

Discourses of professionals and adolescents about the access of adolescents to Health Services in Venezuela, 2017¹

Discursos de profesionales y adolescentes sobre el acceso de esta población a los Servicios de Salud en Venezuela, 2017

Henny Heredia^a

 <https://orcid.org/0000-0002-4609-0481>

E-mail: hennyluzhm@hotmail.com

Elizabeth Artmann^b

 <https://orcid.org/0000-0002-8690-5964>

E-mail: bethartmann@gmail.com

^aInstituto de Altos Estudios "Dr. Arnoldo Gabaldon". Coordinación de Epidemiología. Maracay, Aragua, Venezuela.

^bFundação Oswaldo Cruz. Escola Nacional de Saúde Pública Sérgio Arouca. Departamento de Administração e Planejamento em Saúde. Rio de Janeiro, RJ, Brasil.

Abstract

The aim was to analyze the discourses of professionals and adolescents about the factors that hinder and potentiate this population's access to health services (HS) and the effects it generates in the scope of equity in a Venezuelan state. Twelve interviews were conducted with adolescents and 12 with professionals, based on the Critical Discourse Analysis (CDA) and the triangular structure of Thiede, Akweongo and McIntyre. The results were structured around three themes: the power of stereotypes and beliefs; the law outside the right to health; and building humanized practices. The judicial-legal framework admits unacceptable contradictions that amplify inequalities. Age predominates as a barrier to consultation for alone adolescents, although it is not perceived by professionals and is accepted as a mandatory requirement. Adolescents claim the right to be respected, listened and cared when they are alone. Some professionals defend the rigid application of norms that limit access, and others try to generate forms to guarantee rights. The discourses that confront the hegemonic must be valued because they show that it is possible to facilitate the access with strategies that focus the users. Trust appears as an important value in the formation of links between professionals/adolescents. The gap between professional/adolescent perspectives influenced by organizational culture are elements for (re)thinking new institutional positions in HS to facilitate the

Correspondence

Henny Heredia

Av. Bermúdez Sur. Maracay, Aragua 2101, Venezuela. CP 2101.

¹ This work was developed with the Instituto de Altos Estudios "Dr. Arnoldo Gabaldon" del Ministerio del Poder Popular para la Salud de Venezuela, the support of the Fundação de Amparo à Pesquisa do Estado do Rio de Janeiro (Faperj) and the Programa de Estudantes-Convênio de Pós-Graduação (PEC-PG) of the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Capes) in partnership with the Conselho Nacional para Desenvolvimento Científico e Tecnológico (CNPq) and the Ministério de Relações Exteriores (MRE) of Brazil. The authors also thank the Instituto Fernandes Figueira (IFF) and Escola Nacional de Saúde Pública (Ensp) of Fundação Oswaldo Cruz.

access. The CDA makes it possible to give a voice to minority groups (adolescents), identifying strategies to achieve equity in access to the HS. **Keywords:** Adolescent; Health Services; Equity in Access to Health Services; Stereotype.

Resumen

El objetivo fue analizar los discursos de profesionales y adolescentes sobre los factores que dificultan y potencializan el acceso de esta población a los servicios de salud (SS) y los efectos que generan en el alcance de la equidad en un estado de Venezuela. Se realizaron 12 entrevistas con adolescentes y 12 con profesionales, teniendo como base el Análisis Crítico del Discurso (ACD) y la estructura triangular de Thiede, Akweongo y McIntyre. Los resultados se estructuraron en tres temas: el poder de los estereotipos y creencias; la ley al margen del derecho a la salud y construyendo prácticas humanizadas. El marco jurídico-legal admite contradicciones inaceptables que amplían las desigualdades. La edad predomina como una barrera para atender a adolescentes solas/solos, aunque no es percibida como tal por profesionales y está naturalizada como requisito obligatorio. Las/los adolescentes reivindican el derecho de ser respetados, escuchados y atendidos solos. Unos profesionales defienden aplicar de forma rígida normas que limitan el acceso, y otros intentan generar formas que lo garanticen. Los discursos que confrontan el hegemónico deben ser valorizados porque muestran que es posible facilitar el acceso con estrategias que se centren en los usuarios. La confianza aparece como un valor importante en la formación de vínculos entre profesionales/adolescentes. La brecha entre perspectivas de profesionales/adolescentes influenciada por la cultura organizacional son elementos para (re)pensar nuevas posturas institucionales en los SS que faciliten el acceso. El ACD permite dar voz a grupos minoritarios (adolescentes), identificando estrategias para alcanzar la equidad en el acceso a los SS.

Palabras claves: Adolescente; Servicios de Salud; Equidad en el Acceso a los Servicios de Salud; Estereotipo.

Introduction

Cultural representations are beliefs, ideas and meanings that society uses to organize reality and are constructed, transmitted and transformed, among others, through discourse. Gender is a cultural representation, which contains values, prejudices, ideas, norms, responsibilities, prohibitions and differentiated roles, constructed and seen as natural due to social constructions, which determine what “is to be a man and be a woman”, as well as their reciprocal relations (Caricote, 2006). Cultural representations of gender are manifested through stereotypes, or “preconceived generalizations about attributes/ characteristics of people in different social groups” (Colás Bravo; Villaciervos Moreno, 2007, p. 38). Gender stereotypes are learned since childhood and are the basis for the construction of the gender identity of adolescents (Colás Bravo; Villaciervos Moreno, 2007), by leading them “to internalize expected patterns of behavior, which determine the existing expectations for men and women” (Henriques-Mueller; Yunes, 1993, p. 47).

Adolescence as a social construction is associated with the stereotyped image of a conflictive period and with risk of adolescent pregnancy, sexually transmitted diseases, sexual libertinism, drug/alcohol consumption, violence, rebelliousness, suicide, among others. However, several studies conclude that this is not a more complicated stage than the others (Alonso; Luján; Machargo, 1998). There are hegemonic beliefs/myths and discourses in Latin America that stigmatize and make adolescents invisible, based on conceptions that characterize them as incomplete beings, immature, without reasoning capacity, unsure about themselves, dangerous; others reinforce ideas that adolescents do not get sick, during adolescence problems are only sexual or, on the contrary, adolescents are asexual (Chaves, 2005; Checa; Tapia, 2016; Correa; Cubillán, 2009).

