between violence and the male gender. Additionally, and in view of the information presented above, it is important to consider their opinion, as we can analyze their discrepancies in the traditional female gender stereotypes. Thus, it would be extremely important that practitioners could do a gender cross-sectional analysis taking into consideration the subjective factors of this dimension during consultations[9,41,42] – as a helpful tool to understand, in general terms, the specific causes and the consequences of the issues under discussion. Consequently, it is observed how the formation of values, demands, and self-esteem standards at an early stage, according to different genders, has an impact on adolescents' health-disease-care processes. In this regard, it would be very helpful to consider the needs of genders in prevention campaigns of non-communicable diseases to reduce morbidity and early mortality in the studied population.

SALUD COLECTIVA. 2019;15:e2256. doi: 10.18294/sc.2019.2256

The professionals who were interviewed here emphasized the importance of including adolescent male concerns in the design and definition of healthcare policies, due to the fact that they visualize a gap between what the health system considers should be a reason for consultation of this specific population – related to epidemiological indicators of gender and generation – and young people's reasons to turn to the healthcare system. In other words, adolescents' consultations are a big concern for the healthcare system, but mainly, what this system offers them includes traditional methods for prevention and care, and these methods deter boys from having access to these methods, and when they do, they are not offered what they are asking for. The invisibility of subjective gender components would imply barriers in two complementary ways: on the one hand, health system practitioners find it difficult to provide access and care to men, and on the other hand, men tend to discard the healthcare system as a possible alternative to clarify their doubts about their sexuality. All the situations described above may be considered as material and symbolic barriers to adolescent males when it comes to having access to the healthcare system, and these barriers promote inequity.

In order to eradicate these obstacles, some actions have been implemented such as workshops which took place in the waiting room, or territorial campaigns looking for men in their own territories, for example, school. The concern about the actions which can be carried out for adolescents who are not included in the educational system remains open.

Similarly, professionals pinpointed that a small number of male professionals are working in adolescent services and the Gynecological Department, as the only specialty available, could be barriers to young people regarding healthcare services, showing how gender segregation within the healthcare system organization – at different levels – could impact on health-disease-care processes.

Institutional dynamics themselves have not properly addressed the risks that adolescent males face – in which hegemonic gender constructions play an important role – as they are based on biopolitical paradigms of exclusion. For instance, the testimonies have shown that sexual and reproductive health campaigns are mostly addressed to women, not calling upon adolescents to adopt care practices.

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