Gender stereotypes affect adolescents unequally. In the hegemonic masculinity model, boys are prepared to perform better sexually, use physical force and repress their emotions. In contrast, girls

are trained for motherhood, caring for others and be predisposed to love (Caricote, 2006). For the World Health Organization (WHO, 2014), inequality in gender norms and stereotypes produce biases in policies, institutions and programming, negatively impacting the effectiveness and access to health services (HS). In health institutions, this system of beliefs and values shared by workers/users, using discourse (among other mechanisms), operates invisibly, playing a preponderant role in the definition of organizational culture and this exerts a strong influence on the practices of HS providers (Gilson, 2014).

In low and middle income countries, adolescents are the group that receive the worst attention and that uses HS most rarely (Kruk et al., 2018). Provision is generally restricted to adolescent pregnancy and HIV, ignoring other health needs of this population (Global..., 2018; WHO, 2014). Data about access and quality of care for adolescents are scarce, limiting the generation of measures about “user experience, system competence, confidence in the system, and the wellbeing of people, including patient-reported outcomes” (Kruk et al., 2018, p. e1197).

According to Thiede, Akweongo and McIntyre (2014), access to HS is not restricted to the use, and refers more to the “freedom” to use services. The authors propose to analyze the access using three interrelated dimensions: availability (physical access); affordability (financial access) and acceptability (perception of users and providers). The concept is based on the interaction and adjustment of the health system to individual and community factors (Thiede; Akweongo; McIntyre, 2014).

Acceptability understood as “the social and cultural distance between health systems and their users” (Gilson, 2014, p. 163) covers three components: adequacy between users’ and professionals’ beliefs about health; commitment and dialogue between provider/user; and the influence of organizational adjustments on users’ reactions to HS. This considers the interaction between users’ expectations about professionals and health care facilities, as well as providers’ expectations about users (Thiede; Akweongo; McIntyre, 2014).

In this way, improvements in access depend on the communicative interaction between the actors involved (Aitken; Thomas, 2004; Thiede; Akweongo; McIntyre, 2014). This dynamic process represents the potential to relate and make adjustments that will allow the health system to function better, as well as being the northern axis for promoting equitable access. Therefore, political action to address the dimensions of access must be based on solid qualitative information, in addition to the quantitative information traditionally used (Thiede; Akweongo; McIntyre, 2014).

The perspective of the agents who build lives in the HS - managers, providers, professionals and users - is fundamental to understanding the problems related to access and the possible strategies to confront it (Esposti et al., 2015), especially in the case of the adolescent population that makes little use of these services. In this study, this perspective will be explored through discourse, since it contributes to the construction of social identities and positions of subjects; social relations among people; and knowledge and belief systems (Fairclough, 2001). In addition, discourse has a fundamental role as an act in the interaction (constitutive of organizations or social relations between groups); as well as in the expression and (re)production of knowledge, ideologies, norms and values that we share as members of groups, and that regulate and control acts and interactions (Van Dijk, 2013). The dialectic between communicative action and discourse allows the construction of understanding between the participants of the interaction and the questioning of traditional cultural patterns (Habermas, 2012).

The Agenda 2030 aims to guarantee access to universal, equitable and integral provision of HS, prioritizing sexual and reproductive health (SRH) interventions related to improvements in maternal, child and adolescent health (WHO, 2018; UN, 2019). Universal access is defined as “the absence of geographical/economic/socio-cultural, organizational, or gender barriers [...] achieved by the progressive elimination of barriers that prevent all people from using integrated health

services, determined at the national level, in an equitable manner” (OPS; OMS, 2014, p. 4).

In Venezuela, despite efforts to expand coverage of the first level of health care (70% for 2016) (Venezuela, 2016), barriers to access to HS persist, excluding, among other groups, adolescents. The coverage of this group is among the lowest, even in federal entities that have sufficient health services; the birth rate among adolescents is one of the highest in Latin America; data about adolescent health and access to HS are scarce; as well as studies regarding this subject (Venezuela, 2012).

This article analyzes the discourses of professionals and adolescents about the factors that hinder and potentiate the access of adolescents to health services and the effects it generates in the achievement of equity, in a Venezuelan state, prioritizing the dimension of acceptability.

Methodology

This is a study of discourse analysis, carried out in the Venezuelan state of Nueva Esparta, aiming to understand the articulation of the discursive production on the factors that hinder and potentiate the access of adolescents in their historical-social context, under the perspective of the Social Theory of Discourse, using Fairclough’s (2001) Critical Discourse Analysis (CDA) and the acceptability dimension of access according to the conceptual framework of Thiede, Akweongo and McIntyre (2014) and Gilson (2014). This state was selected because the areas of responsibility of health care facilities were delimited and had basic health equipment, although not complete (Heredia-Martinez; Artmann, 2018). Between September and October 2017, semi-structured interviews were conducted with 12 adolescents (of both sexes, between 10 and 19 years old, users and non-users of health services) and 12 professionals (4 doctors, 4 nurses/nursing assistants and 4 health promoters/social workers) from 12 health care facilities, 6 from the first level of care, 3 from the second and 3 from the third.

The CDA emphasizes the understanding of the relationships between social inequalities

and the ways the texts are used to denote power/ domination and ideology (Iñiguez, 2005). It has a special interest in uncovering how discourse (re) produces the social inequalities that mainly affect minority groups, as well as the possibilities of social change by it. The proposed model of three-dimensional discourse analysis was followed. The first dimension includes the categories of textual analysis. The second concerns discursive practice, in which the cognitive activities of production, distribution, consumption of the text are analyzed, as well as coherence, intertextuality and the relationship between discourses. The third refers to social practice, related to ideology and hegemony in the analyzed discursive instance (Fairclough, 2001).

The results were structured by themes, with the acceptability category and its components as the guiding axes of the analysis (Thiede; Akweongo; McIntyre, 2014). Coherence and cohesion analyses were carried out on the basis of the textual elements. The structure of the argumentation of the sentences, the form of relation of the phrases and its coherence were identified.

Additional analytical devices were identified: metaphor, interdiscursiveness, irony, modality and polish, to approximate the discursive object of the social process where it is produced and to pass from the discursive object to the discursive process.

The recorded interviews were transcribed, maintaining the faithful expression of spoken Spanish in order to preserve all discursive particles and maintain the senses produced in the enunciation. References to the interviews were coded: Interviews with Professionals (IP), Interviews with Adolescents (IA).

The study followed the ethical principles of human research. It was approved by the Ethics Committee of the Research Directorate of the High Studies Institute “Dr. Arnoldo Gabaldon” of the *Ministerio del Poder Popular para la Salud* (MPPS - Ministry of People’s Power for Health) of Venezuela, on 04/03/17 under number 003/2017, as well as by the State Health Directorate of the state of Nueva Esparta on 04/12/17. Informed consent form was obtained from each adolescent, with prior authorization from parents or guardians,

as well as from health professionals who agreed to participate in the research.

Declarative context

The Mission Barrio Adentro, alongside the others HS institutions, expanded the coverage of these services to the excluded population (Briggs; Mantini-Briggs, 2007; PAHO, 2006). Priority was given to strengthening the primary health care network, from 4,605 health care facilities in 2003 to 12,515 in 2016 (OPAS, 2007; Venezuela, 2016), an increase of 172%. Nevertheless, the following persist: the operational fragmentation of HS provision and financing; the institutional segmentation of the health system (Bonvecchio et al., 2011; Madies; Chiarveti; Chorny, 2000; PAHO, 2007); the scarcity of human resources and its unequal distribution; the existence of geographic points that concentrate supply; difficulties in working in integrated networks; and high private spending (out-of-pocket), for which the right to health depends on the ability of Venezuelans to pay (Roa, 2018). The country's economic crisis exacerbated the problems of access to medicines and contraceptive methods, such as HS, due to the shortage of supplies and equipment (Roa, 2018).

In 2017, 5,558,445 of the 31,431,164 inhabitants were adolescents aged 10 to 19 (18%)². In the MPPS, attention differentiated according to the needs of adolescents is regulated by the *Norma*

Oficial para la Atención Integral en Salud Sexual y Reproductiva en la Adolescencia (NOAISSR - Official Standard for Integral Sexual and Reproductive Health Care in Adolescence), in the subproject "Sexual and Reproductive Health in Adolescence" with six areas of intervention, where access to HS is transversal for the fulfillment of objectives (Venezuela, 2013). The *Programa de Salud del Adolescente* (PSA/MPPS - Adolescent Health Program) operates with limited presence at the state level: of the 24 federal entities, only 14 had at least one differentiated consultation for adolescents in 2017. Coverage percentages are low in states that report to PSA.

The main legal conditions for adolescents in Venezuela include: majority from 18 years old; criminal responsibility from 12 years old; age for HS care without parents/representatives from 15 years old; age to consent for heterosexual/homosexual relations, 16 years; and marriage/civil union with the consent of parents/guardians/judges, 16 years old for boys and 14 years old for girls (Venezuela, 2015). Article 435 of the Criminal Code prohibits abortion in its various forms, except when the woman's life is at risk (Venezuela, 2000).

Results and discussion

All discursive enunciations, organized by themes and numbered excerpts, are presented in Chart 1.

Chart 1 – Discursive enunciations by adolescents and professionals about factors that hinder and potentiate this population's access to the HS, Nueva Esparta, Venezuela, 2017

Topics	Adolescents' excerpts	Professionals' excerpts
The power of stereotypes and beliefs: "abortion and sexuality should not be discussed"	[1] <i>It is good that they see us as an adult, that we are already able to understand things and that they support us, that they guide us (IA6).</i>	[4] <i>I feel that we have not given enough importance to the adolescence, it is a difficult age in which there are many unknowns, and problems [...] Right now, we even continue to see the sexual orientation as a taboo, there are doctors who don't like to touch on this subject because they don't feel prepared for it. I feel that we need more training about it, [...] instructing us about how to handle this complicated stage (IP6).</i>

continues...

² VENEZUELA. Ministerio del Poder Popular de Planificación. Instituto Nacional de Estadística. *Proyecciones de población*. c2011. Disponível em: <<https://bit.ly/2nXa6XX>>. Acesso em: 30 set. 2019.

Chart 1 – Continuation

Topics	Adolescents' excerpts	Professionals' excerpts
	<p>[2] First of all take initiative, not with the adolescents, but with the parents, because those who instill in the adolescents the fear of going to the health services are often the parents (IA1).</p> <p>[3] the culture has made us see that abortion and sexuality should not be discussed[...] that's why I feel that they are not direct[professionals]. Do they want to explain something? Go straight to the point[...] abortion is considered very bad and if a person aborts is wrong[...] and it's something that seems illogical to me, it should be legalized, because I think it's unfair to say that a woman doesn't have the right to decide about her body because the fetus is an individual body. But who carries this individual? (IA12).</p>	<p>[5] Who are always afraid to ask, to approach, the sorrow of, to say, I don't know, they never want to ask anything, they are always so eh-h-h as inhibited with, with us [health personnel] (IP10).</p> <p>[6] Well, the hardest thing is that sometimes they lie. So you have to look, eh-h-h, as one says "find a way around things" to be able to face the situation (IP12).</p> <p>[7] can be questions that are inside themselves some kind of question, because suddenly I'm 12 years old and I had my sexual relationship and I'm pregnant and I'm afraid that the social worker is a friend of my mother and she will tell her, or that I had an abortion [...] or that I come for condoms and I don't want to give this information to my mother (IP1).</p>
<p>The law outside the right to health: "Not to the blue shirts"</p>	<p>[8] that they do not attend me because I am not accompanied by a representative or because I am with somebody who is minor, they ignore me and all that, because there is not an elderly person [adult] (IA3).</p> <p>[9] Well, mainly at the time the teenagers arrive, you don't have to treat them different because you're a minor, you have to give them the best attention, egalitarian, equal to that if you're an adult [...] not because you're a teenager they have to treat you worse than someone else [...] if they should rather pay more attention to you than to someone else, because you're still a teenager who's changing and all that [...] lately the attention for teenagers is pathetic [...] (IA5).</p> <p>[10] they treat you as if you were useless then, until you reach 18 years old, even if you reach 18, they still treat you like that. Because I am in full stage of growth, but I am not useless! Maybe I am not able to do much things by myself, but I can give my opinion which is what matters most (IA12).</p>	<p>[11] Oh-h-h in reality for none, only in special cases when they are minors who come without the a representative, it is explained to them, if they are 17, 16 years it is made an exception and they are attended [...] but in general we are going to attend all of them, to all we attend them (IP9).</p> <p>[12] Look, we would not deny the consultation, at least we demand with regard, that is, that "if you are an adolescent, you have to come obligatorily with a representative" [...] because most of the time we explain, but sometimes they arrive, the mother "nooooo, I didn't know how to explain this" and there is always a wrong understanding and then what we are dealing with is that (IP11).</p> <p>[13] Well, sometimes the most difficult thing is that it is difficult for us to know at the moment of attending them, there are some barriers that hinder us from attending them, that make one feels safe, if I am going to attend them [...] or I am not going to attend them, I become the representative and that this entails a responsibility that we should not have assumed and what the representatives may think (IP2).</p> <p>[14] I don't know how legal it is [laughs], so that scares me a bit because I try to help and I don't want to get into trouble for helping (IP13).</p> <p>[15] I don't know if everybody [the health team] have the same perspective as I do, that if they come alone, "take care of them!" this is the most common. The day when this 15 year old patient came, everyone said to me, "Look, are you going to do the Pap smear?", nurses and everybody. And I: "my love, sign here, we are going to do the Pap smear", because she needed it, that is, she was already living with her partner, she was practically, in theory, "adult", in quotes, because she already had a family, in quotes, without children, but she is living with her partner apart, without her parents (IP13).</p>

continues...

Chart 1 – Continuation

Topics	Adolescents' excerpts	Professionals' excerpts
		<p>[16] <i>The one who attends them without the representative is an access facilitator, yes, yes, because I was reluctant to attend adolescents in the consultation [...] but I have seen that, that is not good, because many of them have no parents, as simple as that, they are 16 or 14 years old but they live almost alone [...] then wow it seems to me that it is not fair that they do not receive attention because of this</i> (IP4).</p> <p>[17] <i>When "the blue shirts" go to fourth grade, that's my group, but I don't give condoms to "the blue shirts" no, not to them, I don't give it to them, because I say no, this, they're just 12, 13 years old, they're just starting, but it's my responsibility to save [...] even the "brown shirts" this "beige" say to me: "Hey is those third year boys more awake than we are?". And really the pregnancy rates are mostly achieved between the second and third year</i> (IP1).</p>
<p>Building humanized practices: matches and mismatches</p>	<p>[18] <i>That's to say you arrive at a place and they treat you in a polite way, not with screams, not with a bad look, not with a lemon-sucking face, because to be a doctor, you have to be sociable with the person and talk to him and make him feel confident [...] who can help the patient and doesn't treat you in a way that is too much like ahhh "I am a doctor, I am better than you and I have a postgraduate degree and you have nothing", do you understand me?</i> (IA10).</p> <p>[19] <i>ehhhh to have a special attention to teenagers then, that is not an ordinary and common treatment, because it is a different case ehhe different because [...] That they have a personal and private attention, because, that girl who comes pregnant had the courage to come, even if did what she did. Do you understand? She had the courage and confidence to tell a doctor what she didn't tell to her parents. And if she's badly cared she will never come back again</i> (IA4).</p> <p>[20] <i>are doctors, but sometimes they don't see things from the other perspective [...] I would tell them to put themselves in the adolescent's place and to think like an adolescent. What would I do in their place? And seeing the pain they are suffering: How are they feel? And how to be able to help them</i> (IA7).</p> <p>[21] <i>I think they should inform us about the services they provide to us because it's for ourselves and our health</i> (IA1).</p>	<p>[22] <i>It would be missing to inform adolescents about services we have for them. We give so much importance to the prevention of sexually transmitted diseases, to the prevention of pregnancy in adolescents avoiding the other part, we do not give importance to the issue of the services</i> (IP5).</p> <p>[23] <i>mistreatment can also be when they doesn't achieve anything, that most people come to achieve, but if they can't [...] then they don't take it from the point of view that it's not something we can't do it, but something we don't want to give to them, see?</i> (IPF11).</p> <p>[24] <i>we as health professionals must give them the confidence to express themselves to us, because if we do not give them confidence, they will never speak to us, we must be charismatic, we must be affectionate, we must attract them and not isolate them</i> (IP7).</p> <p>[25] <i>For example, here comes one and says: "no, I want to talk to Dr. Maria", doesn't want another doctor if it's not Dr. Maria, because of the trust, you see? The same with nurses, they always tell you: No, I'm looking for this nurse. Ahh and why not me? "No, I looking for her because she treats me better than you [laughs]</i> (IP3).</p>

The power of stereotypes and beliefs: “abortion and sexuality should not be discussed”

Structural and power relationships influence professional practice and organizational culture, such as user/professional behavior and their interactions (Gilson, 2014). Culture can be both a resource and an obstacle in the process of institutional change and it is not possible to interfere directly in it. Nevertheless, the positive traits of culture can be valued and approached it as a resource (Artmann; Rivera, 2006; Habermas, 2012). Discursive enunciations stand out as the stereotyped image of adolescents sets the tone in the expectations of professionals and users (Excerpt 1-8).

The belief that adolescence is a complicated stage permeates the HS (Excerpt 4); this image is used to generalize “adolescents” as problematic and incomprehensible, although several studies have already shown the opposite (Alonso; Luján; Machargo, 1998). The low priority that adolescents have in health services is also recognized in the speech. The difficulty of professionals to deal with issues related to sexual orientation continues to be “a taboo” in the HS, there is a tendency to stigmatize the different expressions of sexuality and sexual identities that do not conform to social rules, a situation that directly affects adolescents with orientations different than hegemonic (Colás Bravo; Villaciervos Moreno, 2007), such as those who are seeking counseling to address these issues. The training of professionals appears as a strategy to improve the care of the adolescent population.

The argument that access is limited by the adolescent’s problems is referred in several professional statements (Excerpts 5-7). These beliefs constitute a veiled barrier that limits access. The first is that adolescents are “fearful, painful”, so fear is mentioned as a matter proper of the user and not seeking to understand why they act that way (Excerpt 4). Sometimes this attitude can be related to the discomfort/shame of talking about their sexuality or the lack of confidentiality/privacy (Global..., 2018; Henriques-Mueller; Yunes, 1993).

Another stereotype is that teenagers are “liars” (Correa; Cubillán, 2009), the metaphorical resource

used, “*find a way around things*”, has the connotation of an interrogatory where by any fault or neglect of the interlocutor, we try to discover the truth (Excerpt 5). Professional/user trust, understood as “a relational idea, is based on the user’s conviction that the professional will act in his interest” (Gilson, 2014, p. 166). This is not always cultivated, on the contrary, stereotypes undermine the possibilities of establishing a dialogue and links with the adolescent, who demands communicative actions, in the Habermasian sense (Habermas, 2012) in the search for consensus and not with strategic actions to impose the criterion from the HS.

In other cases, the issue of confidentiality is identified, however, it is not recognized as a barrier to HS but as an issue/problem of the adolescents (Excerpt 6). The use of “*questions*”, “*question*” shows the impossibility of defining the barrier (Excerpt 7). The professional then is placed in the adolescent’s place, citing examples of why HS are not used, all referring to confidentiality, but without recognizing that these services must guarantee it (UNFPA, 2015). On the contrary, the phrase “*inside themselves*” makes the adolescent responsible.

The preservation or not of confidentiality is one of the elements used by professionals to exercise power (Gilson, 2014). A fundamental characteristic of HS adapted for adolescents is that they can guarantee confidentiality and privacy, as is required for the rest of the population (Ford; English; Sigman, 2004; Venezuela, 2013). Some studies show how adolescent users prefer to be attended in places outside their community, for fear that their parents would know their situation (Global..., 2018; OMS, 2018).

In contrast to the beliefs of professionals, adolescent discursive enunciations attempt to deconstruct these stereotypes. One expectation of adolescents is to be “*seen as an adult*” and treated as such (Excerpt 1). It refers to enjoying some privileges and being able to assume responsibilities (Chaves, 2005; Correa; Cubillán, 2009), this implies, on the one hand, the demand to be attended in the same conditions, because they are also subjects of rights (with respect, confidentiality, autonomy, among others) (Morlchetti, 2007; UNFPA, 2015) and, on the other hand, to demonstrate that they have sufficient cognitive capacity to understand what

will be said in the consultation and to take care of themselves (Checa; Tapia, 2016).

In the Excerpt 2 with the use of “*but*” two ideas are opposed to reinforce the need to work first with the parents, who appear as an authority figure to instill fear of the HS. Adolescents in the different spaces where they live are subjected to asymmetrical power relations (family/parents, school/teachers, HS/professionals). Thus their capacity to access the HS, independently of their parents, is limited (Global..., 2018), even more so when the health system itself imposes it as an income requirement. This statement reveals the importance of parents/representatives as key agents in improving access to HS, since they can be the main barrier, and devising strategies to involve them in the care process is fundamental, not creating an obstacle to adolescents’ access when they demand care without the presence of parents. In spite of the asymmetries implicit in care, a relational dynamic that results in trust, whose central ethical nucleus is mutual respect, is possible if the HS are open to listening to the users, in the case of this study, adolescents and their parents (Artmann; Rivera, 2006).

Access to information on issues such as abortion and sexuality is limited, as they continue to be taboo in Venezuelan society. Despite being included in the package of services to be provided, it is difficult for professionals to deal with, even more so with adolescents. The statement in Excerpt 3 is categorical in affirming that these issues are not discussed, at the same time that it manifests the difficulties of the professionals in dealing with them. The expression “*go straight to the point*” is used to denote a clear explanation. For adults (including professionals), “talking about sexuality or controversial issues such as abortion can produce fears and confront them with their own difficulties and uncertainties” (Correa; Cubillán, 2009, p. 9).

It is argued that there is disagreement with the non-legalization of abortion, for attempting against a woman’s autonomy to decide about her body. The adjectives “*illogical, unfair*” underline the absurdity/arbitrary nature of the situation. Venezuelan law prohibits abortion and it is only admitted when a woman’s life is in danger (Venezuela, 2000). It is a speech that questions the hegemonic discourse.

In several countries of Latin America and the Caribbean, the stereotypes analyzed prevail and limit adolescents’ access to HS, their deconstruction involves recognizing them and devising strategies/ actions that combine changes in management practices and organizational culture (Caricote, 2006; Morlachetti, 2007; UNFPA, 2015). Some cultural traditions can be criticized from the discourse and allow the construction of new consensuses and new institutional positions (Artmann; Rivera, 2006; Habermas, 2012).

The law outside the right to health: “No to the blue shirts”

The age of care without parents/representatives is pointed out by adolescents as an obstacle (Excerpts 8-9). The figure of the adult is mentioned twice as a requirement for attention (Excerpt 8); the statement emphasizes in the first person the restrictions faced as an adolescent (“*ignore me*”), because they are not recognized as a subject of rights in the HS (Morlachetti, 2007). Discriminatory care for adolescents in health services is highlighted by the phrases “*treat them different*”; “*treat you worse*”. For some authors (Global..., 2018) children and adults are generally better served and these groups have historically been within the priorities of health systems with greater emphasis on structured programs and allocated resources, in contrast to adolescents.

In Excerpt 9, what is recommended in the HS policies for adolescents (Global..., 2018; Venezuela, 2012) is highlighted with the adjectives “*egalitarian*” and “*equal*”, as the importance that this population “*should*” have for the HS. The adjective “*pathetic*” indicates the dissatisfaction and the particularly evident abandonment that adolescents suffer for health services (Global..., 2018). The statement emphasizes that because they are “*minors*”, they should have differentiated considerations.

The Excerpt 10 reveals the scarce autonomy that society grants to adolescents (Morlachetti, 2007) and, at the same time, shows how, to the extent that the analytical capacity and critical sense of adolescents increases, adolescents question the rules/standards imposed in society. Thus, in spite

of their limitations, adolescents communicate their capacity to express their opinions, which is often ignored by adults (health team/parents/representatives). The adjective “*useless*” used two times, highlights, on the one hand, the presence of the stereotype that adolescents are incapacitated (Chaves, 2005) and, on the other, the sensation of repudiation/anger/frustration of the adolescent about the received treatment.

In the speeches of the professionals (Excerpts 11-12), the apparent strategy of conceding access to minors (Van Dijk, 2013) is used and then the resource of modality and expressions of courtesy are used too, to say in a pleasant way that adolescents will only be attended with the presence of an adult (“*special cases*”; “*at least we demand with regard*”). The age is not seen as a barrier; on the contrary, it is naturalized as a mandatory requirement that affects exceptional cases. This is emphasized in Excerpt 11 with the phrase “*but in general*” and is justified by the stereotype that adolescents do not have the capacity for understanding, nor the level of maturity to make decisions about their health (Checa; Tapia, 2016), referred in Excerpt 12, by the use of direct intertextuality about what mothers claim, with the phrase “*I did not know how to explain this*”.

In legislation, age generally appears with a restrictive tendency when referring to adolescents (Morlachetti, 2007). In Venezuela (2015), the *Ley Orgánica para la Protección del Niño y del Adolescente* (LOPNA - Organic Law for the Protection of Children and Adolescents) establishes that from the age of 15 adolescents can be attended without consent by *Servicios de Salud Sexual y Reproductiva* (SSSR - Sexual and Reproductive Health Programs and Services). No mention is made about other kinds of care, which could be interpreted as cases when the adolescent alone can be attended. The first contradiction of this law is that adolescents must be 15 years old in order to be treated alone in SSSR, but at the age of 12 they can be held criminally responsible (Venezuela, 2015). The second is that in the law there is a marked concern about the sexual and reproductive health of adolescents, more than about their integral health. And the third is that the predominant discourse

in the HS is to not attend minors (under 18) alone, regardless of what they require.

Professionals’ fear of not knowing when an adolescent should be attended or not appears in Excerpts 13-14 and is recognized as a barrier (Excerpt 13). The verbs are conjugated in the first and third person, to express the personal and health team’s concern for the responsibility they must assume, especially regarding parents/representatives. In Excerpt 14, the sentences are constructed in the first person, to indicate the insecurity because they do not know the current legal norms. This impossibility of discerning what should or should not be done, within the “legal” framework, manifests the deficiencies of the health system as an organization, incapable of establishing mechanisms to make agreements with professionals and guarantee the care of adolescents.

For the professional speech in Excerpt 15, the adolescents alone have to be attended, because often they do not go with the representative. However, since the accepted/institutional organizational practices are against it, tensions are generated (Gilson, 2014), hence the fear manifested in Excerpt 14. With the resource of direct interdiscursiveness it exemplifies the pressures of other health team professionals, mentioning “the nurses”, a power group/hierarchy within the HS, as well as the measure implemented to “protect themselves” (informed consent).

The professional ironizes with the expression “*in quotes*” to speak figuratively and metaphorically of the condition of being adult, condition demanded by the health team to be able to provide the attention. The family constituted by the adolescent is also seen by the health team as “in quotes”, even more so because it is a girl who assisted alone (without a partner). Gender marking is evident in patriarchal Venezuelan society. An adolescent at the age of 15 who lives with a partner is badly considered, and in the HS this gender stereotype is present, so much so that in some HS they require the girl to go with her partner in order to receive care, a situation that does not happen with boys. Thus, age masks the real reasons for denying attention, often linked to the system of beliefs and values that prevails and influences the culture of health care organizations and it shapes the behavior of workers (Rivera, 2006).

The predominant discourse in the HS is that an adolescent without a representative cannot be attended to. However, there are speeches showing a discourse different than the naturalized one (Excerpts 16-17). Its concretion, by the implementation of strategies focused on adolescents, may be hindered by organizational culture (Gilson, 2014; Rivera, 2006). The professional speech in Excerpt 16 recognizes attention without parents/representatives as an access facilitator. It justifies that this action is necessary in the absence of the parents during the hours in which the health center is open. The “*wow*” denotes astonishment at the inequity generated by the lack of attention for this reason.

Age is not only a barrier to access to care, it restricts access to inputs such as condoms. Its application in practice is contradictory and determined by the attitudes of HS providers. The speech in first person is exhaustive in indicating that to students in grades seventh to ninth (“*the blue shirts*”) do not receive condoms (Excerpt 17). The criterion for determining age is the color of the shirt, which excludes the 12-15 age group, despite knowing that this is the group concentrating the highest number of pregnancies. With the direct interdiscursiveness, the professional brings the opinion of the adolescents of fourth and fifth years old (“*the beige shirts*”), who use an expression “*are more awake than we are*” to denote that the younger adolescents are already sexually initiated and therefore need to receive condoms. Beyond his concern for the “*responsibility*” he must assume when handing out condoms, the professional does not approve that adolescents between 12 and 15 years of age start their sexual activity, and this is the impediment to giving them condoms, despite the fact that the Sexual and Reproductive Health Program establishes that educational activities should be offered to all adolescents (Venezuela, 2013).

Building humanized practices: matches and mismatches

Quality care and the humanization of care are valued in the speeches of adolescents (Excerpts 18-20). Attitudes and behaviors respectful of the provider

towards users, such as good communication practices, are referred in the Excerpt 18 and contribute to create links of trust (Artmann; Rivera, 2006; Gilson, 2014). The “*no with*” is used three times to characterize inappropriate treatments. The expression “*lemon-sucking face*” is a metaphorical resource that indicates the opposite of a dignified treatment, as one of the aspects of the ethical practices of health systems (Global..., 2018). Technical competence is also demanded, as humanized practices, in a quality care, light technologies (relationship) must be used, such as the hard and light-hard ones that are required. Direct interdiscursiveness at the end of the Excerpt demands greater horizontality in the relationship between professionals and non-hierarchical and respectful adolescents (Ferreira; Artmann, 2018). Although the relationship between professionals and adolescents is asymmetric, configured according to the guidelines learned in training and hegemonic medical practice (with emphasis on the case of doctors), it is possible to implement communicative actions that privilege the encounter of the convictions of adolescents with those of professionals in the construction of a humanized culture (Artmann; Rivera, 2006).

Excerpt 19 characterizes differentiated attention as a facilitator of access, where personalized consultation, privacy and trust are privileged. In primary care, when working from the health system with “*user-centered*” approaches, personalized encounters with more time between provider/user, such as continuity of contact, are key strategies for improving access (Gilson, 2014; Global..., 2018). Another point raised in this Excerpt is how negative experiences with HS can cause non-return of adolescents.

A notable barrier (Excerpt 20) is the difficulty that (medical) professionals have in understanding the expectations of adolescents. The recognition of their specific circumstances and the way the professional demonstrates consideration for them in moments of vulnerability is valued (Gilson, 2014). Thus, the expectation is that the doctor tries to understand what happens to the other (the user).

The promotion of services offered to adolescents is a rare practice in HS, identified as a possible

facilitator in Excerpts 21 and 22. Information about the offer of services available to adolescents allows them to feel that they are included in it and can be a facilitator of access; in addition, a component that contributes to strengthening trust is the set of services offered (Gilson, 2014; Global..., 2018).

If the HS organization is not able to respond to needs, trust will be affected. The speech of one professional (Excerpt 23) refers to this situation as “mistreatment”, because the HS cannot offer the adolescent what is demanded. Hence, in addition to the technical competence (perceived) mentioned above, the availability of medicines, supplies and equipment are required, because these items influence the attitudes of the users. The policy implemented to expand coverage in the country at the first level of care, in some cases, omitted this aspect and, in the absence of the basic factors of infrastructure, equipment, inputs/medicines, among others, access is restricted and distrust of users is reinforced (Heredia-Martínez; Artmann, 2018).

The co-responsibility of the HS and their professionals in creating bonds of trust is emphasized (Excerpts 24-25). The option of the adolescent being able to select the professional with whom they want to have the consultation is referred to as an access facilitator (Excerpt 25), a strategy already suggested in similar studies (Checa; Tapia, 2016). With direct interdiscursiveness, the professional explains how trust is a determining factor in the selection of a specific professional by the adolescent (Excerpt 25). In these discursive enunciations, professionals try to (re)invent the way of providing HS to adolescents, valuing humanized practices of this population’s attention, such as quality, reception and their recognition as subjects of rights (Artmann; Rivera, 2006; Rivera, 2006).

Final Considerations

In Venezuela, adolescents continue to be one of the most neglected and stigmatized groups in the health system, a reality common to several Latin American and Caribbean countries (Morlchetti, 2007; Rodríguez, 2009; UNFPA, 2015). At the macro level, the legal framework admits unacceptable contradictions that amplify inequalities: (1)

adolescents must be 15 years old to be treated alone in programs and SSSR, but at the age of 12 they can already be held criminally responsible. On the one hand, the adolescent’s health seems to be only restricted to sexuality and reproduction, and on the other hand, the idea of relating adolescents to the violation of norms is reinforced; (2) girls can legally enter into marriage/civil union with the consent of parents/guardians/judges at age 14, but boys only from the age of 16 (Venezuela, 2015); and (3) a girl (like the other groups of the country’s female population) is prohibited from having an abortion, except when her life is at risk (Venezuela, 2000).

In this sense, the discursive production of professionals and adolescents is strongly marked by the stereotypes (including those of gender) and beliefs present in Venezuelan society. Polarization (Van Dijk, 2013), a key characteristic in hegemonic discourses, highlights the negative characteristics of this minority group as “difficult, liars, poor communicators, without cognitive capacity, among others”, which justifies the different forms implemented to argue “non-attention”, to the point that it is not a concern the low attendance by adolescents to the HS.

Age appears as a naturalized and instituted barrier in the HS and in the juridical-legal framework, in some cases it is used to overlap the real reasons for the lack of care related to: the non-acceptance of adolescents exercising their right to be sexually initiated; the fears of professionals to assume responsibilities before parents/representatives/society; the lack of knowledge and limitations to offer counseling on controversial topics such as homosexuality, abortion, among others. Age represents different types of barriers to access (to care, to condoms, to information), but no mention is made of the legal framework, that is, what is established in the LOPNA - which is also limitative - is ignored in the speeches. There are discourses that confront the hegemonic and must be valued because they show that it is possible to facilitate access with strategies focused on the users.

Like other studies (Checa; Tapia, 2016; Global..., 2018), in the discursive production of adolescents their expectations are to receive humanized attention that respects the principles of responsiveness

-dignity, confidentiality, autonomy, immediate attention, choice, installations and communication- (Gilson, 2014). In opposition to the stereotyped image of adolescents, they produce discourses against hegemonic statements about abortion and inequality of care, thus claiming their right to opportune and quality access to the HS.

Trust appears as an important value in the formation of links between professionals and adolescents, built on the basis of the interpersonal relationship and the quality and opportunity of services. The training of professionals is identified as a strategy for raising awareness and incorporating the information and tools necessary for the care of adolescents.

Some forms of abuse of power in the HS appear, which requires sensitization processes that involve the agents (managers, professionals and users) to understand that this is a violation of rights, as well as to (re)produce practices that combat them. In many cases, adolescents are double victims; on the one hand, parents/representatives may be the first barrier to overcome by denying them the possibility of going to the HS, and on the other, the obstructed access to HS.

The discursive production of professionals is permeated by organizational culture. This can directly or indirectly impede adolescents' access to HS, reinforcing patterns that reproduce norms established by the legal route, as well as those instituted by the organizational task (Rivera, 2006). At the same time, it can promote the creation of more flexible and humanized spaces. The gaps between the perspectives of professionals and adolescents, influenced by the organizational culture, stand out as key elements for (re)thinking about how the HS can facilitate access for this population, with new institutional positions that prioritize communicative actions and struggles for changes in the legal framework. In the case of health and access to HS, it is necessary to think in broad frameworks, supported by the right, that give sustenance and legitimacy to care and, at the same time, protect users with instruments that are opposed to the unethical, non-communicative use of care practices for adolescents, which constitutes a great challenge (Artmann; Rivera, 2006).

CDA as a theory can contribute to acceptability studies because it allows us to understand how practice in health systems is being influenced by social structures, and at the same time identify the counter-hegemonic discourses produced in the everyday life of HS, which can modify health service practices, as well as the dimensions of the social structure. Another aspect is that it makes it possible to capture the social gap between health systems (by the discourse of professionals) and adolescents and to analyze them from a complementary perspective and not as a counterpart. CDA's interest in situations of inequality and abuse of power makes it possible to give a voice to minority groups (such as adolescents) by identifying strategies for achieving equity in access to HS.

References

- AITKEN, J.-M.; THOMAS, D. *Synthesis of final evaluation findings from the Nepal safer motherhood project*. Kathmandu: Ministry of Health, Department for International Development, 2004.
- ALONSO, E.; LUJÁN, I.; MACHARGO, J. Actualidad de los estereotipos sobre la adolescencia. *Anuario de Filosofía, Psicología y Sociología*, Las Palmas, n. 1, p. 27-49, 1998.
- ARTMANN, E.; RIVERA, F. J. U. Humanização no atendimento em saúde e gestão comunicativa. In: DESLANDES, S. F. (Org.). *Humanização dos cuidados em saúde: conceitos, dilemas e práticas*. Rio de Janeiro: Editora Fiocruz, 2006. p. 49-83.
- BONVECCHIO, A. et al. Sistema de salud de Venezuela. *Salud Pública de México*, Cuernavaca, v. 53, p. s275-s286, 2011. Suplemento 2.
- BRIGGS, C. L.; MANTINI-BRIGGS, C. "Misión barrio adentro": medicina social, movimientos sociales de los pobres y nuevas coaliciones en Venezuela. *Salud Colectiva*, Buenos Aires, v. 3, n. 2, p. 159-176, 2007.
- CARICOTE, E. Estereotipos de género ponen en peligro la salud sexual en la adolescencia. *Salus*, Bárbula, v. 10, n. 3, p. 19-24, 2006.
- CHAVES, M. Juventud negada y negativizada: representaciones y formaciones discursivas

- vigentes en la Argentina contemporánea. *Ultima Década*, Valparaíso, v. 13, n. 23, p. 9-32, 2005.
- CHECA, S.; TAPIA, S. (Coord.). *Derechos sexuales y reproductivos de los y las adolescentes*: diálogos posibles entre los jóvenes y los servicios de salud. Buenos Aires: Sociedad Argentina de Pediatría, 2016. Disponível em: <<http://bit.ly/2zuc7xt>>. Acesso em: 29 ago. 2019.
- COLÁS BRAVO, P.; VILLACIERVOS MORENO, P. La interiorización de los estereotipos de género en jóvenes y adolescentes. *Revista de Investigación Educativa*, Salamanca, v. 25, n. 1, p. 35-58, 2007.
- CORREA, C.; CUBILLÁN, F. *Manual de capacitación salud sexual y reproductiva*: desde una mirada de género. Maracay: IAESP Dr. Arnoldo Gabaldon, 2009.
- ESPOSTI, C. D. D. et al. Representações sociais sobre o acesso e o cuidado pré-natal no Sistema Único de Saúde da Região Metropolitana da Grande Vitória, Espírito Santo. *Saúde e Sociedade*, São Paulo, v. 24, n. 3, p. 765-779, 2015.
- FAIRCLOUGH, N. Teoria social do discurso. In: FAIRCLOUGH, N. *Discurso e mudança social*. Brasília, DF: Editora UnB, 2001. p. 89-132.
- FERREIRA, L. R.; ARTMANN, E. Discursos sobre humanização: profissionais e usuários em uma instituição complexa de saúde. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 23, n. 5, p. 1437-1450, 2018.
- FORD, C.; ENGLISH, A.; SIGMAN, G. Confidential health care for adolescents: position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*, Nova York, v. 35, n. 2, p. 160-167, 2004.
- GILSON, L. Aceitabilidade, confiança e equidade. In: MCINTYRE, D.; MOONEY, G. (Org.). *Aspectos econômicos da equidade em saúde*. Rio de Janeiro: Editora Fiocruz, 2014. p. 163-190.
- GLOBAL Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation. *World Health Organization*, Washington, DC, 24 set. 2018. Maternal, newborn, child and adolescent health. Disponível em: <<http://bit.ly/2NGachQ>>. Acesso em: 29 ago. 2019.
- HABERMAS, J. *Teoria do agir comunicativo*. São Paulo: WMF Martins Fontes, 2012. v. 1.
- HENRIQUES-MUELLER, M. E.; YUNES, J. Adolescência: equivocaciones y esperanzas. In: GÓMEZ, E. (Ed.). *Género, mujer y salud en las Américas*. Washington, DC: OPS, 1993. p. 46-67.
- HEREDIA-MARTÍNEZ, H.; ARTMANN, E. Criterios para la (re)distribución equitativa de los equipos básicos de salud en el nivel local en Venezuela. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 34, n. 10, e00171117, 2018.
- IÑIGUEZ, L. A análise de discurso nas ciências sociais: variedades, tradições e práticas. In: IÑIGUEZ, L. *Manual de análise do discurso em ciências sociais*. 2. ed. Petrópolis: Vozes, 2005. p. 105-160.
- KRUK, M. E. et al. High-quality health systems in the sustainable development goals era: time for a revolution. *The Lancet Global Health*, Londres, v. 6, n. 11, p. e1196-e1252, 2018.
- MADIES, C.; CHIARVETTI, S.; CHORNY, M. Aseguramiento y cobertura: dos temas críticos en las reformas del sector de la salud. *Revista Panamericana de Salud Pública*, Washington, DC, v. 8, n. 1-2, p. 33-42, 2000.
- MORLACHETTI, A. Políticas de salud sexual y reproductiva dirigidas a adolescentes y jóvenes: un enfoque fundado en los derechos humanos. *Notas de Población*, Santiago, v. 34, n. 85, p. 63-96, 2007.
- OMS - ORGANIZACIÓN MUNDIAL DE LA SALUD. *Salud para los adolescentes del mundo: una segunda oportunidad en la segunda década*. Ginebra, 2014.
- OMS - ORGANIZACIÓN MUNDIAL DE LA SALUD. *Estrategia mundial para la salud de la mujer, el niño y el adolescente (2016-2030)*: salud sexual y reproductiva, violencia interpersonal y desarrollo en la primera infancia. Washington, DC, 26 mar. 2018. Disponível em: <<https://bit.ly/2oBJqwl>>. Acesso em: 30 set. 2019.

ONU - ORGANIZACIÓN DE LAS NACIONES UNIDAS. *Objetivos de desarrollo sostenible (ODS)*. Nova York, 2019. Disponível em: <<http://bit.ly/2ZAZSho>>. Acesso em: 29 ago. 2019.

OPS - ORGANIZACIÓN PANAMERICANA DE LA SALUD. *Barrio adentro: derecho a la salud e inclusión social en Venezuela*. Caracas, 2006.

OPS - ORGANIZACIÓN PANAMERICANA DE LA SALUD. *Salud en las Américas 2007*. Caracas, 2007. v. 1.

OPS - ORGANIZACIÓN PANAMERICANA DE LA SALUD; OMS - ORGANIZACIÓN MUNDIAL DE LA SALUD. *Estrategia para el acceso universal a la salud y la cobertura universal de salud*. Caracas, 2014.

RIVERA, F. J. U. *Análisis estratégico en salud y gestión a través de la escucha*. Rio de Janeiro: Editorial Fiocruz, 2006.

ROA, A. C. Sistema de salud en Venezuela: ¿un paciente sin remedio? *Cadernos de Saúde Pública*, Rio de Janeiro, v. 34, n. 3, e00058517, 2018.

RODRÍGUEZ, J. *Reproducción adolescente y desigualdades en América Latina y el Caribe: un llamado a la reflexión y a la acción*. Madrid: OIJ, 2009.

THIEDE, M.; AKWEONGO, P.; MCINTYRE, D. Explorando as dimensões do acesso. In: MCINTYRE, D.; MOONEY, G. (Org.). *Aspectos econômicos da equidade em saúde*. Rio de Janeiro: Editora Fiocruz, 2014. p. 137-161.

UNFPA - FONDO DE POBLACIÓN DE LAS NACIONES UNIDAS. *Análisis sobre legislaciones y políticas que afectan el acceso de adolescentes y jóvenes a los servicios de SSR y VIH en América Latina*. Nova York, 2015.

VAN DIJK, T. A. *Discurso y poder*. Barcelona: Gedisa, 2013.

VENEZUELA. Extraordinario nº 5.494, de 20 de octubre de 2000. *Gaceta Oficial de la República de Venezuela*, Caracas, 20 out. 2000.

VENEZUELA. Ministerio del Poder Popular para la Salud. *Fundamentos de las normas de los programas de salud*. Caracas, 2012.

VENEZUELA. Ministerio del Poder Popular para la Salud. *Norma oficial para la atención integral en salud sexual y reproductiva*. Caracas: UNFPA, 2013.

VENEZUELA. Ley Orgánica para la Protección del Niño y el Adolescente (LOPNA). *Gaceta Oficial de la República de Venezuela*, Caracas, n. 6185, 8 jun. 2015.

VENEZUELA. Ministerio del Poder Popular para la Salud. *Plan nacional barrio adentro 100%*. Caracas, 2016.

Authors' contribution

Heredia collected and analyzed data. Both authors contributed to the study's conception, design, writing and final review of the article.

Received: 03/01/2019

Approved: 08/05/2019